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Factors influencing obstetricians' acceptance of termination of pregnancy beyond the first trimester: a qualitative study

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Abstract

Background In Belgium, termination of pregnancy after the first trimester is exclusively allowed on medical grounds. When faced with fetal or maternal health complications during pregnancy, patients typically turn to obstetricians for guidance on the diagnosis, prognosis, and available options. Patients' decisions and their actual access to termination of pregnancy can be profoundly influenced by the quality of this counselling and the willingness of professionals to present termination as an acceptable option. This paper aims to explore the factors influencing obstetricians' acceptance of TOP requests after the first trimester of pregnancy. We subsequently analyze these acceptance dynamics from a multidisciplinary angle, incorporating ethical perspectives and a socio-legal exploration into how the interviewed health professionals experience, interpret, and apply the law.

Methods We conducted an interview study with 23 hospital obstetricians who had prior experience with termination of pregnancy decision-making beyond the first trimester in Flanders, Belgium. Interviews, on average, lasted 1h30 and followed a semi-structured format guided by a topic guide. The transcripts were coded with NVivo software and subsequently thematically analyzed by a multidisciplinary research team to provide a comprehensive understanding of obstetricians' acceptance of termination of pregnancy after the first trimester.

Results Obstetricians' acceptance of termination of pregnancy after the first trimester mainly depends on the presence of compelling clinical factors. Secondary factors, including patient/couple preferences, institutional and collegial processes, timing and viability, technical considerations, obstetricians' ethical and professional values, the wider background of the patient/couple, and perception of alternatives, could sway decisions in the absence of compelling clinical factors.

Conclusions Secondary factors help sway obstetricians' decisions in favor of or against termination of pregnancy after 12 weeks when a request is characterized by inconclusive clinical factors. The multifactorial acceptance dynamics of obstetricians illustrate the limits of a strong emphasis on fetal interest argumentation. Moreover, they exhibit a degree of divergence and complexity absent from the Belgian Abortion Law. The presented typology of factors could stimulate and guide debates on legal reform and the importance that should be attributed to various factors in professional decision-making on termination of pregnancy.

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Background

Pregnancies affected by a maternal or fetal health problem often involve complex ethical and clinical decisions. Although the pregnant patients are the pivotal decision-makers in this regard, they rely on health professionals to counsel them on the diagnosis, prognosis, and legally available clinical options. In Belgium, abortion legislation allows termination of pregnancy (hereafter: TOP) upon request of the pregnant woman up to 12 weeks of pregnancy[1]. Performing TOP after 12 weeks, however, is only lawful when the future child is certain to suffer from a 'particularly severe and incurable condition' or when the continuation of pregnancy poses a 'severe threat to the pregnant woman' [1]. If an abortion is carried out after 12 weeks in the absence of these medical circumstances, criminal sanctions may be imposed on both the abortion-seeker and the abortion provider. The Belgian Abortion Law requires healthcare providers to assess the fulfilment of the legal conditions prior to performing TOP after the 12th week of pregnancy. This assessment could be challenging considering the open phrasing of the law and the level of uncertainty affecting fetal-maternal medicine at large. Understanding health professionals' values in this area of TOP decision-making is crucial since these may determine the information that patients receive and the services they are granted access to.[2]

While numerous studies have investigated parental[3] decision-making on TOP for medical reasons, much less is known about the attitudes and views of health professionals [3–10]. Research highlights the complex ethical nature of professional intervention after diagnosing fetal anomalies [11–16], illustrating a lack of consensus about the prognosis and severity of certain fetal conditions and about the latest gestational age at which TOP for these conditions may be acceptable [17–24]. In some countries, TOP for certain anomalies, including trisomy 21 (Down's syndrome), is widely accepted by professionals without prior debate [25], although the viability of the fetus may reduce TOP acceptance [26, 27]. Research has also indicated that physicians' decision-making processes are influenced by their personal opinions [28] and by the perspectives of colleagues within the unit and of other consulted specialists [25, 29]. Studies on feticide[4] have demonstrated that healthcare professionals perceive feticide as a challenging yet necessary aspect of performing late TOP [32–35].

Few studies have examined health professionals' acceptance of TOP on medical grounds in the second and/or third trimester of pregnancy in the Belgian context. One study indicates positive attitudes from neonatologists and neonatal nurses toward so-called 'late' (= post-viability) TOP in cases of severe or lethal fetal anomalies [36]. Lower professional support rates are reported for late TOP when the pregnant person is affected by a severe psychological condition (15% agreement) [36]. In 88.3% of the studied TOP cases, physicians believed that the underlying fetal anomalies could be classified as either serious or very serious (understood as incompatible with life outside the womb or resulting in severe neurological or physical impairment) [2].

This qualitative study of obstetricians' acceptance of second and third trimester abortion in the Belgian context addresses important research gaps. Most studies in this field are focused on TOP for fetal conditions, leaving TOP for maternal health reasons out of scope. In addition, the majority tends to concentrate on (the perceived severity of) clinical factors, often only briefly touching upon non-clinical factors that may influence professional attitudes and decisions. These studies provide a (predominantly quantitative) overview of professionals' acceptance of TOP but do not explore the multitude of factors *explaining* TOP acceptance rates. In the specific context of Belgium, research on professional attitudes towards TOP would provide an interesting angle for comparative analysis and help close a major research gap in the country. Laws and guidelines from countries where most of the on-topic research has been performed (e.g. the United States[5], the United Kingdom, and Canada) allow abortion on relatively broad grounds up to gestational age limits at or near fetal viability. In contrast, Belgium adopts a first trimester limit for abortion on request but makes no reference to viability. Studying Belgium offers a unique opportunity to explore how viability and advanced gestational age influence health professionals' acceptance of medically indicated TOP beyond

[1] In the Belgian Abortion Law the 12 weeks are dated from conception.

[2] Recent research highlights that, in 26% of studied cases of post-viability TOP in Flanders (Belgium), the option of TOP was first suggested by the physician rather than spontaneously requested by parents [2]. This underlines the important role that health professionals play in informing patients on the availability of TOP.

[3] Although we acknowledge that pregnant individuals and their partners are not mothers/parents in the legal sense, we use the terms 'parental' and 'maternal' in this paper due to its common use in medical practice and literature concerning high-risk pregnancies.

[4] In this paper, in line with the use of terminology we observed in our interviews and in literature, we understand the term feticide as referring to the intentional administration of lethal injection to cause fetal death *in utero*, preventing live birth after medically induced termination of pregnancy [30–33].

