Self, Influence and choice in maternal decision-making

Author list

Dr Carol Lambert PhD, BSc, RM, PG Dip,
Researcher in Maternal and Reproductive Health (Honorary)
University of Hull
HU6 7RX
UK
Tel: 07745264426
Email: carol.lambert@hull.ac.uk *subject to change. Please use carol@plambert.karoo.co.uk for the time being

Professor Julie Jomeen PhD, MA, RGN, RM
Dean: Faculty of Health Sciences
Professor of Midwifery
University of Hull
HU6 7RX
UK
Admin support:
Julie Poskitt: J.Poskitt@hull.ac.uk/+44 (0) 1482 465995
Email: j.jomeen@hull.ac.uk

Professor Wilf McSherry
Professor in Nursing
Department of Nursing
School of Health and Social care
Staffordshire University and University Hospitals North Midlands NHS Trust.
Staffordshire
ST4 2DE

Tel: 01785 353630
Email: wilf.mcsherry@staffs.ac.uk

This is the accepted version of an article published in MIDIRS Midwifery Digest

Self, Influence and choice in maternal decision-making

The basic principle central to UK maternity policy is that women should be able to make informed choices throughout their maternity care (Department of Health. 2007) and that their opinions, and what they want from their care should be valued (National Institute for Health and Care Excellence 2017). The National Maternity Review Better Births (NHS England 2016), highlighted women are not being offered choice and are often told what to do instead of being given information on which to decide for themselves. If women are to be encouraged and supported in their choices, it is paramount that professionals understand what influences this process of decision-making and illuminate why some women might make some decisions that may be seen to be going against perceived safe care.

Women should be encouraged to be active decision-makers in partnership with health professionals, yet there is limited understanding about what factors influence women in the choices they make (Lambert 2013). Maternity policy supports offering choice of birthplace setting for low risk women, despite this, the majority of low risk women still book to obstetric unit care (Hollowell, Li et al. 2016). In a maternity culture that provides high quality safe services it is also about keeping things normal, and where doing too much too early, can be just as harmful as doing too little (Warwick 2017). Up until now, little is known about what influences women's decision-making, to understand from women's' perspective the choices they make. Learning from their experiences may inform policy and practices.

Background to the study

The study initiated as a result from a clinical encounter when the first author was in clinical practice caring for a woman who stated preferences of what she wanted for herself and for the birth of her baby. As care was temporarily handed over to another midwife, her preferences were dismissed in an instant. Questioning what had happened in this situation, there was need to understand what impact midwives have on the decisions women make about birth.

The case study presented here is part of an Interpretive Phenomenological PhD study that sought to examine women's decision-making. It evaluated from women's perspective, what social influences exist for women in a maternity framework that promotes choice, and how this impacts on their decision-making about birthplace choice. The study considered how women are socially influenced and pressured to conform to authority in pregnancy and birth. Authority here, being the midwives and doctors, whom women perceive as experts. Case studies can examine more closely one or more parts of a larger evaluation and are a common research method within psychology, sociology and in health-related disciplines such as nursing (Yin 2014). The case study presented here illuminates findings from the larger study and summarises a narrowing down of the complex social phenomena to illustrate the relationship of social influence and conformity in choice and maternal decision-making.

Methods

The study was granted full ethical approval and explored women's lived experiences of booking for hospital, birth centre or home confinement. Semi structured interviews were undertaken with 19 antenatal and 6 postnatal primigravida and multigravida women receiving either antenatal or postnatal care regardless of health/risk factors. Women were recruited following 36th week of pregnancy when final decisions about birthplace were made. The interest was to find out why some women might make decisions about where to birth, especially if these were choices against perceived safe practice as all women want a safe birth, a healthy baby and a favourable experience. Findings from the antenatal women in the full study have previously been reported (A/N author paper- in typescript with journal editor IJCB). This is the first written commentary from one woman's, postnatal perspective.

