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The influence of self in women's decision-making about birthplace:

An Interpretive Phenomenological Study.

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Carol Lambert BSc (Hons)

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Dedication

This thesis is dedicated to my dad Ray Flint

In loving memory

Abstract

In the United Kingdom current maternity policy advocates the importance of flexible individualised services that fit with the needs of women. Choice of services for women as consumers is paramount in a system that aims to promote safe, high quality care. As women make choices, they navigate a complex journey; learning from women's experiences is fundamental to understanding this journey and influencing future policy and practice. Literature on what influences decision-making demonstrates a paucity of information and a limitation of women's voices. Following an Interpretive Phenomenological approach grounded in a feminist perspective to promote women's voices, a group of 25 antenatal and postnatal women were asked about their experiences, perceptions and choices in the context of their maternity care. This study explored how they may be socially influenced and pressured to conform to authority in birthplace choices. It illuminates how emancipation and conformity are linked to consider whether emancipation reduces pressure to conform and what the implications of this might mean in a wider sociological context of birth experience.

Based on Interpretative Phenomenological Analysis, a unique, seven stage iterative framework of analysis was developed. Self and aspects of self emerged as the most significant theme for decision-making existing within a frame of constant interplay of external influences such as environment, knowledge and professionals. As different pregnancy identities emerged, it was evident that this interplay has positive and negative effects as women experience decision-making.

Conformity and emancipation are profoundly linked to decision-making; self is complex but critical to this process. For women to be self-determined and assured in their birthplace choices there is urgent need to reconsider interactions at every level. This approach must address the complexities of self so women and midwives remain equal partners. The implications of this reach beyond the discipline of maternity care.

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Publications/conferences/related work

Publications

Lambert, C., Jomeen, J., McSherry, W. (2010) Reflexivity: a review of the literature in the context of midwifery research. British Journal of Midwifery, vol 18, No 5 pp 321-326.

Mercer, T.G., Kythreotis, A.P., Lambert, C. & Hughes, G. (2012) Student-led research training within the PhD: "PhD experience" conferences. International Journal of Researcher Development, 2 (2), pp. 152-166.

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Conferences

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Invited Papers

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Abbreviations

ADU	Antenatal day unit
C/S	Caesarean Section
CTG	Cardiotocograph
DOH	Department of Health
EFM	Electronic fetal Monitoring
GP	General Practitioner
NHS	National Health Service
NICE	National Institute for Clinical Excellence
NMC	Nursing & Midwifery Council
PCT	Primary Care Trust
RCM	Royal College of Midwives
RCO	Royal College of Obstetricians
RCOG	Royal College of Obstetricians & Gynaecologists
RCT	Randomised Control Trial
SIS-M	Social Influence Scale for Midwives
UK	United Kingdom
USA	United States of America

Glossary of terms

Antenatal/Antepartum	Before birth
Augmentation	Acceleration of a labour which has been diagnosed as not progressing adequately
Auscultation	Method of examining the fetal heart rate, using a pinnard stethoscope or a hand held doppler
Cervical dilatation	Stretching of the cervix during the first stage of labour
Cervix	Neck of the uterus
Cholestasis	Build up of bile acids causing persistent itching in last stages of pregnancy
Doppler Ultrasound	Used in the detection of the fetal heart rate
Doula	Female birth attendant offering support to the birthing woman
EMLSCS	Emergency lower segment caesarean section
Epidural	Form of pain relief used in the first and second stage of labour
Fetus	The name for human offspring before it is born
Fundus	The top of the uterus the part farthest part from the cervix
Free birth	Unassisted childbirth
Intrapartum	In labour
IOL	Induction of labour
Latent phase	An inactive period as in the early part of the first stage of labour
Liquor	Fluid that fills the amniotic sac and surrounds the fetus
Meconium	Material that is passed from the intestinal tract of the fetus
Multigravida	A pregnant woman who has previously had more than one pregnancy
NICU	Neonatal Intensive Care Unit
Parity	The number of live born infants

Partogram	A graphical record of the progress of labour
PGD	Patient Group Directive
Pinnard Stethoscope	Trumpet shaped instrument placed on the maternal abdomen over the fetal chest to hear the fetal heart sounds
Postnatal	After birth
Primigravida	A woman pregnant for the first time
Stretch and sweep	Stretching of the cervix and sweeping of the membranes
T+10	Denotes how many days over a term 40 week pregnancy
Tracker	Information record of maternal service engagement. E.G. phlebotomy results/clinic attendance/multidisciplinary services accessed in the course of care
Ventouse delivery	Delivery of the fetus using a suction cup to the fetal scalp. Alternative to forceps

Chapter 1: Introduction

This is a qualitative interpretive phenomenological inquiry that explores social influence in a context of childbirth. The aim of this thesis is to examine women's decision-making, evaluating what social influences exist for them within a policy context that promotes choice and how this impacts on decision-making about birthplace choice.

