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Power Dynamics in Doctor-Nurse-Patient Roles: Negotiating Decision Making for C-Section in Mardan, Khyber Pakhtunkhwa

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ABSTRACT

Aim of the Study: The relationship between doctor, nurse, and patient is a complex phenomenon in negotiating cesarean section (C-sections) decisions. Power dynamics are involved in doctor-nurse-patient roles discussing C-section decisions. This study explores the complex power dynamics in doctor-nurse-patient relationships when making a C-section decision.

Methodology: Using a flexible qualitative research design, the researchers ask how the authoritative and expertise-based relationship between doctor, nurse, and patient influences this negotiation and reshaping patients' decision for C-sections.

Findings: Authors found the involvement of power dynamics in the doctor-nurse-patient relationship discussing cesarean sections. Due to doctors' authoritative approach, a boundary of medical professionalism between doctors and nurses and a boundary of authority between doctors and patients were absent which affected patients' decision for a cesarean or vaginal delivery of the baby.

Conclusion: These findings may be used as valuable insights and guiding principles for healthcare professionals working in labour rooms, ultimately benefiting patients.

Keywords: Power Dynamic**,** Patient**,** Healthcare Professional, Cesarean Section, Normal Delivery.

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Introduction

Understanding C-Section

A C-section alternatively known as a cesarean section is a procedure where the delivery of a baby is made possible through a surgical procedure (Simões *et.* al., 2021). The birth of a baby is made possible through making an incision in the mother's uterus and abdomen (Gudu & Bekele, 2015). The obstetrician performs a c-section when normal vaginal delivery is not possible. Memon *et.* al., (2023) identified different indications of c-section, such as prolonged labour, fetal distress, scare, and maternal medical conditions. Obstetricians must consider these indications before performing a cesarean delivery. There are different types of c-section. Emergency c-section is performed in urgency when the patient goes through a

life-threatening situation (Maneschi, 2017). Elective c-section refers to the convenience and personal choice of the patient. However, a planned c-section is performed for medical reasons (Elnakib, 2019).

C-section involves various risks, such as creating complications in future pregnancies, the patient undergoing a long-time infection, bleeding, fever, adhesions, and influencing future pregnancies (Tinelli, 2023). It causes the death of a patient if the procedure is not proper and any medical error occurs during the process. Obstetricians, staff nurses, and operation theatre (OT) staff have a critical role in c-sections. Adequate coordination among these stakeholders and shared responsibilities are of great significance to C-sections (Andrews, 2023). Besides, a C-section has various benefits, such as the mother's convenience, reducing the risk of vaginal prolapse, and reducing the risk of certain medical conditions (Sethi, Rajaratnam, & Abdullah, 2023). The recovery process after a C-section takes 3 to 4 days in which hospital stay remains mandatory. Wound care and pain management are crucial during the patient's stay in the hospital (Sardimon *et.* al., 2022). Besides, the above-discussed risks and benefits, every patient experiences the C-section differently. These experiences are influenced by the roles and relationships among doctors (obstetricians), nurses, and patients. Power dynamics in these relationships while making a C-section decision cannot be denied. Murata (2014) has revealed doctors' influence on patients making a C-section decision. The forthcoming sections discuss how and what role is played by doctors, nurses, and patients, and what power dynamics are involved among these stakeholders in making a C-section decision.

Role of Doctor in Making C-Section Decisions

The literature thoroughly discussed the role of a doctor (obstetrician) in making C-section decisions (Panda, Begley, & Daly, 2018). Going through various technical and medical grounds, the doctor decides whether to perform or not a cesarean section. The doctor considers the informed consent of the mother before performing a C-section, examines the health of the baby and mother, assesses labour involved in the delivery, looking the medical history of the mother with previous surgeries, understands post-operative care, considers risks and benefits of the C-section compared to normal delivery, and finally documents the decision-making process before heading to the cesarean section (Berghella, 2022). The literature revealed these general standard procedures and techniques followed by the doctors before performing a C-section. However, in reality, these procedures are quite contextual and more complex. The medical infrastructure and resources available to the doctors and patients in one context may not be available to others across different contexts. Ramani, Sivakami and Gilson (2019) indicated that contextual factors, for example, primary healthcare facilities, lab examination, doctor's expertise and surgical equipment influence the role of doctors in making C-section decisions. Ideally, the doctor's role must prioritise the health of the mother and baby when making a C-section decision based on their medical expertise and professional judgements (Eide & Bærøe, 2021). However, a doctor's role is contextual in reality due to various personal, institutional, and managerial factors while making C-section decisions.