A semi structured interview was conducted with Katie following the birth of her baby and analysed by Interpretive Phenomenological Analysis (IPA). Katie, who despite having epilepsy and advised to book to birth in hospital, booked to birth her baby at home. This was a decision that was right for her. Her narrative, is not generalisable to all women in the study but in the nature of the process of IPA (Smith, Flowers et al. 2009), she provides an exemplar on which to begin to understand how one

women experienced social influence and pressure to conform to authority within her maternity care.

Defining Social influence

As human beings we are gathered in organised communities. Aristotle was considered to be one of the first thinkers to have formulated ideas about the nature of human beings and some basic principles of social influence (Aronson 2008, Law 2007). Considering this in simple terms, *social* relates to human society or organisation (Summers, Holmes 2006 p1142) and *influence* is the effect of one person or thing on another (Summers, Holmes 2006 p 613). In the realms of social psychology Aronson (2008 p6) defines this as "*Influences that people have on beliefs, feelings and behaviour of others". D*efining this within a midwifery perspective, and acknowledging the complex associations that exist within maternity culture, where not just individuals can cause effect on one's behaviour, for example previous experiences, birthing practices or protocols (Smythe 2011, Kirkham 2010, Edwards 2005, Kirkham 2004), this was defined as *"Something or someone within a structure of human social organisation that has capacity to cause effect on an individual including their character or behaviour"* (Lambert 2013 p 58).

Social Influence in Midwifery Practice

Social influence is a common factor that exists in all situations and causes an effect on all individuals' behaviour, beliefs and feelings. Aronson (2008) demonstrated how judgements can be changed because of interaction with other forces such as individuals or mass media or general attitudes. A good illustration of this behaviour change was the Peel Report (Department of Health and Social Security Welsh Office 1970). The report recommended that *"sufficient facilities should be provided to allow for 100% hospital delivery and the greater safety of hospital confinement for mother and child justifies the objective"* (Department of Health and Social Security Welsh Office 1970 p 60). The changes implemented at this time influenced care provision causing a cultural shift in social attitudes. In so doing, not only did this remove choice for women as we understand choice provision today, but recommendations under the idea of greater safety, attained by giving birth in hospital (1970 p 61) has remained influential today. Forces of social influence were identified in seminal research into social influence, obedience and conformity of midwives in a study by

Hollins Martin, Bull & Martin (2004) and demonstrated an impact that senior authority midwifery figures have on junior midwives' decision-making. A further study demonstrated how high-status midwives have more capability to influence decisions than junior midwives make (Hollins Martin, Bull 2004) and when a hierarchy exists a senior midwife is likely to lead care, even when another midwife has a lucid image of a woman's preferences & ideas about birth (Hollins Martin & Bull 2005).

Changes in an individuals' behaviour

Changes in behaviour occur either by conformity or obedience. Conformity is the action of a person when she/he goes along with their peers who have no special right to direct behaviour (Milgram 1974) and are what others might do in similar situations. Aronson describes conformity as *"a change in a person's behaviour or opinions as a result of real or imagined pressure from a person or a group of people"* (Aronson 2008 p19). Practice examples might include women conforming to the notion of natural childbirth, portrayed as gold standard, or in not wanting to breast feed but does so and her behaviour is changed because she might perceive it as the right thing to do by her peers or others in society. Obedience which is a form of compliance (Aronson 2018) is the action of a person who complies with authority (Milgram 1974). Professionals such as midwives and doctors can be very influential, as they are perceived as experts by women.

Social Influence, obedience and conformity illustrated by women in maternity care

From the larger study, Tricia's account confers her thoughts on a scenario of another woman and illustrates this change in an individuals' behaviour as a result of real or imagined pressure: *"if it was me I would probably go with the consultant and think well if the consultants telling me that I need a caesarean there must be a reason for that, there must be some risk possibly and if the consultant somebody who is educated to that extent and has got that much experience if they're saying you need a caesarean to me it's well, that's it then".* What Tricia exemplifies is how people can conform without question, without knowing the reason why and can change their behaviour in line with pressure from the expert advising what is best for her. However viewing someone as expert isn't necessarily the reason why individuals conform without question as Denise illustrates *"that's what I was told, that I would have to go and see a consultant and there was a chance that they'd advise me not to*

go ahead with the home birth but, apparently, now they can't stop you, they can advise you". The degree between *advice* from someone and *imagined pressure* from someone is a fine line. What is key here is what one-person views as advice another may view as pressure to conform.