[5] Before the US Supreme Court decision in 2022 in *Dobbs v. Jackson Women's Health Organization*, the Supreme Court had recognized a state-binding constitutional right to abortion up to viability (specifically in its previous judgments *Roe v. Wade* and *Casey v. Planned Parenthood*).

the first trimester in a context where no law or formalized guidelines impose a time limit around the point of viability. Furthermore, studying Belgium may offer valuable insights for comparative perspectives by shedding light on approaches to TOP in the absence of institutionally standardized policies and professional guidelines. In contrast to other jurisdictions that have dominated academic literature, Belgium lacks national and regional guidelines on professional TOP decision-making or the application of the law. Finally, to our knowledge, no qualitative research on the subject matter has previously been conducted in Belgium, nor the region of Flanders. The decision-making process surrounding TOP is inherently complex, involving nuanced ethical, medical, and personal considerations. A qualitative approach allows for an in-depth exploration of these complexities, providing rich insights into how health professionals navigate such sensitive decisions. The few (quantitative) studies performed in Belgium and abroad, which focus on numerical data, do not capture the complexity of underlying dynamics shaping health professionals' acceptance of TOP. These observations underscore the need for a qualitative study within this local context, marking it as the first study of its kind.

The main objective of this study is to capture and explain the complexity of professional TOP acceptance through identification of influencing factors. Generally aligning with a Grounded Theory approach [37], we theorize what factors drive obstetricians' acceptance of TOP after the first trimester. We understand 'acceptance' broadly, capturing both the willingness to recognize TOP (after the first trimester) as a justifiable intervention and/or to perform TOP in a given situation. In the discussion section, we subsequently examine these multifactorial acceptance dynamics by drawing on literature from different academic fields, with a primary focus on (medical) ethics and law.

Table 1 Characteristics of the obstetricians who participated in the study

		N
Age		
	30–39	8
	40–49	5
	≥ 50	10
Gender		
	Male	8
	Female	15
Years of professional experience		
	< 5	1
	5–10	6
	11–19	6
	≥ 20	11
Frequency of involvement in TOP decision-making		
	on a weekly basis	13
	on a monthly basis	5
	less than on a monthly basis	5
Involved in performing feticide		
	No	15
	Yes	8
Hospital type		
	With NICU	12
	Without NICU	11

Methods

We conducted semi-structured interviews with 23 hospital obstetricians in Flanders, Belgium. We selected obstetricians from Flemish hospitals[6] who had previously been involved in decision-making regarding TOP beyond the first trimester. Through the research team's academic network and a targeted internet search, we purposively contacted obstetricians by email. In addition, we asked department heads to contact potential participants through email and applied snowball sampling at the end of the interviews. To reflect a variety of institutional practices, we selected participants from hospitals with neonatal intensive care unit (NICU) (which tend to be larger hospitals with academic ties) and from hospitals without such a unit. We contacted 40 potential participants, 23 of whom agreed to participate in an interview. Operating in eight different hospitals in total, 12 of the 23 participants operated in hospitals that have a NICU and 11 operated in hospitals without a NICU. Other relevant characteristics of the participants were obtained through a small questionnaire at the onset of the interview and are included in Table 1. Most interviews (21/23) were conducted via online video meetings due to COVID-19 safety restrictions (2020–2021). The interviews lasted 1h30 on average and involved the use of a semi-structured topic guide[7]. All the interviews were performed by a duo consisting of the first author (legal researcher) and one of the co-authors (a psychologist, ethicist, or sociologist, in alternating composition). To maintain consistency, the principal researcher attended all interviews, observing and addressing any varying emphasis to align with the study's core objectives. Moreover, through our team's multidisciplinary makeup, regular feedback sessions, and the rotation of interview pairings, we maximally mitigated unintentional bias.

[6] Note that two interviews were conducted with obstetricians working in hospitals in Brussels, which is formally not part of the Flemish region.

[7] The interview consists of two parts (part 1 and 2), of which this study only reports responses to part 1. The semi-structured topic guide has been translated to English and was uploaded as a supplementary file. Part 2 of the interview [not reported in this study] deals with the obstetricians' experiences with and views of legal requirements, such as the 12-week time limit for abortion on request and the 6-day mandatory waiting period.

The topic guide began with general questions about obstetricians' familiarity with termination of pregnancy and the factors influencing or complicating their assessment of TOP requests beyond the first trimester. It then shifted focus to factors specifically relevant to TOP in two contexts: fetal health conditions and maternal health conditions. We hypothesized that the following factors would be considered significant and used them to design our prompts: clinical, ethical, legal, social, timing-related, institutional, and experience-related factors. The discussion centered on two key open-ended questions:

A. What factors do you consider when deciding whether fetal conditions warrant or necessitate pregnancy termination after 14 weeks?
B. What factors do you consider when deciding whether certain conditions in the pregnant woman warrant or necessitate pregnancy termination after 14 weeks?

All the recorded interviews were transcribed *verbatim* by a professional bureau working under a confidentiality clause. The coding process began after the first five interviews, initiated by the principal researcher to refine the interview topic guide where necessary. The research team collectively coded and analyzed interview transcripts using NVivo software. To ensure reliability and minimize potential bias from a single coding method, one researcher also manually coded the transcripts. The team adopted the thematic analysis approach described by Braun and Clarke [38], which is well-suited for studies affiliated with Grounded Theory [39]. The principal researcher coded all transcripts to maintain a comprehensive overview of emerging themes, while four additional team members each coded approximately six transcripts. This process ensured that every transcript was double-coded by at least two researchers. The principal researcher then compared coding results across team members, resolving ambiguities through team discussions. These regular team debates facilitated consensus on the emerging themes and subthemes ('factors' in this study).

Results

Our analysis resulted in a typology of factors which influence obstetricians' acceptance of TOP beyond the first trimester. Our participants frequently aligned their views with the opinions of their colleagues/departments, implying that their acceptance of TOP can be more comprehensively understood as reflecting the acceptance dynamics prevalent within their hospital.

We identified the following nine factors as influencing factors: (1) **Clinical factors**; (2) **Factors related to background of patient**; (3) **Factors related to patient's request for TOP**; (4) **Factors related to the professional**; (5) **Institutional and team factors**; (6) **Technical factors**; (7) **Time-related factors**; (8) **Legal factors**; and (9) **Factors related to perception and availability of alternatives**.