By exploring the influences that surround women as they make decisions about birth choices, what is uncovered is a concept of *self* that is central to emancipated decision-making. This inquiry demonstrates how the interplay of social influences identifies this dynamic state of *self* that causes continual effect on women's self-identity. Moreover, the inquiry illustrates how critical moments occurring within the pregnancy journey can result in both positive and negative effects on *self* and decision-making about birth choices. A new concept of emancipated decision-making for childbearing women is offered.

The rationale for this inquiry originated from an encounter in clinical practice when caring for a woman who voiced clear preferences of what she wanted for herself and for the birth of her baby. These preferences were dispelled in an instant when care was temporarily handed over to another midwife. Questioning what had occurred in this situation and in the context of her care, I wanted to understand what impact midwives have on the decisions women make about birth.

In the United Kingdom, current maternity policy advocates the importance of flexible individualised services that fit with the needs of women (Department of Health 2004), promising national choice guarantees of being able to make informed choices throughout their maternity care (Department of Health 2007). Embedded in this healthcare aim is the promise that the views, beliefs and values of women will be sought and respected (National Institute for Clinical Excellence. 2008a). For women that access maternity care, this means they are valued as consumers of services and are active decision-makers about their care.

Historically, the policy context began with *Changing Childbirth* (Department of Health 1993) and represented the beginnings of significant change in English maternity care policy. Change in recognising that services needed to adapt to women being at the centre of care and enabling them to take part in decision-making about their own care.

Moreover that maternity care should no longer be driven by a medical model of care (Jomeen 2010). The commitment to provide safe and accessible services to all women by the end of 2009 where a guarantee of national choice in where and how they have their babies was ensured to women (Department of Health 2007) at a time when a more modern personalised NHS was being called for (Department of Health 2008).

The concept of choice is now accepted as a maternity cultural norm and has remained on the maternity policy agenda since its introduction (Department of Health 1993). Despite the rhetoric over the last two decades maternity practice still do not appear to be getting this right (Edwards 2005, Kirkham 2004, Mander 2001). Choice remains largely elusive and illusionary (Jomeen 2012, Beech 2003) and little has appeared to have changed in this time as authors have consistently highlighted difficulties and barriers to the 'choice' concept (Hollins Martin 2007a, Jomeen 2007, Kightley 2007, Edwards 2005, Kirkham 2004). We need to understand more about this, not from policy makers, but from women whose care is framed by them. Despite the once new concept of choice (Department of Health 1993), the reality is we still don't have a clear picture why the policy statements presented at that time, perceived to bring forth significant change for women, midwives and maternity culture, still do not make a difference today.

Literature indicates that for maternity services to be women centred, women's experiences especially those relating to decision-making regarding choice and their perceptions of care must be given further attention (Tinkler and Quinney 1998). Yet literature demonstrated a paucity of women's voices with no enquiry and limited evidence about care.

A continuous thread throughout this thesis will be the voice of women. Voice according to Ribbens (1998 p24) is our *internal self* in contemporary living and is a way to express the more "private ways of being" that allows for the personal perspectives to be communicated that can often be a struggle to voice and express amid public powerful bodies of knowledge. The single voices heard from interviews presented in this thesis, personify such complex experiences and knowledge of individual women that are representational of many voices. In being, they reach beyond the single voice and befall a multitude of voices that share these same complexities. Different accounts therefore can create something more whole (Smythe 2011). These voices remain constant throughout this thesis as they tell their stories about their personal insights, perceptions and experiences that relate to the decisions they craft. In this, what you are

about to read may be thought of as bold amid a non-traditional process of thesis writing. The voices of the women interviewed are employed from the beginning to provide understanding and illumination to theory development. This is prior to the study design chapter and their formal introduction in the findings chapters. This is described further in the methodology chapter which comes after their first introduction. The significance of this is that it underpins and exemplifies importance of the interpretive methodology and inter-subjective nature of meaning making; hence, I remain true to the intersubjective nature of this study. This illustrates the value women's narratives hold in providing such clarity and illumination for the concepts introduced in this thesis and in knowledge development in recognising inter-subjective meaning making.

It was not the intention at the beginning of this thesis to present this in this manner. The writing of this thesis occurred in prospective retrospect that presents a truth in temporal development and signposts the reader through the footsteps I undertook in development of new theory. This recognises these women and what they have to say as a powerful body of knowledge (Thomson, Dykes, and Downe 2011) that illuminates real understanding to existing and developing theory.

This approach is fundamental to feminist methodology and to this thesis in drawing on a feminist perspective. Pregnancy and childbirth belong, as a type of personal specialism of women; only experienced by women and central to womanhood as a life changing event. This results in transition to motherhood and a changed identity in her social context. Thomson (2011) describes childbirth as the "most significant rites of passage in a woman's life and has long-term implications for maternal well-being. The nature of this thesis is phenomenological and humanist in approach and fundamental to appreciation and understanding of the uniqueness of individuals, their existence, experiences and perceptions. Therefore this study represents a feminist philosophy in that it maintains true to its aim and embraces women and their voices as the foundation for understanding what influences women encounter as they make decisions in pregnancy and birth.