<u>Women are socially influenced and pressured to conform to authority in pregnancy and birth</u>

There are both *'internal and external influences'* that influence women's decision-making processes, hence the choices they make. Internal influences are those internal to her individual *self* like concepts of self and include; *self-concept, self-determination, self-assurance, self-doubt, self-expectation, self-perception*.
External influences are those described as being external to her and might include *control, system, support, fear, experience, knowledge, professionals*.
These influences, both internal and external are in constant interplay and cause changes in her *state of self* in different situations. At times we can feel very self-determined and self-assured but through our interactions with other forces this can change our state of self and where we were self-assured we can very easily become self-doubting.

This interplay between internal and external influences is illustrated by Sue and Alex. Sue's narrative demonstrates the self-belief and self-assumption she has in her understanding practitioners are experts, and she conforms without question to advice to the external influence of practitioner: *"I would go along with the advice that they're giving… so I wouldn't challenge them because they're the experts and they know what they're talking about."*

Alex's narrative demonstrates the internal influence of self-perception and self-doubt about risk, fear and pain that interplays with external influences of having no knowledge or experience. Her self-perception of lacking in knowledge because it's her first baby and in having no previous experience means she self-doubts and worries. This perception of birth is why she books to the hospital: *"I'm so conscious of the risk with it being my first baby and not knowing what's going on I'm just worried about bleeding… rupturing and the pain".* Without understanding perceptions

midwives do not have the ability to positively influence her to change her judgements in receipt of new knowledge.

Case study

Excerpts from one participant in the study, Katie gravida 3 para 2, illustrates this of internal and external interplay. Katie was advised to birth in hospital due to the fact she has epilepsy, she did not accept birthplace advice the professionals were advising, and she booked to birth her baby at home. Katie was self-determined and self-assured in her choice in that it was right for her. Her narrative case illustrates how interactions with her midwives influences and changes her judgements. Whilst reading this case study, think about the influence of the midwives that were looking after her. Were they positively or negatively reinforcing her internal influences of *self*

Background to the case

Term +12 was looming, and Katie was conscious at this date her homebirth would be ruled out. Her (first) midwife performed a routine, vigorous stretch and sweep at T+9 and 24 hours later she awoke with pink, watery loss. She rang the antenatal day unit (ANDU) and asked to attend for review. The CTG recording was within normal limits, her baby was active, and Katie was fine.

Internal influences were either positively or negatively reinforced

Katie begins… "*I still had it in the back of my head, the experiences that I'd been through in the hospital itself and thinking I don't want to be sat in a hospital getting anxious, getting panicky... and then being treated the way I was in my second labour where it was just people flitting and floating, not giving the proper support that I need and I thought I'm going to end up more stressed, upset and probably more likely for something to happen if I'm in that situation".*

This justified the reason Katie had opted for a homebirth, it was the right decision for her and for her family. Katie continues, and explains the positive influence she had and how her midwife supported her in the decisions she made. Her narrative illustrates how Internal influences were positively reinforced by her midwife:
"[midwife] was wonderful right from the start, she was always very optimistic, she didn't see it being a problem. She said at the end of the day you seem to be

absolutely fine in your health, nothing's the matter with you or your baby. If you say you haven't had a seizure in three years then it seems a minimal risk to take… obviously we'll be constantly observing you and if we feel that there is something that is of concern, then obviously we would report it back to you and it is, at the end of the day, your decision to take whether you feel okay I'm going to go to the hospital under the advice of the midwives, or whether you think okay I'm going to risk it a little bit more".