We differentiate between major and minor factors using several criteria. These include the frequency with which factors recurred across interviews, the extent to which obstetricians introduced these factors without prompting, and the importance obstetricians appeared to assign to them. Additionally, consensus among obstetricians served as a key criterion, with major factors reflecting broader agreement across participants, while minor factors often represented more individualized or less universally endorsed considerations.

Compelling clinical factors relating to fetal and maternal health were identified as primary factors influencing obstetricians' acceptance of TOP beyond 12 weeks. These clinical factors stood apart from what we refer to as "secondary factors" due to their decisive nature; they were often sufficient on their own to ground TOP acceptance, overriding other considerations.

In addition to clinical factors, obstetricians identified a range of secondary factors that further influenced their acceptance of TOP. Secondary factors often merely reinforced the acceptance of TOP but could occasionally sway decisions when accompanying inconclusive clinical factors. Among secondary factors, several emerged as major influences on TOP acceptance, including: factors related to the patient's request for TOP, institutional and team factors, factors related to the patient's background, and factors related to the professional. Although there was substantial alignment between the legal framework and professionals' acceptance of TOP, we classify legal factors as a minor secondary factor due to the limited explicit references made to the (abortion) law by obstetricians. Additional minor factors include technical factors, time-related factors, and factors related to the perception and availability of alternatives.

The typology of factors driving obstetricians to consider TOP an appropriate clinical pathway in the second and third trimesters is shown in Table 2. For each factor, we identified influential sub-factors that were frequently mentioned by the obstetricians. The Results and Discussion sections delve further into the weight and direction of influence of these (sub-)factors, providing a more detailed analysis.

Primary factors: compelling clinical factors

Clinical factors relate to the presence and nature of a medical condition affecting the health of the fetus and/or the pregnant person. In line with the Belgian Abortion Law, obstetricians made a clear distinction between abortion requests motivated by clinical factors and those

Table 2 Typology of factors influencing obstetricians' acceptance of TOP after the trimester

Clinical factors	
	Presence of a fetal health problem
	Combined deviating test result + detectable physical defects
	Mortality risk
	Treatability - operability
	Type of health consequences: mental vs. physical impairment
	Perceived suffering and quality of life future child
	Level of certainty of (severe) prognosis
	Level of severity
	Presence of a maternal health problem
	Mortality risk
	Level of certainty of (severe) prognosis
	Level of severity
	Treatability - operability
	Type of health problem: somatic vs. psychological vs. social health problem
	Estimated effect of TOP decision on evolution of health problem
	Estimated level of prematurity and related issues for neonate
	Combination of maternal and fetal health problems
Factors related to background of patient	
	Impact on other children
	Care capacity and support network
	Patient or family member has the same condition
	Possibility to conceive again
	Socio-economic background
	Psychosocial vulnerability
	Mental vulnerability
	Forced, unwanted, or unplanned conception
Factors related to patient's request for TOP	
	Persistence and determination from patient - pressure on professional
	Wish of patient ultimately decisive
Factors related to the professional	
	- Ethical and professional values and role perception
	- Distancing from decision - non-directive counselling
	- Acknowledging interests of the future child
	- Acknowledging parental and family interests
	- Valuing consistency
	- Personally feeling (un)comfortable with performing TOP
	- Loyalty to patient as treating health professional
	- Past experiences
	- In professional life
	- In personal life
Institutional and team factors	
	Ability to refer patient and relinquish authority to decide to other institution
	Precedents - consensus has emerged in team/department/institution
	Protocols or agreements from team/department/hospital
	- Collective decision-making or advice process
	- Advice from specialist
	- (Multidisciplinary) team decision
	- Advice from Ethics Committee
	Types of specialisms involved in collective decision or advice organ
Technical factors	
	Positive experience with medical TOP
	- Perceived challenges of surgical TOP method or prior feticide (when considered necessary to perform TOP)

Table 2 (continued)

Clinical factors	
	- Technical challenges for health professional
	- Surgical TOP or feticide considered morally challenging
	- Health or emotional challenges for patient
Time-related factors	
	- Advanced gestational age
	- Increased certainty over clinical factors
	- Identical health condition, identical decision
	- Preventability of later timing of TOP
	Viability
Legal factors	
	Abortion/feticide (not) clearly permitted by the Abortion Law
	Risk of medico-legal complaints
	Flexibility of the Abortion Law
	Fetus is not a legal person before birth
Factors related to the perception and availability of alternatives to TOP	
	Adoption - psychosocial and financial support of patient/parents
	Birth and palliative comfort care
	Postnatal active end-of-life intervention

motivated by social factors, only accepting the validity of the former after 12 weeks. Acceptability of TOP for fetal health problems depended on the presence of clinical factors that the obstetricians perceived to be compelling. The majority of **TOP requests *for fetal health problems*** beyond the first trimester were regarded by the obstetricians as having a particularly compelling nature [2, 20]. Obstetricians mentioned an imminent or early-age mortality risk, high levels of expected suffering, and a poor expected quality of life for the future child as compelling clinical indications. Elements frequently presented as evidential of clinical severity, and thus, acceptability of TOP were the identification of congenital abnormalities[8]in combination with a deviating (genetic) test result, anticipation of severe intellectual impairment, and anticipation of high-risk/unpromising operative and curative options after birth.

Some fetal conditions were associated with more challenging decision-making and less professional consensus on the appropriateness of TOP. These challenges usually appeared in cases of isolated and manageable physical defects, conditions with an uncertain prognosis, or conditions that allowed for a reasonable quality of life in the perception of the obstetrician.

> *"The hardest part is when you do not have a clear-cut diagnosis and cannot suggest a clear-cut bad prognosis either."*

Examples mentioned by our respondents include isolated bilateral cleft lip, Turner and Klinefelter syndrome, cytomegalovirus infection with minimal or no visible fetal injuries, gastroschisis, corpus callosum agenesis, renal agenesis, some mild forms of spina bifida, and early ruptured membranes.

> *"[If you have] a kidney defect and the child has no additional amniotic fluid at 35 weeks. Then, you actually know the child will need to go on kidney dialysis, need a kidney transplant… Man, I find that very serious. In our team, most think that this is not serious enough."*

The clinical factors that obstetricians discussed mainly related to fetal conditions. TOP cases primarily grounded on a ***health problem affecting the pregnant individual*** were rarely spontaneously raised; an observation plausibly explained by its overall rare occurrence. Obstetricians considered such TOPs acceptable in case of life-threatening, somatic health conditions such as acute hypertensive disorders or severe cardiac issues. Support for TOP in case of a somatic condition affecting the pregnant patient was considered less straightforward when the impact of the continuing pregnancy and the process of birth/TOP itself on the prognosis of the pregnant patient's health was uncertain.