This thesis will aim to provide an understanding of the consequence of the relationship between external influences and the internal influence of aspects of self on women's decision-making. The concept of *self* in relation to this study will be explored further within this thesis. Salient narratives will furnish an appreciation of how these positive and negative external and internal influences interplay throughout the process of women's decision-making. Critical moments are illustrated on an undulating trajectory

of decision-making throughout pregnancy and illustrate explicitly the route to a complex journey of decision-making that women must negotiate to what becomes understood as emancipated decision-making.

Aspects of self and external influences are in a continuous state of interplay. The knowledge and perceptions women have are socially constructed and are based on the interplay of internal influences such as self-determination, self-assurance and self-doubt, and external influences such as professionals, risk, fear and environment. This is the knowledge women use to make choices and decisions about what they want for themselves and why they want these; hence are extremely powerful.

This thesis draws on knowledge, understanding, theories and concepts from a wide range of disciplines including sociology, psychology, feminism and health. As individuals living in society we live within social contexts (Barnett and Casper 2001). These social contexts:

> encompass the immediate physical surroundings, social relationships, and cultural milieus within which defined groups of people function and interact (Barnett and Casper 2001 p465).

Moreover, these social contexts influence us; who we are; what we do; what we believe; how we perceive things; and the decisions we make in how we choose to live our lives. How we begin to interpret our worlds is what Sociologists, Psychologists and Philosophers aim to expose amongst their own discourses.

As individuals we are socially organised beings. The choices we make are dependent upon the social norms of the social group in which we live and have been nurtured. Such norms are the foundations of what may be perceived as normal within our social group and these can very often be dependent upon what resources are available.

Birth has a life changing significance for self-identity of a woman as she grows and develops in advancement to motherhood in her family unit and position in her social group, and in the wider cultural and global health context. It is argued in this thesis that in order to begin to understand the challenges women face in this transition, it necessitates the inquiry to begin with women themselves, their voices. The voices of these women possess an authority to advance what is already known about decision-

making, and can have a real impact on the microcosm of midwifery care as they anticipate the births of their babies.

Socially, as pregnant beings, women are a juxtaposed pregnant group in a microcosmic context of midwifery culture. This sits within a macrocosmic milieu of human sociological organisation in which we all exist. Any representation about the microcosmic context of maternity culture therefore, must be acknowledged against the macrocosmic political, economical and social milieu as this remains influential on the micro-culture existing within.

Within this thesis confirmation is offered that the midwife-woman relationship influences women's experiences and perceptions of maternity care (Kirkham 2010b) and is an important aspect of women's satisfaction (Tinkler and Quinney 1998). Empowerment through midwives and midwifery practice seems to be of great importance for women's experience in childbirth. It is suggested, however, that women comply with rather than choose how to give birth. Furthermore, professionals' attitudes potentially influence and convince women to try certain birth options. This 'professional gate-keeping' (Levy 1999b p115), relates to practitioner beliefs and leads to manipulation of women in this decision-making process. This concept concurs with 'obedience' as described by Milgram (1974).

What has transpired in this thesis from the analysis of the literature on women's decision-making, is the phenomenon of emancipation demonstrating that its use has become unique to a midwifery and decision-making concept for childbearing women. It is a notion primarily addressed critically by both social and feminist theory and considered in relation to caring for women in the process of decision-making about their healthcare issues (Wittmann-Price 2004). Midwifery culture aims to be women centred and emphasises the true value of caring but a lack of knowledge from women's perspective limits our understanding of how women effectively deal with decisions about their desired birth experience.

Research examining social influence, conformity and obedience and the power this has over midwives practice, has been the work of Hollins Martin (Hollins Martin and Bull 2006, Hollins Martin and Bull 2005, Hollins Martin, Bull, and Martin 2004, Hollins Martin 2004). Further research examining how social influence impacts on women making decisions about childbirth options is both necessary and pertinent, particularly in light of current government policy and rhetoric surrounding maternity care. Examining

women's perspectives could reveal the potential role of emancipation within decision-making or reaffirm conformity to authority and expose how this might affect birth experience.

This thesis should not be perceived as an isolated study but a study that subsists in a national and international framework of knowledge. It explores the perceptions of women in experiencing their birthplace options. Through the window of their experiences, their narrative, the study shows an understanding of women's perceptions, views, feelings and influences. It offers a theoretical understanding but also considers their concerns in relation to health promotion and well being of themselves, their babies and their families.

The intention of this thesis is to meet scholarly intent and distinctiveness that makes a modest and valid contribution to knowledge and to the body of existing maternity knowledge; one that has a positive influence on midwifery practice and midwifery care.