This exemplifies how her midwife was keeping things normal for her, weighing up risk in this individual situation and taking Katie's decision-making into consideration. Her pregnancy advanced and this midwife was on annual leave at the time of the home visit to discuss the birth. Two different midwives from the same team visited Katie to discuss this. Katie's narrative demonstrates how the internal influences of *self-determination* and *self-awareness* were negatively reinforced by these midwives: *"I felt like they were trying to make me a little bit more anxious than I needed to be necessarily... but one of the other midwives she was the one that looked a little bit more not happy about it you could tell she was a little bit dubious of me actually choosing to have this baby at home and she kept saying to me 'I think you need to think about it a little bit more. Maybe you and your husband should have a talk'. And of course, the problem was [husband] hearing all of these facts was getting a little bit, sort of 'are you sure we should be doing this".* Her decisions were undermined in the language the midwife used in *'I think you need'* and Katie found herself having to justify again decisions made. Her husband and Katie's support, was now doubting the decision made previously to birth at home and the influence of the midwives was causing a change in his judgements.

<u>The morning after Katie's stretch and sweep</u>

Katie was now term +10 and she woke that morning feeling as though she had wet herself. She did not know what was going on and was a bit confused because it was all pink. She rang the antenatal day unit for advice: "*I don't know what it is really or whether to be worried or not'… they said 'it sounds like your waters have gone but', they said, 'it should really be clear so if you could come in for us to check you and obviously if it's all okay you can go back home. You're on the books for a home birth and if there's no worries and you can just go home".*

Antenatal day unit visit

Katie was examined, and the midwife confirmed her waters had ruptured: *"we got there, and they examined me and said 'yeah, your waters have definitely gone' but they said they were not happy because they shouldn't be that colour".* The midwife had said it '*should be clear'* this message indicates it is something other than normal and in that *'if it's OK, she can just go home'* there are mixed messages in the midwife's narrative. Katie had had a stretch and sweep of her membranes the day before and described this as watery pink. This could be normal considering her stretch and sweep. Her baby was active, she had a normal CTG, and there was good maternal wellbeing. As interviewer I asked her if this was a show with her waters: *"No, apparently, I'd already had my shows and confirmed that with [midwife], but this was more like, it was very funny like watery pink and they said that it shouldn't really be that colour and it could be a number of reasons. They said it could just be the case of the baby rubbing against the placenta and bursting a couple of the cells or…it could be something more that they're not sure about".*

The language used causes changes in Katie's behaviour, pressured by thoughts of putting stress onto the midwives who would be caring for her: *"but then they said to us that they were still not happy really for me to be going home though because of the pink. And they said, obviously, you've got to put yourself in the situation with your midwife as well. You're putting sort of undue stress onto them by expecting them to come out to you if something's not necessarily right".* Katie is now self-doubting and somewhere within the interactions a definite change is apparent in the language from 'pinkish' to 'bleeding and blood': *"[we] sat there waiting in the waiting area saying 'look what are we going to do, is it best that we are going home or should we stay here... we was already debating, thinking about if something happens what are we going to do... the other thing is that we've got the kids in the house and I'm thinking if they're saying this is bleeding and it could be a case of that all of a sudden I rupture or something, I don't want my little kids seeing me being rushed out of the door covered in blood".*

Risk is firmly fixed in her mind now and conforming behaviours are evident due to perceived risk.

The management plan

Katie describes the next steps: *"they were telling us. we'd have to go up to the labour ward eventually, they were saying, to actually stimulate and progress the labour, they were trying to say, to get the baby out, so as to obviously reduce the risk of whatever it was that was making the bleeding they said that that was the actual plan of action... so we sort of accepted it".* Considering this perceived risk, Katie unquestioningly complies to this authority of what the experts were saying.

<u>Up on labour ward</u>

Katie was eventually transferred to labour ward and she recounts the next steps in her care: *"but she said the problem is 'your baby's still not moved down and that's because of the water's all in front of its head' so she said 'what I'm going to have to do is break those forward waters to allow him to move down' she said 'the other problem is apparently he's still got his head facing the wrong way and he needs to tuck that under to then progress down' she said 'I'm going to give you options now because once I've broken your waters these options are going to go and obviously I want you to be prepared for everything that's going to come' she told us that once the waters were broken the contractions would obviously intensify very quickly.*

Katie felt supported by the midwife, but it is worth reflecting upon the language used that Katie conveys, the language of 'problems' 'I'm going to have to', 'I want you to be prepared' and 'obviously intensify'. This language influences Katie in how she thinks and feels about the situation and herself.