Significantly, in this context, the role of doctors in making C-section decisions in private hospitals in Mardan, Khyber Pakhtunkhwa is different. Doctors' authoritative approach to nurse and patient influences C-section decisions. They (the doctors) mostly look to make the money instead of making the judgement for C-sections on medical and professional grounds. Literature reveals that patient willingness is one of the factors that influence doctors' decisions for C-sections instead of making it on medical and professional grounds (Diamond-Brown, 2018). However, our study indicated that medical professionals, such as doctors, nurses along private hospital management create an environment where patients are left with no other options except a cesarean section. Bendtsen (2023) argued that normal delivery is effective for mother and baby both. Our study presents a dissimilar situation explaining doctors' authoritative approach in making C-section decisions instead of focusing on mother and baby health.

Nurses' Role in Making C-Section Decisions

Nurses and doctors occupy identified roles while going through a joint venture of performing C-sections. Preliminary, nurses provide constant care and intensive attention to the baby and mother during labour (World Health Organization, 2018). They monitor the patients during nursing and inform the doctor if complications arise. Nursing is significant in assessing the mother's and baby's health condition. Hane *et.* al., (2015) concluded an undeniable role of nursing in discussions about deciding cesarean sections. Of great significance is the nursing role to prepare the mother and his family for the cesarean process. Educating the mother and providing emotional support to her is indispensable in nursing (Lauwers & Swisher, 2015). Nurses' role also remains paramount in the operating room during the cesarean process. Burke and Allen (2020) have recognized the importance of nursing in post-operative complications. Nurses vigilantly monitor mothers going through the cesarean process and inform the doctor if any complication arises.

Generally, nurses do not make a final decision for cesarean sections. However, their suggestions and recommendations are valued in the decision-making. They bridge the doctors and mothers through their close work with both which is why their input and observations are undeniable in the cesarean process. Nurses' role is crucial in finding maternal complications, such as fetal distress, hypertension, placental abruption, and gestational diabetes (Fant & Tucker, 2023). They advocate for the mother's choices and preferences and communicate to the doctors and other stakeholders involved in the C-section process. For instance, nurses assist doctors and other healthcare professionals in post-operative care, including supervising food, exercise, and medication recommended by the doctors (Herbert *et.* al., 2017). In sum, these are the general roles and responsibilities nurses perform before, during and after the cesarean process across the contexts. However, contextual variations cannot be denied in this discussion.

Role of Patient in Making C-Section Decisions

The patient has a crucial role in deciding whether to go or not through a cesarean section. Patients have the right to informed consent for C-sections. They have the right to intensive care and whether to go through a cesarean section or not (Srinivasan, 2020). Autonomy, education, and informed decision-making are the other aspects of a patient making a C-section decision. Montanari Vergallo, Ricci, and Gulino (2023) believe that a patient should be autonomous in making an informed decision aligned with her beliefs and preferences. Patient's knowledge and information about the risks and benefits of C-sections is significant in this context. This plays a paramount role in shared decision-making between patients and healthcare providers (Simiyu, 2022).

Likewise, the support system is undeniable in this discussion. Emotional support from family and friends makes the patient role effective in decision-making about the cesarean section (Story, 2022). The patient's clarification on questions related to C-sections is an important part of this discussion. Eide and Bærøe (2021) argue that patients' role may not be effective in decision-making about C-sections if they are not provided the opportunity to question the process. Some other aspects of patients' role in the decision-making for C-sections are also on the plate of discussion. For example, taking second opinion and refusal of treatment. Patients can seek an expert opinion if they are not satisfied with the doctor's or nurse's recommendations. In this connection, refusal of treatment or having a cesarean birth of the baby is the patient's right (Loke, Davies & Mak, 2019). Of paramount significance is the patient's role as an advocate for herself and the upcoming baby. A patient's effective advocacy can ensure a proper treatment and informed decision for having or not a cesarean birth of the baby (Stohl, 2018). In contrast to this discussion, contextual differences cannot be denied in this debate. How power dynamics are involved in affecting patient's role in decision-making for C-sections in the context of Mardan, Khyber Pakhtunkhwa are presented in the forthcoming section.