> *"I do remember a case where there was a serious vision problem for the mother and where the idea was that a pregnancy was going to cause that vision to drop sharply, hence the request to abort (…).*

[8] These anomalies affect the developing fetus' body parts, such as their heart, lungs, kidneys, limbs, or facial features.

However, there was also a lot of discussion about the vision being already impaired at that point (…), and about how well we could assess what impact it would have."

Obstetricians rarely mentioned mental health when considering the acceptance of TOP on maternal health grounds. When asked whether a TOP request could be granted after the first trimester for a severe mental health issue, strong disagreement and doubt about its legality were expressed. Some obstetricians automatically equated these requests with abortion requests for 'social' reasons, which are not legally permitted after 12 weeks, and felt no obligation to involve themselves in such cases.

"Someone who has severe cardiomyopathy whom we know will not survive the pregnancy or has a one-in-two chance (…). That is what it covers. However, it does not cover psychiatry; it does not cover (…) rape; it does not."

Others believed that at least some mental health problems (including suicidality) amounted to medical emergencies for which abortion could be considered. Some respondents indicated that in such cases the decision should not be made without consulting a multidisciplinary team, including a psychiatrist.

"Personally, I do think that there is a point to be made for that, provided that we examine the patient's physical condition. Then we can rely on, for instance, the psychiatrist and others who, together with us, could argue, 'Look, for this patient, it is emotionally so heavy that it is not feasible."

In certain scenarios, a **combination of clinical factors affecting fetal and maternal health** led health professionals to accept TOP after the first trimester. These fetal and maternal health problems were sometimes causally related or, alternatively, appeared simultaneously by coincidence.

"We performed a late termination of pregnancy a few months ago for a moderate form of hydrocephalus. The patient had a severe history of mental decompensation after the previous pregnancy (…), which influenced our decision to terminate the pregnancy."

In these 'combined' and sometimes inconclusive cases, obstetricians also more readily invoked secondary factors such as parental care capacities to justify TOP as an appropriate intervention.

"I think with an addiction problem, you have two factors, don't you? Extreme alcohol use or drug use can also have serious consequences for the unborn child. These consequences appear together with the [patient's] psychiatric problems and the fact of not being able to raise the child."

Major secondary factors

Obstetricians' acceptance of second and third trimester TOP could additionally be influenced by **secondary factors**. As noted earlier, these secondary factors primarily served to strengthen acceptance of TOP in scenarios where compelling clinical factors were already present, but could become pivotal in cases where maternal or fetal health conditions were inconclusive.

Factors related to the patient's request

Among secondary factors, **the patient's request for TOP** was strongly valued. Evidently, obtaining patient consent is legally mandated before any clinical intervention. Additionally, in cases where clinical factors did not provide a clear direction, the patient's request often functioned as a decisive criterion that could tip the balance in the decision-making process of the obstetricians.

"For the case of [agenesis of the] corpus callosum, we actually go along with the couple themselves a bit. If they say "look, we truly want a healthy baby, we can try again", then we will do it."

Some obstetricians also recounted rare cases where they felt pressured by patients or couples to terminate a pregnancy despite the absence of compelling clinical factors. These situations were described as challenging, as health professionals had to navigate a delicate balance between their commitment to supporting the patient/couple and their responsibility to prioritize termination only in cases of severe medical necessity. These cases usually required (multidisciplinary) team discussions to carefully weigh the decision to either grant or refuse TOP.

"In this case, there was some disagreement about whether it was serious enough. (…) However, they [the couple] persisted in their request. How do you deal with that?"

Factors related to the professional

Obstetricians' acceptance of TOP was directly and indirectly influenced by factors related to their own **ethical and professional values**, **role perception**, and **previous experiences**. Among ethical and professional values, respondents often referred to the "interests of the future child" as a paramount consideration, focusing on the

future child's suffering and wellbeing to determine the acceptability of TOP after 12 weeks [14].

> *"If parents choose a termination aimed at reducing suffering [of the child], then I think it is a good thing."*

While the future child's interests were frequently presented as a major factor influencing *parental* requests for TOP, these considerations thus also appeared to impact obstetricians' general attitude towards TOP. References to the future child's interests included both physical health and social-emotional interests such as the child's mental wellbeing and availability of care. Concerns about fulfilling these interests seemed to strengthen the acceptability of TOP and became compelling in more clinically ambiguous cases.

> *"The social and altruistic idea of 'we do not want to leave our son or our daughter behind with a very big problem in a very hard world when we are no longer here.' That becomes especially important when you are dealing with situations such as Turner syndrome or a rare skin disorder, where it is not 100% clear whether you are always doing the right thing by doing a termination there."*

In addition to placing emphasis on the interests of the future child, obstetricians also considered the interests of the parents, particularly when confronted with inconclusive clinical factors. The rationale behind considering parental interests covered a range of emotional, psychological, socio-economic, and other aspects, often intertwining with interest-of-the-child argumentation.

> *"There was a woman (…), who had no lower legs, and she had a child with the same issue, and she wanted a termination because she was called a dwarf all her life. (…) The ethics committee said look: with our full understanding, if she truly demands it, fine. [This was] at 28 weeks."*

Despite their potential legal accountability under the Abortion Law, obstetricians did not consider themselves as the ultimate 'decision-makers' in the area of TOP. Obstetricians firmly limited their role to non-directive counselling, delegating the authority to decide in more complex cases to the patient/couple, the wider team or an institutional body (see *infra* institutional and team factors).

> *"You cannot put yourself in the position of the parents to decide whether or not a termination can take place. However, you have to try to provide the best possible information."*

For obstetricians, the importance of consistency in the approach towards TOP was a recurrent theme when considering the appropriateness of TOP. This included consistency between different hospitals' policies, consistency in decision-making by one's own institution/team, consistency in decision-making for identical medical cases, and consistency in the attitudes and decisions of the pregnant person/couple.