<u>On labour ward</u>

Katie was now compliant unquestioningly in her decision-making. Her self-reliance had diminished, and she is a changed *self.* The influence of the midwifes' language is profound, and Katie self-justifies the information given in light of this expert:
"I was getting to the point where I was getting quite tired, I'd been up for a long time… I'd been pushed from pillar to post on wards and told all these things and she said to me 'have you considered having the epidural then' I'd said to her I'd hoped not to but she said if 'I'm going to be honest I don't like advising epidurals but in your situation I probably would advise you have it because I've obviously been in situations with this and they can go on for a long time and I've seen women almost passing out from the pain'. So obviously she was trying to be honest and say look if

you're going to do it you've got to do it now though, because once those waters have gone then you're going to be too far for them to actually put it into you so you're going to have to have the epidural put in before I actually break your waters".

What happened

Katie explains what happened: *"she ruptured the membranes and then she said the waters looked fine she said there was slight pinkiness in it but nothing that she felt was of high concern".* The midwife had said the pain would probably immobilise her and Katie had the epidural: *"at the end of the day you're looking, and you think, do you really want to put yourself through all the unnecessary pain for the sake of just having one big pain in your back that will take away all that".* At this point her judgements had changed and she began thinking about why put herself through all this unnecessary pain. Katie wanted a natural birth at home, she was aware about pain relief in the hospital setting and although she had hoped to birth without an epidural, her narrative that follows discusses her previous birth, she perceives the influence experts have regarding this: *"obviously I'd got to the second stage and they said to me, 'oh, we see you've had an epidural with your first one, are you going to have one now then?'. You know, it was just straight away an automatic presumption that I was going to have one. We discussed it and she just said 'well, I personally think if you had a long labour with your first, you're probably going to have a long labour again so you're probably best having it now rather than prolonging your pain'".*

Closing the interview

On closing the interview with Katie, I *asked "do you think women can be coerced into things?"* Her reply*: "definitely, I think it's a case of you're sort of in a situation like mine where you're thinking there's problems and you do start getting backed into a corner by the professionals and being made to feel like well they are the professionals, so they know best… so you've got to go with it".* It is pertinent to reflect on the fact that she had knowledge of the concept of coercion and this was the very reason she had booked for a homebirth this time, because of her experience previously and about what she didn't want for herself.

Conclusion and implications

Social influence is a common factor that exists in all situations that causes an effect on an individual's behaviour, beliefs and feelings. Judgements can be changed because of our interactions with other forces such as individuals or mass media. Changes in behaviour occur either by conformity or obedience and is described as a change in a person's behaviour or opinions as a result of real or imagined pressure from a person or a group of people. Katie was advised to attend the Antenatal Day Unit for a check-up after her waters had broken at home following a routine stretch and sweep. Katie ended up birthing her baby in hospital even though she had wanted to birth at home.

This case study illustrates changes in Katie's behaviour as a result of pressure to conform to the expert advising what was best for her. Interactions with the *external* influence of her midwives changed Katie's own internal influence, hence, her state of '*self'* in certain situations. She was self-assured in her decision-making about what she wanted for herself at one point but changes her behaviour and conforms through interactions and perceived pressure from the midwife. In light of this perceived risk, she complies unquestioningly to the authority of what the experts were saying. Her story illustrates how women can be socially influenced and pressured to conform to the authority of professionals, and how the interactions with some professionals, can change believes that results in women complying unquestioningly with what they are told. Katie's interactions with her midwives were either positively or negatively reinforced, where she was supported, felt self-assured, self-determined, self-reliant and self-confident at one stage, to where she was undermined in her decision-making and having to justify certain choices that resulted in a changed sense of *self* and she became self-doubting, and self-sacrificing to a point of self-blame. Reflecting on her passed birthing experiences in hospital and following her birth this time, Katie had knowledge of being coerced during her interactions with some professionals. This had been the very reason she had chosen to birth at home in knowing what she did not want for herself this time.