Power Dynamics in Doctor-Nurse-Patient Roles

Power dynamics are involved in the doctor-nurse-patient relationship negotiating C-section decisions in Mardan, Khyber Pakhtunkhwa. There is a lack of medical professionalism recorded in the boundary of profession between doctors and nurses. Doctors often do not accommodate nurses' opinions in negotiating a C-section decision. They instruct nursing staff about cesarean sections to be followed and communicated to the patients. This situation prevails in another context also. Johnson (2022) found doctors approach authoritative where nurses instruct them and sometimes do not hear back from them when negotiating C-section decisions. In the hierarchy, the doctor holds a higher authority which creates an imbalance in communication with nurses influencing C-section decisions. Nurses in Mardan face do not feel comfortable collaboratively working with the doctors because of authoritative boundaries. It is believed that clear communication between doctors and nurses confirm constant information and care for patients going through the discussion for cesarean cases (Schmiedhofer *et.* al., 2021). However, this has been influenced by doctor's authoritative behaviour with the nurses.

Similarly, a doctor's authoritative approach influences patient's decisions about their C-section decisions. Patients believe seriously in doctors' opinions because they hold an authoritative position in this conversation of C-sections.

Methodology

Since this research is grounded in a particular context of private hospitals dealing with baby delivery cases in Mardan, Khyber Pakhtunkhwa, it uses a qualitative research design comprising a constructivist grounded theory approach. Researchers have used three different interview guides for each group of doctors (obstetricians), nurses, and patients. These participants were purposively selected. Doctors were asked about their roles in C-sections, what they focus and how they negotiate with both nurses and patients when making a C-section decision. Researchers then asked nurses about their role in making a C-section decision and how they bridge the relationship between doctors and patients when making C-section decisions. To gather patients' personal stories, we asked them about their knowledge regarding the risks and benefits of C-sections communicated by doctors and nurses. The patients were also asked about the vulnerability they had regarding C-sections and their say in making a C-section decision. Lastly, researchers asked doctors, nurses, and patients about their relationship during making a C-section decision. Our female research collaborator (Hiba) played a significant role in data collection while conducting in-depth interviews with the participants. Using these interview guides, we collected the data from 9 obstetricians, 9 nurses, and 9 patients. We analysed the data by finding some repeated phrases, concepts, and trends, which we used further to organize and recognize the answers from each group. We used NVivo for coding the data and some codes were manually created.

Initially, researchers created a four-part structure. These parts were the doctor-nurse relationship, nurse-patient relationship, doctor-patient relationship, and doctor-nurse-patient relationship negotiating C-section decisions. This allowed us to have the opinions of doctors, nurses, and patients distinctly. This also helped us in creating categories in connection to all these three groups. Researchers observed the differences in opinions agreements and disagreements in making C-section decisions. This resulted in the creation of the following themes. Using pseudonyms, each of the following themes has direct quotes from the interviews with the doctors, nurses and patients. Some of the quotes have been amended to make corrections for grammatical mistakes; however, efforts have been made to keep the originality and integrity of the participants' opinions.

Discussion and Results

Doctor: Healthy Mom Healthy Baby

A common phrase that frequently arose from the interviews with the doctors (obstetricians) was the purpose of having a "healthy mom and healthy baby". It was the guiding principle of providing intensive care to the patients while having a normal or cesarean delivery. The ultimate goal for the doctors was the

safe and healthy delivery of the baby. The means of justification whether the baby is delivered vaginally or through C-section, secure delivery of the baby and the good health of the mother were the guiding norms. Generally, this approach seems very rational and workable. However, some mothers think the other way around. They believe that a "healthy mother and healthy baby" should not be the only principle because the delivery process can create other complications even if the physical safety of mother and baby is ensured.