> *"We also try, if there has been a certain case with a certain decision, to keep track of that. So that when it appears again, you can say: we did this the last time, we must remain consistent, right?"*

While consistency was highly valued, the case of late TOP for trisomy 21 illustrated the inherent tensions between the different demands for consistency. Some obstetricians reported a trend of increased acceptance of late TOP for trisomy 21 in their hospital, stressing that the condition does not change over time and that there is no upper gestational limit for TOP on medical grounds in the law. By contrast, others began to question their hospital's liberal policy on late trisomy 21 TOPs in view of the increased availability of prenatal tests. They called for a consistent commitment from parents to undergo these tests in a timely manner if they would contemplate TOP. Balancing these different demands for consistency was a central challenge in TOP decision-making after 12 weeks.

Institutional and team factors

Professional TOP acceptance, including willingness to perform TOP, was strongly impacted by **institutional and team factors**, such as (multidisciplinary) staff meetings and, in some cases, consultation of the hospital's Ethics Committee. Acceptance of TOP was influenced by the composition of these bodies, their prior decisions, and their established protocols. In most hospitals, collegial team discussion and the involvement of specialists were integral parts of all TOP decision-making processes, and the obstetricians' desire to feel supported by other health professionals was strongly underscored [25].

> *"I do not think anyone should decide alone on such things. Even if you are truly fantastic [at the job], it is always a team meeting. This is also because, obviously, we bear the responsibility. If I have to terminate, I want the whole team, everyone, to support me."*

When serious doubts about the acceptability of TOP existed, obstetricians delegated decision-making to a broader multidisciplinary team or an (ad hoc) Ethics Committee (see *infra* about how these institutional decision-making processes strongly relate to timing).

Alternatively, they asked a colleague at another hospital for a second opinion or referred the patient/couple to that hospital. Obstetricians reported subtle differences between the institutional policies of hospitals regarding the acceptance of more complex TOP requests. For instance, different policies were reported for TOP following late trisomy 21 or a Turner syndrome diagnosis [24, 26]. Despite these variations, obstetricians in our study generally asserted that variations between hospitals were minimal and that, over time, policies tended to converge.

> *"Over the years, the policy was developed that a trisomy 21, from the point of viability, is not interrupted in our centre. So we refer it, because it is a viable anomaly."*

Factors related to the patient's/couple's background

Furthermore, we identified **factors related to the patient's/couple's background**, comprising crucial subfactors such as economic circumstances and the capacity to provide care. Obstetricians perceived these factors as relevant to the decision-making processes of the parents and downplayed their significance in their decision-making on the acceptability of TOP.

> *"I think the main [factor] is the pathology, and I also think that the parents' care capacity is always taken into account. However, that is a very difficult one, and if the pathology is not serious enough, regardless of the parents' capacity, it [TOP] is not going to be approved in an Ethics Committee."*

Again, perspectives shared suggested that the likelihood that the patient's background could sway decisions was higher in scenarios where clinical factors alone were not considered inherently compelling.

> *"A mother with a low socio-economic background, having already had five pregnancies where five children have already been taken into care, also with spina bifida (…). If she asked for a termination, I would be more positive about it."*

Minor secondary factors

Time-related factors

Time-related factors influenced our respondents' acceptance of TOP after the first trimester. Advanced gestational age was associated with support for TOP after 12 weeks when it enhanced the certainty of clinical prognosis. Yet, it could also lead to diminished support as late TOP was perceived as posing greater moral and technical challenges. Obstetricians generally preferred terminating pregnancies as early as possible, stressing that later-stage abortions that result from poor prenatal diagnosis or parental rejection of testing could be prevented. In particular, the emergence of fetal **viability** as a specific time-related factor complicated obstetricians' acceptance of certain TOPs. In some hospitals, TOP requests for certain fetal conditions in the viable period would reportedly be declined, while similar requests would be approved in the previable period, indicating that a higher threshold of clinical severity was required for TOP as gestation progressed.

> *"What we tell people, more or less, is that you do not need an indication to do an abortion before 14 weeks, that you need a severe indication up to 23, 24, 25 weeks and that you need a life-threatening indication after 25 weeks."*

Despite viewing viability as a relevant ethical and medical threshold [40] and reporting varying institutional acceptance policies towards certain post-viability TOPs, the majority of our respondents personally disagreed with distinguishing pre- and post-viability TOP access for identical, severe fetal anomalies.

> *"So I don't agree with that [rejection of TOP for late trisomy 21], but you're part of a team, aren't you?"*

Technical factors

Technical factors, which cover the required and available abortion methods and their estimated impact on professionals and patients, mainly affected decisions on *how* and *where* a TOP would best be performed. Nonetheless, we found that the availability and perception of TOP techniques could ultimately play a decisive role in determining *whether* to perform TOP. Obstetricians found it more challenging to approve performing a TOP after the first trimester if it would involve a surgical intervention. Both surgical abortion after the first trimester[9] and the specific act of feticide[10] were described as distinct, potentially distressing, and more "active" forms of TOP interventions [32, 33]. In contrast, obstetricians were comfortable with medical methods[11] to terminate a pregnancy, perceiving it as more "passive" and "natural" ways of terminating a pregnancy.[12]

[9] During the surgical procedure known as dilation and evacuation (D&E), the cervix is medically dilated over a period of 24–48 h, and fragmented fetal tissue is later removed from the uterus using forceps. Belgian obstetricians are not familiar with this procedure, although some are acquainted with surgical abortion techniques in the early second trimester.

[10] Definition provided in footnote 5.

[11] Medical abortion concerns the preterm induction of labor using a combination of medicines (usually mifepristone and misoprostol), resulting in the vaginal expulsion of fetal tissue. If the fetus is viable, *in utero* feticide is performed before medical abortion to prevent live expulsion.

[12] To a certain extent, these perceptions bear analogies with the presumed ethical distinction between "passively" and "actively" causing death [37, 38].

> *"We all, and then I speak for a lot of colleagues here, become extremely nervous about a TOP after 12 weeks, and all of us are very supportive of vaginal delivery (…) instead of doing it surgically."*

Despite recognizing the necessity and importance of feticide in their profession, feticide impacted TOP acceptance dynamics in two ways. First, since some obstetricians/institutions lacked the technical skills to perform feticide, these requests were instantly referred to colleagues or other hospitals, often simultaneously relinquishing the authority to take a position on the acceptability of the TOP request itself. Second, in hospitals that performed feticide, requests for TOP which would require feticide were often subject to tighter scrutiny, typically requiring more compelling clinical factors, prior approval by a (multidisciplinary) team or Ethics Committee, or a combination of both. Hence, acceptance of TOP, especially in the absence of compelling clinical factors, was heavily dependent on a strong interplay between temporal, technical, and institutional factors.