This thesis is presented in 10 chapters. This introduction provides the context and rationale for the research study, outlining the current national government policy for maternity service provision and how this provides the maternity service backdrop for investigating women's decision-making about birth choices. In Chapter 2, a critique of the literature is presented. This leads to a clear statement of research aims and objectives and questions to be answered. Chapter 3 and 4 provides the conceptual and methodological frameworks that underpin this thesis. Chapter 3 addresses the theoretical concepts of social influence, emancipation and empowerment that underpin the conceptual thread that knits together initial ideas, and how these influenced questions asked in this study. Chapter 4 justifies the interpretive phenomenological stance and the theoretical perspective of Social Constructivism and how these perspectives influenced the research design and method of analysis. Chapter 5 offers rationale and justification for the method of study design and its development process. Reflexive accounts from researcher diary entries illustrate the 'real' life difficulties faced in the research process.

Chapters 6 and 7 begin the concluding process. These present antenatal and postnatal data findings and present the factual conclusions of the study. Here the social representations of different pregnancy identities are demonstrated with rich narrative accounts to illustrate findings. Reflexive accounts from my researcher diary will also be evident to further demonstrate the inter-subjective characteristic of theory development.

Chapter 8 presents a cohesive discussion and addresses the interpretive conclusions of the findings. These are discussed in application to the theoretical concepts addressed in chapter 3. These answer the stated research questions, present conceptual conclusions and the contribution to knowledge will be defined. Chapter 9 draws conclusions of this thesis. It raises implications of the findings in relation to women, midwives and practice. Chapter 10 presents recommendations for future research and practice followed by a concluding statement.

Throughout this thesis the personal pronoun of 'midwife/midwives' will be used. Whilst this could be perceived in the feminine, and on some occasions *she* might be used in relation to a *midwife,* this does not imply all midwives are women. This is merely used for ease of writing. Moreover, the term midwife or midwives is used to denote midwives as specific to the debate and practitioners to indicate the wider professional field within the debate. A glossary is provided for readers who may not be familiar with any midwifery terms and this should be referred to as required.

Chapter 2: Literature Review

Introduction

This study begins with a literature search using specific criteria to explore women's decision-making about childbirth options. This chapter provides the critique of the literature and lays foundations for the research study presented in this thesis.

This section of the thesis aims to give an overview of published works with a specific focus on decision-making in midwifery practice and women's decision-making in the context of their midwifery care. Women and decision-making was an obvious focus of the search, however in wanting to investigate decision-making of women in maternity care I did not feel I could limit my search to just women. Midwives and women have a relationship between them that is fundamental to midwifery care and one that is the foundation of the service we provide (Leap 2010). Maternity care is a tapestry, weft threads represent clinical outcomes, policies, protocols and technologies and the interwoven warp threads represent the relationships between midwives and woman that hold it all together (Hunter et al. 2008 p136)

In the process of literature searching to gain insight, understanding and determine what is already known within a phenomenon, we do not necessarily know what we are searching for or what we have found. Only through personal engagement and becoming acquainted with the corpus can this become apparent. In undertaking the literature review that follows, a substantial section referred to practitioner decision-making with a focus on how practitioners arrive at decisions through the cognitive processes one uses for clinical decision-making, such as perception; comprehension; decision-making; problem solving and reasoning. Although interesting, this was not the intention and was therefore excluded from the review as no longer directly relevant to this investigation. However, the importance of this literature did highlight a number of potential factors that women may face in their interactions with practitioners (Levy 1999b) and in signposting to Hollins Martin's work on social obedience.

The original review identified sources between the years 1976 to 2007. The same search strategy was repeated from 2007 to 2013 in the writing phase of this thesis to determine if any new published material was available that may add to this investigation. Additionally, an email alert service had been set up at the beginning of

the research process to maintain the identification of contemporaneous literature. This ongoing search continued throughout the duration of the investigation to ensure the literature pertinent to this study remained up to date.

The review

The intention of this literature review was to examine the concept of decision-making and consider its relevance to decision-making within midwifery practice. I wanted to gain access to a diverse body of knowledge and access a corpus of published works that crossed disciplines and shared similar and respective bodies of knowledge. For this reason a search strategy using Zetoc, CINAHL and EBSCO Search Elite and Elsevier databases was used. I wanted to draw on literature that was specific to midwives as autonomous decision makers in the context of their midwifery care, but literature relating solely to midwives and decision-making proved to be limiting so papers were included from allied health professionals including doctors, nurses and student midwives.

The rationale for presenting the evidence and understanding the key concepts is to look for omissions within existing knowledge. It is envisaged that by examining decision-making within a midwifery context; this will not only add to existing knowledge about practitioner decision-making, but will do so from the women's perspective rather than from a practitioner perspective. It is the aim to present this new knowledge in a way that could be used to inform midwifery practice and policy. The conclusions drawn from this review led to the formation of the research questions to be investigated and informed the aims and objectives of the study.

Methodology for Literature Search

The aim of the search strategy was to gain overview of research papers with specific focus on decision-making in midwifery practice and women and decision-making within a maternity context.

Sources for inclusion were identified from Zetoc, CINHAL, EBSCO Search Elite and Elsevier databases from 1976 to 2007. Only sources in English were to be included and a search strategy of terms below was used.

Midwif* 'and' decision making,

Autonomous 'and' decision making,

Women's' decision making 'and' midwif*,

Women 'and' decision making 'and' pregnancy.