There is a need to understand why women make certain decisions and the reasoning behind the choices they make, as women often make decisions on misinterpretations. Midwives can have a positive influence and should encourage women to question and not just accept what is said, unquestioningly accepting,

because we are seen as experts. It is important that women are not having to revisit the decision-making processes in continued justification to professionals about the choices they have made.

References

ARONSON, E., 2008. *The Social Animal.* 10th edn. New York: Worth Publishers.

DEPARTMENT OF HEALTH AND SOCIAL SECURITY WELSH OFFICE, 1970. *Domiciliary Midwifery and Maternity Bed Needs. Report of the Sub-Committee.* London: Her Majesty's Stationary Office.

DEPARTMENT OF HEALTH., 2007. *Maternity Matters: Choice, access and continuity of care in a safe service.* London: HMSO.

EDWARDS, N., 2005. *Birthing Autonomy Women's Experiences of Planning Home Births.* 1st edn. Oxon: Routledge.

HOLLINS MARTIN, C.J. and BULL, P., 2004. Does status have more influence than education on the decisions midwives make? *Clinical Effectiveness in Nursing,* **8**(3-4), pp. 133-139.

HOLLINS MARTIN, C.J., BULL, P. and MARTIN, C.R., 2004. The social influence scale for midwifery: factor structure and clinical research applications. *Clinical Effectiveness in Nursing,* **8**(2), pp. 118-121.

HOLLOWELL, J., LI, Y., MALOUF, R. and BUCHANAN, J., 2016. Women’s birth place preferences in the United Kingdom: a systematic review and narrative synthesis of the quantitative literature. *BMC pregnancy and childbirth,* **16**(1), pp. 213.

KIRKHAM, M., ed, 2010. *The Midwife-Mother Relationship.* 2nd edn. England: Palgrave Macmillan.

KIRKHAM, M., ed, 2004. *Informed Choice in Maternity Care.* 1st edn. London: palgrave macmillan.

LAMBERT, C., 2013. *The influence of self in women's decision-making about birthplace: An Interpretive Phenomenological Study.* Doctoral Thesis edn. Hull: University of Hull.

LAW, S., 2007. *Philosophy.* 1st edn. London: Dorling Kindersley Limited.

MILGRAM, S., 1974. *Obedience to Authority an experimental view.* 1st edn. London: Tavistock Publications Ltd.

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE, March 2017, 2017-last update, Antenatal Care for uncomplicated pregnancies [Homepage of National Institute for Health and Care Excellence], [Online]. Available: www.nice.org.uk/guidance/cg62/chapter/Introduction [30/06/2018, 2018].

NHS ENGLAND, 2016, 2016-last update, National Maternity Review. Better Births; Improving outcomesof Maternity Services in England. [Homepage of NHS England,

London], [Online]. Available: /www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf [03/02/2018, 2018].

SMITH, J.A., FLOWERS, P. and LARKIN, M., 2009. *Interpretive Phenomenological Analysis.* 1st edn. London: Sage Publications Ltd.

SMYTHE, E., 2011. From beginning to end. How to do hermeneutic interpretive phenomenology. In: G. THOMSON, F. DYKES and S. DOWNE, eds, *Qualitative Research in Midwifery and Childbirth Phenomenological Approaches.* 1st edn. Routledge, pp. 35-54.

SUMMERS, E. and HOLMES, A., eds, 2006. *Collins English Dictionary and Thesaurus.* 4th edn. Glasgow: Harper Collins.

WARWICK, C., 15th August, 2017-last update, Words matter and so does evidence based thoughtful care [Homepage of Royal College of Midwives], [Online]. Available: https://www.rcm.org.uk/news-views-and-analysis/views/words-matter-and-so-does-evidence-based-thoughtful-care [September 20th, 2018].

YIN, R., K., 2014. *Case study research: design and methods.* 5th edn. London: Sage.