> *"Before 22 weeks, it [TOP] is arranged in our center in such a way that it gets accepted more easily than later in the pregnancy, because afterwards more people are involved. Then, the subcommittee of the ethics committee, with other disciplines, with pediatricians (…), provides its opinion so that some cases do not receive approval, while they would have been more easily accepted it in the second trimester."*

Legal factors

Despite general awareness of and conformity with the law, obstetricians rarely grounded their (dis)approval of TOP by *explicit* reference to **legal factors**. Our respondents experienced the level of ambiguity in the legal provisions as a positive aspect that benefitted, rather than complicated, their decision-making on TOP.

> *"The fewer the rules, the more interesting it gets, precisely because it depends on the couple. (…) I am not in favor of a list of what can and cannot happen."*

Furthermore, most obstetricians refrained from spontaneously raising concerns over potential criminal scrutiny over their TOP conduct. In the rare cases where references were made to a so-called 'chilling effect', these references related to internal complaints from patients and colleagues rather than to the prospect of criminal prosecution by state authorities.

> *"If a child is viable and decisions are made, then you have to ensure that your team supports it. People can file a complaint, right? If a midwife says, "I do not think that is okay here", she can file a complaint against that."*

Although feticide was common, a few obstetricians doubted its legality and preferred to not use the term explicitly when registering a TOP with state authorities. This reluctance aligns with the reported hesitancy towards performing TOP in the viable period / if feticide was required.

Factors related to the perception and availability of alternatives

The acceptance of TOP after 12 weeks was influenced by **obstetricians' perceptions and the availability of alternatives to TOP**. Adoption and psycho-social support were frequently mentioned as preferable alternatives to TOP in cases of psycho-social or psychiatric maternal health problems, further decreasing the likelihood that TOP after the first trimester would be accepted in these scenarios. By contrast, adoption was not considered an appropriate alternative for TOP in cases of fetal anomalies and was never routinely discussed.[13] The presentation of TOP as being in the interest of the affected fetus re-emerged when evaluating these alternatives.

> *"I do not think there is anyone who wants to adopt a child with trisomy 21, and second, then I think you truly have a problem with those parents, right? (…) When they're interrupting their pregnancy with a baby that has abnormalities, that is out of love for that baby. You do not give a baby up for adoption out of love for that baby, that does not really fit into our narrative."*

Discussion

Obstetricians consider a complex interplay of factors when determining the justifiability of TOP beyond the first trimester. Building on relevant literature and the provisions of the Belgian Abortion Law, our discussion examines how these practical acceptance dynamics align

In the context of abortion, some authors have posited the idea that a person's right to terminate a pregnancy does not, per definition, entail a right to cause the death of a (viable) fetus [39–41]. However, these theories usually do not confront the issue through the lens of abortion techniques, nor consider (potential interests) of a future child affected by inherent or prematurity-related impairments. Further research may consider if and on what premises a right to TOP on medical grounds would cover a right to (or duty to use) a specific TOP method.

[13] This is remarkable since the Belgian Abortion Law obliges health professionals to discuss the option of adoption when TOP is requested. It should, nonetheless, be noted that some obstetricians mentioned other factors, including parental interests, to reject adoption as a suitable alternative to TOP for fetal anomaly. This included viewing it as a burden for the pregnant person to carry the affected pregnancy to term.

with ethical and legal perspectives on the justifiability of later-stage TOP.

Gradualism & 'fetal interests' argumentation

Our study found that respondents exhibited an increasing concern for fetal life as gestation advanced, a viewpoint commonly referred to in philosophical literature as a "gradualist" perspective on fetal moral status [41, 42]. Gradualism holds that the moral value of a fetus develops progressively over time as the fetus matures. While the general principle of gradualism is that early-stage abortions should face little to no restriction compared to those performed later in pregnancy, considerable debate persists regarding the appropriate onset and scope of restrictions for later-stage abortions. This debate was also reflected in our study, particularly in how obstetricians placed various emphases on time-related factors. On the one hand, obstetricians highlighted the challenges of accurately diagnosing and prognosing fetal conditions in earlier pregnancy. In alignment with the Belgian Abortion Law, they argued that timing should not play a role in the acceptance of TOP in such cases, emphasizing the need to provide patients and health professionals with the flexibility to delay TOP decisions until a more definitive diagnosis or prognosis is available. On the other hand, we observed that TOP was not consistently accepted among all institutions and regardless of timing in case of less settled conditions, including spina bifida, trisomy 21, Turner syndrome, and psychiatric health problems. Obstetricians exhibited varying degrees of willingness to grant TOP in these scenarios, particularly post-viability. Viability and gradualism have previously been identified in literature as influencing obstetricians views on moral status [40]. We found that moral and technical reservations surrounding viability and feticide may continue to restrict access to TOP on medical grounds even when such TOPs are legally available. However, we also observed that legal availability generally takes precedence over these concerns, ultimately driving TOP acceptance among professionals.

Furthermore, our study highlighted that the decision-making process of obstetricians in Flemish hospitals when contemplating the acceptance of termination of pregnancy after the 12th week is profoundly influenced by the anticipated impact on the future child. This perspective, commonly referred to as the 'interests of the future child' or 'fetal interests' argumentation, seeks to justify TOP by positing it as a means to sparing the future child from a life of suffering [43, 44]. This focus on fetal anomalies that are predicted to result in profound suffering aligns with the spirit and the letter of the Belgian Abortion Law, reflecting the "common-morality intuition that (at least some) abortions for fetal defects are morally defensible" [45].

Nevertheless, literature has pointed out that justification of fetal anomaly TOP based on fetal interests faces significant limitations [42, 46]. Firstly, a fundamental challenge to fetal interest argumentation, explored in the philosophical literature, questions whether, if the (anomalous) fetus has interests at all, it is ever in its best interest to not come into existence [47]. Convincing suggestions have been made that this is not the case for at least a substantial number of anomalies that give rise to TOP [18, 42], especially those our respondents associated with 'inconclusive clinical factors'. A second, related criticism prominently voiced in disability studies concerns the potential eugenic effect of fetal anomaly justifications in both abortion law and practice [48, 49]. Some scholars therefore recommend either removing fetal anomaly grounds from abortion legislation, introducing various grounds for later-stage abortion in addition to fetal anomaly, or solely valuing the patient's will and interests in TOP decision-making [18, 50, 51]. These approaches have been adopted to varying degrees by certain jurisdictions, sometimes with the specific aim of avoiding a eugenic effect of legislation (e.g., in Germany, which removed its explicit fetal anomaly ground and solely allows abortion after the first trimester on (broadly interpreted) maternal health grounds) [46, 52, 53]. While adopting a similar approach in the Belgian Abortion Law may hold symbolic importance in addressing disability critiques, its actual impact on TOP practices should be carefully considered. Research on jurisdictions that have excluded fetal anomalies from their abortion legislation demonstrates that this approach does not eliminate fetal anomaly based TOP [52] nor produces a more consistent understanding among professionals on fetal interests and their relationship to parental interests [46]. From a legal perspective, completely removing any reference to fetal anomaly from the law could raise the question whether the law still genuinely reflects this dominant motive behind second- and third-trimester TOP requests.