These terms were applied to the search strategy; the purpose was to recover and include literature explicit to decision-making linked to midwives as autonomous decision-makers and women as decision-makers in the context of their midwifery care. 1551 sources were identified from across disciplines in the form of editorials, letters, theses, books, review papers, anecdotal articles and commentaries. Exclusion of articles was achieved by systematically searching out and evaluating sources so only primary research papers specific to the critical discussion remained. A total of 43 original research papers remained and were included in this review. These identified papers, provided a well validated evidence base and any references cited within them considered pertinent were also included.

Three categories of literature analysis

The papers were ordered through a process of naturally emerging categories into an adapted framework based on a template by McSherry (2004). Through this process, three categories evolved.

- Decision making and the autonomous practitioner

- Women and decision making

- Influences on decision making

Papers within the first category focused predominantly upon the concept of decision-making and the autonomous practitioner. As mentioned in this introduction due to the focus of these being linked to clinical decision-making and arriving at judgements this was not the intention of the inquiry and so were excluded. However the work of Levy from this category (Levy 1999b) will be drawn upon as her work remains pertinent to the investigation in highlighting interactions between midwives and women.

Table 1 shown on page 15, presents 14 papers that were examined and critically analysed in the second category, women and decision-making, and Table 2 shown on page 34, shows 17 papers included in the third category relating to influences that surround decision-making. Figure 1 overleaf illustrates the three categories of evidence used within this review. Empirical perspectives relate to studies that are based on or concerned with observations or experiences and not based on theory or pure logic. The theoretical perspective draws on theory rather than practical application; these are calculated through theoretical models of decision-making that underpin the research inquiries, while anecdotal accounts are based upon the story telling of real incidents where participants' accounts are purely hearsay.

Figure 1 Conceptual perspective that informs research evidence.

Anecdotal

Empirical

**Body of
Evidence**

Theoretical
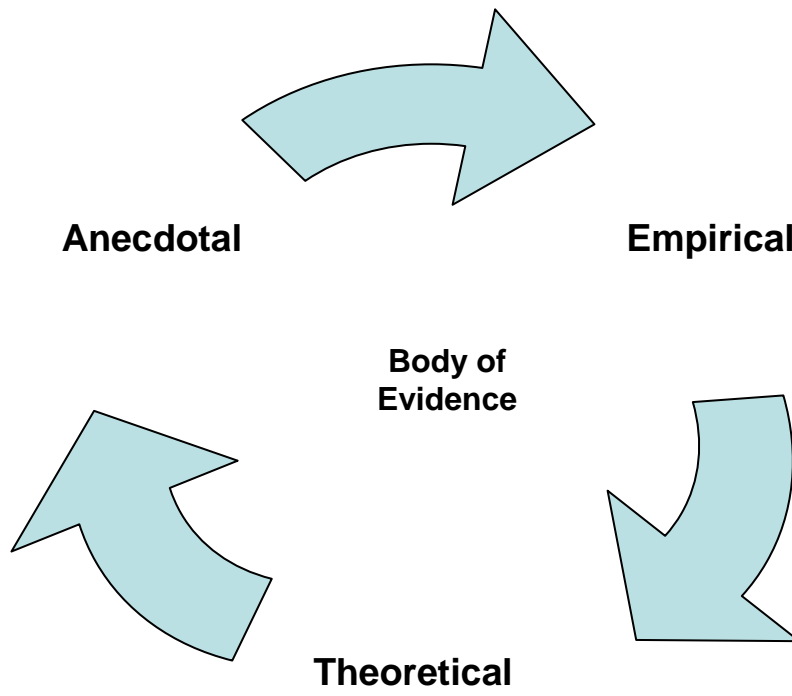
The relevance of work of Levy to this study

Levy's (1999b) qualitative study using a grounded theory approach was first to address issues surrounding informed choice and how midwives facilitate this process to women during pregnancy. Levy (1999b) sought to identify the factors and processes that midwives involve when they assist women to make informed choices during pregnancy. Her study identified how midwives communicate with women in their choices towards a safe course of care. She termed this 'protective gate keeping', which she refers to as courses of action that are perceived to be safe by the midwife and how midwives would 'protectively steer' women into making safe decisions about care, as the midwife perceived them (Levy 1999b p115). The midwife prioritised information according to her own perceptions of what she felt women required. This was by trying to protect the woman and her baby from any physical harm by guiding her away from a specific course of action, or by influencing her to adopt a healthy lifestyle. Furthermore, she highlighted how midwives 'walked a tightrope' when facilitating informed choice in an attempt to meet the wishes of women. Midwives steered their way through several dilemmas, anxious to meet the wishes of women and to appear unbiased in advice giving, whilst acknowledging their own strong feelings regarding some issues. A limitation of her study is its age and the medically dominant environment of the time in which the data was obtained. Awareness of informed choice within maternity care has grown following recommendations set out in Changing Childbirth (Department of Health 1993) and remains reinforced by current policy (Department of Health 2007) hence, her work remains significant to this study.