From a doctor's perspective the notion of "healthy mom and healthy baby" is the outcome of the discussion held among doctor, nurse, and patient for deciding a cesarean section. In the context of private hospitals of Mardan, doctors claim that most women don't opt for C-section and demand more time for a vaginal delivery ignoring the severity of the case. An obstetrician in a private hospital indicated that:

> *"I tried for a normal delivery last night for 8 long hours but was unsuccessful and went through a cesarean process at the end. All this happened because the patient insisted on the normal birth of the baby although he was educated about the severity of the case"* (Droctor Rehana).

Even though doctors communicate with the mothers directly and through nurses that C-section is a safe method and it gives the desired results still, they (mothers) are reluctant to choose a cesarean birth of the baby. The doctor takes time and tries time and again to convince the patient for a C-section to ensure the desired result of a "healthy mom healthy baby". For instance, Doctor. Noreen explains that:

> *"According to my professional responsibility, I have to convince my patient for a cesarean birth of the baby if that is safe and that is so hard and time-consuming. This happens because of the ignorance of the patient about her health and the baby."*

Most of the time, obstetrician focuses on the final product 'baby' and their decision of pathway would not affect the patient opinion of whether it is safe or not. Doctor Fouzia agrees with the outcome that: 'A cesarean birth of a baby saves mother and child both. The mother remains safe from vaginal bleeding, uterus pain, and labour pain'. Of paramount significance is the baby and mother's health. Doctor Sultana explains that:

> *"I don't get confused about patients' opinions regarding deciding on a C-section because they (patients) are not aware of the medical complications if a normal birth is not possible. Most of the patients don't know about fatal distress. If the baby is unable to tolerate the labour then C-section remains a natural selection. In this context, it remains the prime responsibility of the doctor to convince the patient for a healthy mom and healthy baby."*

Some of the time women contrast the doctor's opinion by arguing that a "healthy mom and healthy baby' should not solely be considered. Many mothers waste an amount of time by insisting upon the normal delivery of their baby. Oakley (2018) concluded the same results from a study that mothers waste time and push their and the baby's health into danger by rejecting C-sections. Prolonged labour and maternal health conditions put the mother and baby at risk. Doctor Nadia explains that 'if the labour is not progressing and mother is experiencing medical complications then we do not take risk by considering how much the patient is insisting for a normal birth of the baby'.

Obstetricians argue that if the mother is not healthy physically and emotionally, the normal birth of a baby may not be possible and the baby can be born with disabilities which can affect the mother and child bond. Mothers do not agree with this and they consider this as a story. However, doctors know the reality behind this scene. Doctor Rizwana explains 'I have seen many babies born with disabilities because mothers were insisting on normal deliveries and that was not possible'. This conflict between doctors and

mothers remains common. Doctors know the technicalities of opting for a C-section while mothers are afraid of this process. Betran *et,* al., (2018) concluded that doctors' fear is based on the safety of the mother and baby that's why they prefer cesarean sections. So, the above discussion clarifies that doctors always focus on 'healthy mom healthy baby' which remains an unacceptable reality and a source of conflict between doctors and patients.

Nurse: Bridging Doctor and Patient Relationships

Nurses as medically important stakeholders play a vital role in making C-section decisions while bridging the relationship between doctor and patient. They bridge the discussion between doctors and patients for making C-section decisions. The risks, benefits, and recovery process are determined in this discussion. Nurses' effective communication with the doctors and patients makes the initial agreement for C-sections possible. Doraiswamy *et.* al., (2021) argued that open communication between nurses and doctors and nurses and patients is undeniable in the decision-making for C-sections. This bidirectional role of nurses eliminates patients' unnecessary fear about C-section decisions. Zeenat, a staff nurse from a private hospital in Mardan explains that:

> *"I understand that effective communication between doctors and patients is not possible without nurses when deciding C-sections. Daily, I deal with mothers who disagree with the C-section process but when I effectively communicate with them about the safe and beneficial C-section, they agree."*

Of paramount significance is the power dynamics involved in the bridging role of nurses between doctors and patients. Nurses, sometimes on technical grounds disagree with the doctor's decision about C-section but due to the doctor's authoritative position, nurses still have to communicate that decision to the patients. This shows the absence of a boundary of professionalism between doctors and nurses. Ford (2017) considered this doctor-nurse authoritative relationship as unproductive in the decision-making for C-sections but nurses are professionally bound to obey the doctors. Many nurses in this study talked about the similar doctor-nurse authoritative relationship. For example, Marwa indicated that:

> *"Once the doctor called me and told me to prepare the patient for a C-section as she was leaving the hospital and was unable to wait for the vaginal delivery of the baby. I was aware that the baby can normally be delivered but I was compelled in the hierarchy to communicate the same to the patient."*

This case proves doctor-nurse relationship in the C-section discussion as an authoritative one where a boundary of professionalism is crossed by the doctors. Another nurse working in a private hospital explained that *'doctors sometimes indirectly stop us from talking to the patients about the benefits of a vaginal delivery of a baby even in the cases when it is possible'*. Similarly, Haseena, a staff nurse working with a senior obstetrician shared that:

> *"A patient came from a very far area insisting on normal delivery of her baby and it was possible according to my knowledge. When I communicated the initial investigation to the doctor, she denied the vaginal delivery as the doctor was leaving for home."*

Many nurses who worked with senior obstetricians in private hospitals at Mardan for many years have similar doctor-nurse authoritative experiences. Shaista indicated that *'we always obey the doctor's orders in deciding whether to have a vaginal or cesarean delivery of baby because it's a question of our survival in the hospital'*. Similarly, Wolf (2018) has concluded that nurses have to obey doctors in making C-section decisions because it is necessary for their jobs in the hospital. It is believed that nursing bridges effective communication between doctors and patients making C-section decisions but doctors'

authoritative approach to nurses and patients makes it unserviceable sometimes. Staff nurse Safia pointed out:

> *"Doctors in our hospital very rarely voice our opinions even when we are right in our opinions to have a normal or cesarean delivery of the baby. This happens because doctors are more authoritative than us in the hierarchy."*

Another nurse shared that *a few weeks ago we went through a cesarean section at midnight in which normal delivery was possible but the doctor decided to go for a C-section.* In the same context, Bilal, Aiman, and Hussain (2023) found that women nurses face many structural barriers to their professional lives when caring for patients. Communication between doctor, nurse and patient is a crucial part of discussion when deciding a C-section case. Nurses' bridging role is undeniable in this communication; however, the doctor's authoritative behaviour makes this insignificant. In sum, the nurse has a significant role in being a line of communication between doctors and patients, however, doctors have made this role an insignificant one by their authoritative approach to nurses.

Patient: Limited Knowledge, Vulnerability, and Powerlessness

Limited knowledge about C-sections, vulnerability, and powerlessness were common phrases noted from the interviews with the patients. A boundary of authority between doctor and patient was absent in this context. Patients' knowledge about the risks and benefits of cesarean sections is of paramount significance, however, it was affected by doctor's authoritative approach. The limited knowledge of patients about the risks and benefits of C-sections created vulnerability among patients and they remained powerless in making a C-section decision.

Patients reported that we do not have enough knowledge about the benefits of normal delivery and a cesarean one. It makes us weak in deciding about the C-section decisions. One of the patients reported that *in my last C-section when the doctor through the nurse asked me about the C-section, I replied that I don't know about that and you could decide on your judgement.* This was extended by another patient in his interview that:

> *"I am an uneducated woman who knows very few things about the advantages and disadvantages of cesarean section or normal delivery of the baby. Last time, when I was going through a second C-section, the doctor asked me about cesarean section and I left it to the doctor's judgement because I had little knowledge about that."*

The knowledge of patients about C-sections plays a significant role in deciding about cesarean-section decision-making (Sultana *et*. al., 2022). However, this study finds little knowledge among patients about the advantages and disadvantages of C-sections. Noreen, a patient who has been through a C-section recently shared *this was my first cesarean section and I was not aware of the disadvantages of a C-section.* Normally, the doctor has to brief the patient about the advantages and disadvantages of C-section and normal delivery of a baby, however, in this case, the doctor failed to inform her about that.