Secondly, an overemphasis on arguments pertaining to fetal interests may obscure the multitude of factors that help determine the appropriateness of TOP, particularly those relating to parental interests. Indeed, legal and ethics experts argue that the narrative centered around fetal interests might not fully reflect the actual motivations behind the decision to perform TOP on medical indication [18, 54]. These limitations of the fetal interest narrative were, however, explicitly recognized by some of our respondents, and implicitly acknowledged by most, especially when considering TOP requests based on inconclusive clinical factors. In these cases, our respondents combined uncertain clinical assessments with secondary considerations, including the patient's request and broader interests. Strong commitment to non-directive counseling similarly highlighted obstetricians' readiness

to perceive medically indicated TOP beyond the first trimester as a complex decision ultimately resting in the hands of the patient/couple.

Thirdly, obstetricians' overwhelming acceptance of (most) fetal anomaly abortions contrasted sharply with their disapproval of abortions requested for non-medical reasons [46]. Obstetricians generally perceive the latter category of abortion requests as fundamentally different and falling outside the scope of their professional responsibility. These attitudes align with our respondents' professional dedication to prenatal diagnosis and obstetrics and compliance with the legal prohibition on (non-medical) abortion after 12 weeks in Belgium. At the same time, however, the varying interpretations among obstetricians of concepts such as 'maternal health' and 'severity' simultaneously illustrate the challenges inherent in maintaining a strict dichotomy between so-called 'elective' and 'medical' abortions. In this line of reasoning, some authors have criticized this distinction between 'elective' and 'medical' abortion for being deceptive and morally judgmental [55–57]. Others advocate for a shift away from grounds-based approaches to abortion in favor of prioritizing patient autonomy [58]. In subsequent research, we delve further into how Belgian health professionals construct the dichotomy between so-called 'elective' or 'social' abortion and abortion on medical grounds.

Legal consciousness and the limits of the law

The Belgian Abortion Law allows for a degree of professional discretion with regards to the severity of the health conditions required [59]. Adopting a socio-legal perspective, this study sheds light on health professionals' use of this discretionary space and their broader legal consciousness.

We found that obstetricians regarded TOP after 12 weeks for fetal or maternal health conditions as a healthcare issue rather than as a legal issue. When collegial support was present for a TOP request on medical grounds, compliance with the law was generally deemed satisfied. Our respondents also tended to view the Abortion Law as a framework that safeguarded their professional autonomy and discretion rather than as one imposing professional obligations.

In terms of legal compliance, our study suggests that obstetricians generally adhered to the provisions of the Belgian Abortion Law when assessing the appropriateness of TOP requests beyond the 12-week threshold. They refrained from performing abortion in the absence of fetal or maternal health complications, especially when a request was considered purely "social". Despite a general overlap between law and practice, we noted that some obstetricians shared disparate perspectives on TOP acceptance/disapproval for certain conditions. Some of these disapproval/acceptance dynamics were formalized and institutionalized in some hospitals, but not in other. While the Belgian Abortion Law permits conscientious objection to individual participation in a legal TOP, institutional objection is not necessarily granted the same right. From the perspective of patients, varying TOP acceptance policies should be discouraged as they subject patients to an 'institutional lottery' [46], unnecessary referrals, and delays. From a legal perspective, disparate TOP acceptance policies raise legal certainty and rule of law concerns.

Two legal hypotheses arise with regards to disparate acceptance policies, each requiring different interventions in TOP law and practice. Under the first hypothesis, it is assumed that differences result from obstetricians'/hospitals' disparate readings of legal criteria, including of what is considered 'particularly severe', 'incurable', or a 'severe health threat to the pregnant woman'. In this regard, we found that TOP was sometimes performed for conditions where uncertainty remained about whether these attained the law's severity threshold. In line with French research [25], we observed that requests for pregnancy termination following a diagnosis of trisomy 21 were unanimously approved by the involved obstetricians (at least pre-viability), despite expressed doubts about whether it qualifies as a 'particularly severe' condition. Furthermore, despite some parliamentary statements having implied the lawfulness of TOP after 12 weeks for severe psychological issues, its contested acceptability persisted among our respondents. Importantly, our study also revealed subtle departures from relatively straightforward legal criteria. For instance, obstetricians sometimes merged mild or uncertain impacts on both fetal and maternal health to substantiate their endorsement of TOP. However, a strict reading of the law demands that (particular) severity is achieved in at least one category of conditions (maternal *or* fetal). Our respondents also frequently cited an (elevated) *risk* of adverse clinical outcomes as the threshold justifying TOP, whereas the law demands *certainty* regarding the presence of the fetal condition. Addressing perceived disparities between law and practice could be facilitated through legal amendments and parliamentary clarifications. In line with recent recommendations from a Scientific Committee Evaluating Belgian Abortion Law and Practice, the legal requirement of certainty could be replaced with the concept of elevated risk to better reflect medical realities [60]. Similarly, the law might benefit from clarification regarding whether threats to maternal health encompass psychiatric health threats [60]. Although legal clarifications are valuable, legal certainty alone may not eliminate the ambiguity and complexity surrounding the medical and social interpretation of 'severity' [61, 62]. Moreover, our study revealed that health professionals

were generally comfortable with the discretionary space provided by the law and expressed caution toward legal clarifications that could limit their flexibility. If the legislator prioritizes professional discretion over legal clarity, professional and institutional exchange among those who provide TOP services may help streamline interpretations to the advantage of patients.