What emerges from Levy's (1999b) study is how midwives use involved factors, including policies, personal and professional views to assist women in decision-making and how informed choice is conceptualised and conveyed to women by midwives. Furthermore, how factors relating to language and power, midwife beliefs and perceptions within individual decision-making are communicated to women. Important concepts within the content of decision-making are further highlighted as they illustrate clearly the implications of power over women in a given situation, as midwives protectively gate-keep women into courses of action that are perceived as safe by the midwife.

Women and decision-making

This section aims to examine the central themes that emerge from 14 original studies relating to decision-making and women and whether the voices of the participant women are evident. The concept of true voice is taken to mean the ability of the researchers, by methods undertaken, to give women a genuine ability to express themselves and to put across their own opinions and attitudes to whatever is being explored. The importance of research in facilitating true voice is an integral and essential part in clinical practice; policy development and management; and the recent quality agenda; patient and public involvement (Department of Health 2012), provides contemporary rationale for why we must 'hear women's voices'. Asking and understanding how women feel about and experience their care, supports the provision of effective and appropriate practice development that can offer not only real choice to women (Department of Health 2007, Jackson-Barker 2006), but have a lasting impact on future health (Department of Health 2004).

Table 1 illustrates the studies for review.

					Table 1 Women and decision-making		
Date	Reference	Country	Design	Sample	Setting	Focus of study	Limitations of study
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1990	Waterworth & Luker	UK	Qualitative: grounded theory by informal conversation style interviews	12 patients. Convenience sample	3 mixed sex medical wards	How patients perceive being involved in decisions concerning their own treatment and nursing care	Age and size of study, not transferable to midwifery as not synonymous with active patient involvement. Questionable whether patients could speak freely.
1998	Santalahti, Hemminki, Lattika & Ryynänen	Finland	Qualitative: questionnaire, response rate of 88%	45 women (index), 46 women (control group) women with negative serum screening results matched for parity, age and previous miscarriage	2 towns. 1 maternity centre from each town	To examine how women themselves in an unselected population describe their decision-making in the different phases of serum screening.	Only examines one decision-making process in pregnancy. Highly emotive decision-making cannot generalise to decision-making in general in pregnancy.
1998	Pelkonen, Perälä, & Vehviläinen-Julkunen.	Finland	Quantitative: mailed questionnaires. Response rate of 73%.	Random sample of women aged between 18-44 (n= 1289)	Mailed to participant	To acquire knowledge of the opportunities that expectant mothers had to participate in decision-making regarding their care in maternity clinics during their last pregnancy.	Estimation from memory 7-15% did not remember experiences, potential for bias in findings. Not transferable to England.
1999	VandeVusse	USA	Qualitative: re-analysis of 33 birth stories using exploratory descriptive design including analysis of content and themes.	15 women representing a variety of birth experiences (8 primiparous ,7 multiparous , birthed in previous 4 months).12 were Euro-American descent, 3 women of colour		To examine the four major categories of decision-making identified in the original study for the patterns of control in the ways that decisions were made and to identify how these related to the emotions expressed by the women.	Small study one geographical area.
2000	Galotti, Pierce, Reimer & Luckner	USA	Qualitative: interviews Quantitative : survey	88 women (paid to participate) recruited through signposted information in several small towns and suburbs/word of mouth advertisements	College laboratory, participants' homes, places of employment	Choice of birth attendant	Paid participants, possibility of influencing motives to take part. No participant narrative to aid interpretation. No voice.

2002	O'Cathain, Walters, Nicholl, Thomas & Kirkham	Wales	Quantitative: cluster trial postal questionnaire. 64% overall response rate.	4 separate samples of women using maternity services: antenatal before/after intervention. Postnatal before/after intervention	13 maternity units	To assess the affect of leaflets on promoting informed choice in women using maternity services.	Definition of 'informed choice'. Under representation of certain groups. Implementation difficulties of the intervention leaflets.
2003	Harrison, Kushner, Benzies, Rempel & Kimak	Canada	Qualitative: in-depth interviews postnatal	47 women with hypertension or threatened preterm delivery	Community based or in-patient prenatal care	To examine women's experiences of and satisfaction with their involvement in healthcare decisions during high-risk pregnancy	Reflection on emotive decisions following a safe outcome may influence decision-making.
2004	Skea, Harry, Bhattacharya, Entwistle, Williams, MacLennon & Templeton	Scotland	Quantitative/Qualitative: Structured questionnaire preoperative - 66% response rate. Post operative in-depth interviews.	104 women questionnaires returned. 20 women interviewed (purposive sampling)	Teaching hospital and a district general hospital	To explore women's perceptions of and satisfaction with various aspects of decision-making relating to hysterectomy.	Questionable approach of some participants for inclusion in study
2004	Blix-Lindström, Christensson & Johansson	Sweden	Qualitative: modified grounded theory. Open ended interviews	20 newly delivered women who had received oxytocin infusion for augmentation of labour during childbirth	Postnatal wards in 5 hospitals	To describe women's experiences of participating in decision-making related to augmentation of labour.	Short reflection time. Perceptions may have been distorted by emotional highs/lows, pain, medication, sleep deprivation.
2004	Seibold	Australia	Qualitative: pilot study, face to face open ended interviews (interviewed in 2nd trimester and 6-8 weeks postnatal. Brief telephone interviews 6 months post birth. Types of grounded theory used in coding and identifying themes.	5 English speaking participants of 17-23 years of age.	Major metropolitan hospital and community setting	To explore young pregnant women's experiences of embodiment, ongoing identity construction, decision-making processes and the way in which these are influenced by temporary discourse, information sources and interaction with health professionals and others.	Small sample. Only 4 participants recruited by the method and 1 recruited due to being known to the researcher.