Vulnerability among pregnant women has commonly prevailed when deciding about a cesarean section (Karim *et.* al., 2020). They think about the surgery process and the baby's health. Improper communication among doctors, nurses, and patients is a dominant reason behind this phenomenon (Todd, 2016). Similarly, this study finds that vulnerability among participants near the delivery time of their babies is common. Many participants shared that they remain undecided about the delivery of their baby through C-sections because of the physical and psychological vulnerabilities of their health. Shabana, one of the patients indicated that:

> *"I was distressed when making a C-section decision because of my health. The doctor was in a hurry and through the nurse she informed me*

> *to decide quickly. I was nervous and emotionally upset because of the multiple worries involved in this process."*

Some participants reported about the social and cultural vulnerabilities involved in the C-section process. They talked about social vulnerability in terms of the social support a patient needs after having a C-section. One of the women revealed that *I have vulnerable feelings about my C-section because I don't have a suitable family member for my social support after the C-section is done*. Cultural vulnerabilities are also undeniable while having a cesarean section (Nyarkoaa & Boateng, 2022). Similarly, this study finds that societal pressure is common in the area to have a vaginal birth. C-section is considered a stigma in *Pakhtun* culture. One of the women shared that *I was worried about my C-section because then people in the family would stigmatize me.*

Of significance is the patient's powerlessness when deciding about a C-section. Many participants' opinions show that they are powerless when they decide C-section. One of the patients indicated that *I felt powerless last time when decided on a C-section because the doctor had communicated with me in an authoritative way* (Sameena). Similarly, another participant shared:

> *"A nurse came to me and communicated that the doctor was going to have a cesarean section. I replied to kindly wait for the normal delivery but the nurse replied that the doctor says that she would not be responsible for any medical complication if it is delayed."*

Several participants explained that doctors' authoritative behaviour makes us powerless in the decision-making about C-sections. Doctors directly or sometimes through nursing staff communicate a worrisome situation where we are left with no option other than a cesarean birth of the baby. Shabana, a mother of the cesarean baby revealed that *'my C-section is done in a hurry situation because the doctor made such situation and I felt myself powerless in that scenario'.* In sum, the discussion proves that in most cases, the patients remain powerless when deciding about the C-section or normal delivery of their babies.

Conclusion

The analysis presented in this article gives us three dimensions in conclusion about the power dynamics involved in doctor, nurse, and patient roles negotiating C-section decisions. Firstly, it found the dimension of the doctor who is primarily focusing on a "healthy mom healthy baby" notion. We found from the analysis of interviews held with the doctors that they use their expertise and making C-section decisions having a safe birth of the baby and focusing mother's health as well. However, here an absence of the boundary of medical professionalism is noted between doctors and nurses. Due to this absence, there was a lack of autonomy in nursing which influenced the decision about C-sections because nurses' opinions were not considered by the doctors.

The second dynamic of power highlighted in this article is nursing as a bridging role between doctor and patient relationships in negotiating cesarean section decisions. Ideally, nurses should have an effective bridging role between doctors and nurses when making C-section decisions because they educate patients about the risks and benefits involved in cesarean sections. Nevertheless, it was affected by the absence of a boundary of medical institutionalism between nurses and patients. Here, the analysis concluded that doctors didn't hear patient's voices insisting on normal delivery as communicated by the nurses. Due to power dynamics between doctors and nurses, neither the nurses' opinions nor the patients' insistent on normal delivery communicated through nurses were considered by the doctors.

This article further emphasized the third dynamic of power in the relationship between doctors and patients when discussing C-section decisions. We found the absence of a boundary of authority between doctors and patients negotiating a cesarean section. Although doctors should effectively communicate with the patients educating them about the risks and benefits involved in C-sections here the reality is the other way around. Doctors crossed the boundary of medical authority by instructing the patients for cesarean sections instead of trying for a vaginal delivery of the baby. As a result, patients are left with

limited knowledge about the risks and benefits of C-sections which affects the notion of a "healthy mom healthy baby". Vulnerability among patients about their health and baby was common because of the authoritative doctor-patient approach. Patients felt powerlessness in this relationship with the doctors negotiating to have a cesarean or vaginal delivery of their babies. This research may offer valuable insights and guiding principles for healthcare professionals working in labour rooms, ultimately benefiting patients. Future research may focus on the context preferability of these findings in other parts of the country.

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