Under the second hypothesis, disparate acceptance policies do not result from disagreement about the fulfilment of the legal criteria, but from dissimilar value attached to factors like timing, fetal viability, the patient's/couples' will and persistence, or other secondary considerations. This hypothesis permeated, for instance, discourse on conditions like trisomy 21, a prevalent fetal anomaly and a common reason for TOP in the first half of the second trimester, but not necessarily at and beyond viability [63]. These findings suggests that secondary factors not currently recognized by the Belgian Abortion Law sometimes determined and limited abortion access. If the legislator, aligning with some professional attitudes expressed in this study, deems secondary factors relevant to TOP decision-making, legal reform is advised. In contrast to Belgium, certain countries acknowledge secondary factors influencing TOP justifiability in their abortion legislation.[14] It is, nonetheless, crucial to underline that any intended reform should be preceded by a broader, normative consideration of the values relevant to TOP decision-making, including (but not limited to) those empirically identified in this study. Moreover, grounds-based abortion laws may still face criticism from autonomy and disability perspectives, as mentioned in the previous section, even if secondary factors are acknowledged. Finally, while acknowledging certain secondary factors in abortion law would better reflect the multifactorial decision-making reported in this study, this approach would not guarantee institutional consensus on TOP provision in the second and/or third trimester [42]. Further research is needed to assess the desirability of institutionally streamlined TOP policies[15] and the impact of different legal strategies on patients' access to later-stage TOP services. Supplementing legal clarifications with professional guidelines, ongoing institutional collaboration, improved quality of prenatal diagnosis, and further research on the subject remain crucial in addressing the complexities highlighted in this study.

Strengths and limitations of this study

This qualitative study offers a unique provider perspective into the complexity of TOP decision-making beyond the first trimester of pregnancy. It is the first qualitative study in the local setting of Flanders, Belgium, that identifies factors influencing TOP acceptance after the first trimester. Our analysis of multifactorial decision-making is particularly valuable because it is multidisciplinary in nature, addressing both socio-legal and ethical implications. The typology of factors presented in the paper offers health professionals a valuable tool to reflect on the factors they personally value and those valued within their team or department. Furthermore, it provides a framework for professionals to engage in a dialogue aimed at fostering uniformity in institutional TOP policies, ultimately benefiting patients. Finally, policymakers can use the insights derived from this study to identify and address socio-legal gaps, potentially paving the way for legal reforms, the development of professional guidelines, and the facilitation of discussions on TOP policies among the professionals and medical institutions involved. This approach may contribute to a more coherent and patient-centered framework for TOP decision-making within the Belgian healthcare landscape.

Notwithstanding these strengths, this study inevitably presents certain limitations. Our deliberate emphasis on factors that could complicate decision-making in TOP led us to focus on more complex and uncertain TOP cases, which may inadvertently give the impression that such cases are more common in clinical practice than they actually are. Furthermore, while the study provides valuable insights into the interaction and overlap of various factors, additional research is required to develop generalizable theories. Additionally, due to practical and language constraints, this study was confined to obstetricians operating in Flemish or Brussels' hospitals with a Dutch language affiliation. Given that some participants reported variations in TOP policies between hospitals in the Brussels and Walloon regions, there is a need for future comparative research aimed at mapping the nuances of TOP acceptance across these institutions. It should be borne in mind that this study primarily centers on the experiences and perceptions of obstetricians, occasionally reflecting on what obstetricians believe are the considerations of their colleagues, hospitals, and patients in the context of decision-making on TOP after the first trimester. It is crucial for future research, especially within the Belgian context, to broaden its focus to include the perspectives of other stakeholders involved in TOP decision-making. This will contribute to a more

[14] The UK Abortion Act allows TOP up to 24 weeks on maternal health grounds but also if "the continuance of the pregnancy would involve risk of injury to the *physical or mental health of any existing children*". The assessment of maternal health grounds may take account of the pregnant person's "*actual or reasonably foreseeable environment*". The New Zealand Abortion Legislation Act 2020 stipulates that abortion after 20 weeks must be clinically appropriate, having regard to all relevant legal, professional and ethical standards", the person's physical health, mental health and overall wellbeing, and the gestational age of the fetus.

[15] Considerations other than conscientious objection could explain institutional differences, e.g. the need for centralization of specific technical expertise.

nuanced and comprehensive understanding of the complex dynamics that characterize decision-making on second and third trimester TOP in the Belgian healthcare landscape.

Conclusions

Hospital obstetricians in Flanders, Belgium, give precedence to clinical factors impacting maternal or fetal health when determining the acceptability of termination of pregnancy beyond the first trimester. Secondary factors exert a compounding effect and can sway decisions on TOP when clinical factors are inconclusive. Among these secondary factors, collective decision-making processes and the preferences expressed by the patient/couple are particularly influential in informing obstetricians' endorsement of TOP. In addition, their acceptance of second and third trimester TOP is influenced by considerations such as timing, technical aspects, ethical and professional values of the obstetrician, and the broader background of the patient. These multifactorial acceptance dynamics not only highlight the limitations of the fetal interest argument dominant in ethical discourse surrounding later-stage TOP, but also reveal a level of complexity not reflected in, and divergence from, the Belgian Abortion Law. Legal amendments have the potential to improve legal certainty and streamline practices, though legal instruments may perhaps never fully encompass the complex, multifactorial decision-making processes involved in medically indicated TOP.

Abbreviations

TOP Termination of pregnancy

Supplementary Information

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Supplementary Material 1

Supplementary Material 2

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Author contributions

All the authors played equal roles in shaping the study and crafting the interview protocol. FDM assumed the role of study coordinator and served as the interviewer for all 23 interviews. SS, KC, KB, and SVDV took turns as second interviewers in a rotating fashion. FDM handled the coding for all 23 interviews, while SS, KC, KB, and SVDV individually coded 5 to 6 of those interviews each, contributing to a collectively constructed code tree. KVA managed the research project, overseeing tasks such as ethics review, data processing and storage, and coordinating the transcription of the interviews by a professional transcription agency. FDM drafted the final manuscript, which underwent collaborative review and commentary from all the authors. All the authors read and approved the final manuscript.

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Data availability

A detailed research protocol is available upon reasonable written request to the first author of this study. The semi-structured topic guide is included in the supplementary information file. Data are presented through illustrative quotes in the manuscript. Transcripts will not be made publicly available due to privacy constraints.

Declarations

Ethics approval and consent to participate

We obtained each participant's written informed consent and ethical approval to conduct this study from the Ethics Committee of the University Hospital of Ghent (UZ) and the University Hospital of Antwerp (UZA). The study adheres to the Helsinki Declaration regarding 'Ethical Principles for Medical Research Involving Human Participants'.

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

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