2005	Weaver & Statham	UK	Qualitative: questionnaire (20% response rate) and semi-structured interviews	44 postnatal English speaking women	2 districts	Choice and decision-making in caesarean section	Very low response rate. Doesnot clarify the distribution amount of questionnaires so cannot be clear of the true response rate.
2007	Montgomery, Emmett, Fahey, Jones, Ricketts, Patel, Peters & Murphy	England & Scotland	Qualitative/Quantitative: RCT baseline questionnaire. Follow up 6 week postnatal questionnaire	742 pregnant women with one previous LSCS. All English speaking	3 maternity units SW England & 11 Scotland	To determine the effects of 2 computer based decision aids on decisional conflict and mode of delivery amongst pregnant women with a previous caesarean section	All English speaking women. Findings can only generalize to English speaking women making decisions about mode of delivery after previous C/S.
2007	Moffat, Bell, Porter, Lawton, Hundley, Danialian & Bhattacharya	Scotland	Qualitative: diaries, observations and semi-structured interviews	26 women who had previously have had caesarean section for a non recurrent cause	Antenatal unit in a teaching hospital and participants homes.	To explore prospectively women's decision regarding mode of delivery, following delivery, following previous caesarean section.	Clinic staff recruited sample, cannot guarantee all who potentially could have been included in criteria were. Incomplete information non attendance at hospital appointments, diaries not returned and unavailable for interviews.
2008	Hindley, Hinsliff & Thomson	England	Qualitative: exploratory descriptive design. Completed antepartum survey using questionnaire.63% of sample group completed postpartum questionnaire.	63 pregnant women of low obstetric risk	2 hospital providers of maternity services	To investigate the degree of choice pregnant women of low obstetric risk had in making informed decisions on the use of intrapartum fetal monitoring techniques.	Unable to recruit certain sample groups, all were white and English speaking. Findings limited, not transferable to all women.

The studies

The 14 studies spanned 1990 to 2007. Of these two (Skea et al. 2004, Waterworth and Luker 1990), related to decision-making about nursing care, one from a gynaecological surgery perspective, the other a medical/surgical perspective. The remaining studies relate to maternity care and woman in the decision-making process. Seven were undertaken in the UK (Hindley, Hinsliff, and Thomson 2008, Moffat et al. 2007, Montgomery et al. 2007, Weaver and Statham 2005, Skea et al. 2004); three were European (Blix-Lindström, Christensson, and Johansson 2004, Pelkonen, Perälä, and Vehviläinen-Julkunen 1998, Santalahti et al. 1998) and the remaining four from the wider global community including USA, Canada and Australia (Seibold 2004, Harrison et al. 2003, Galotti et al. 2000, VandeVusse 1999).

Nine studies were qualitative in design, two were quantitative and three used a mixed method approach. Six investigated from a 'high risk' situation and included; decision-making about mode of delivery following a previous C/S (Moffat et al. 2007, Montgomery et al. 2007); women who had reported making a decision about C/S during pregnancy (Weaver and Statham 2005); augmentation of labour (Blix-Lindström, Christensson, and Johansson 2004); women's experiences and satisfaction with decision involvement during high risk pregnancy (Harrison et al. 2003) and prenatal screening following a positive Down's Syndrome serum test (Santalahti et al. 1998). Only one study utilised a group of low obstetric risk women making informed choices about the use of intrapartum fetal monitoring techniques (Hindley, Hinsliff, and Thomson 2008). In the seven remaining studies no reference to any specific context was made (Seibold 2004, Skea et al. 2004, O'Cathain et al. 2002, Galotti et al. 2000, VandeVusse 1999, Pelkonen, Perälä, and Vehviläinen-Julkunen 1998, Waterworth and Luker 1990).

A high proportion of sample groups in the studies were from an antenatal perspective (Montgomery et al. 2007, Weaver and Statham 2005, Harrison et al. 2003, Galotti et al. 2000, Pelkonen, Perälä, and Vehviläinen-Julkunen 1998, Santalahti et al. 1998), with some, following up with postnatal interviews (Weaver and Statham 2005, Harrison et al. 2003), whilst others used intrapartum perspectives of decision-making (Hindley, Hinsliff, and Thomson 2008, VandeVusse 1999). Only two studies utilised an antenatal/postnatal focus (Seibold 2004, O'Cathain et al. 2002).

Seibold's (2004) study effectively captured the voice of participants but a limitation to the study was its small sample group of English speaking women and cannot be assumed to be the same for other cultures. Only four women were recruited from a single antenatal class, a fifth member was known to the researcher which could potentially lead to bias. O'Cathain et al's (2002) quantitative study into assessing the effects of decision aids, showed how these can be an effective tool under certain circumstances, though not necessarily effective in the real world. There was a lack in definition of 'informed choice' and the researchers acknowledged the question used to measure this, was potentially insensitive. An underrepresentation of non-white women and women in manual occupations alongside poor distribution of questionnaires meant that this study was unable to achieve its objectives. Skea et al (2004) explored decision-making in relation to hysterectomy in pre and post operative situation. No studies related solely to context specific decision-making in the postnatal period for example, infant feeding techniques.

The higher proportion of antenatal perspective studies reflect an increased interest by researchers for studying this period, potentially because more decisions about the different care options are made in this phase (Galotti et al. 2000, Santalahti et al. 1998). Four studies (Blix-Lindström, Christensson, and Johansson 2004, Skea et al. 2004, Galotti et al. 2000, Santalahti et al. 1998) raised concern about the short decision-making time that often characterises obstetric/maternity care decisions. These studies promote decision-making as an emotive high anxiety state (Santalahti et al. 1998) made in a specific time period, where women do not generally have long to weigh up the options before arriving at a decision (Blix-Lindström, Christensson, and Johansson 2004). Galotti et al (2000), refer to these as important related life decisions where there are few other important life decisions one encounters in such a well defined time frame.

Santalahti et al (1998) explored different phases of prenatal screening and women's decision-making. They highlight one women's expression at having a diagnostic test as 'a horrible big decision with whatever you decide, the rest of your life you will wonder whether you chose right' (1998 p1072). This demonstrates the complex nature of decision-making and choice as a basic human experience and highlights the nature of how Patel, Kaufman and Arocha (2002 p53) express decision-making as, 'being nearly synonymous with thinking'. Whilst the aim was not to ask women about their reasons

for participating in screening, in Santalahti et al's study (1998), only describing decision-making in a period of higher anxiety states, limits understanding and findings cannot be contextualised to non-anxiety decision-making states in pregnancy. Understanding personal reasons for participating in screening may shed more light as why particular decisions are made. Examining from a phenomenological perspective how women themselves experience their decision-making may provide understanding as to what influences the process in the different phases of pregnancy.

Four emerging themes were evident following analysis

In deeply engaging with the literature, themes did begin to naturally emerge. Studies cross over themes and illustrate the connectedness they had with, and to, one another. The themes in this section on women and decision-making are listed below. What determined these was the focus of each study and represented, what aids the process; the process itself; engaging in and the result of the process.

- Use of decision aids for decision-making

- Types of decision-making

- Satisfaction with decision-making

- Opportunities to participate and degree of choice

Use of decision aids for decision-making

Two studies presented the use of decision aids as a way of assessing effects upon decision-making for women in the antenatal period (Montgomery et al. 2007, O'Cathain et al. 2002). Montgomery et al's (2007) medical based study aimed to determine the effects of two computer based decision aids on decisional conflict regarding mode of delivery in women with a previous C/S. They explain decisional conflict as a degree of uncertainty about which course of action to take. Research aims were to explore which

system could best suit a 'high risk' category of women to potentially aid more women in achieving vaginal birth. A secondary aim was to assist doctors make better decisions about care (Godlee 2007). Findings showed that computer based decision aids can reduce decisional conflict among pregnant women with one previous C/S, this and in sampling only English speaking women, findings cannot be generalised to other groups of women, for example those who had experienced more than one C/S or others who might have different social or cultural considerations. These present a different set of variables that may alter findings.

A randomised control trial (RCT) into use of evidenced based leaflets was undertaken to examine the effectiveness of decision aids in promoting informed choice and decision-making for women using maternity services (O'Cathain et al. 2002). Despite claiming limitations to their study as, a response bias and a poor definition of informed choice, their indication that decision aids can be effective under certain circumstances is comparable to Montgomery et al's findings (2007). RCT of the use of informed choice leaflets overall did not change the proportion of women who reported exercising informed choice and this failure may have been due to difficulties with implementation of the intervention. The conclusions drawn were, that in everyday practice, evidence based leaflets were not effective in promoting informed choice and did not help to promote informed choice in maternity care. A secondary measure looked at changes in women's knowledge, satisfaction with information, choice and discussion. Findings illustrated a small increase in satisfaction with information in the intervention group and supports the claim for use of decision aids to improve knowledge and active participation in decision-making (O'Cathain et al. 2002). Moreover, this can reduce decisional conflict and anxiety (Montgomery et al. 2007).

These studies suggest decision aids can help patients to participate in their care in certain circumstances, especially in influencing the mode of delivery following previous C/S. Although these may not be effective always in everyday practice, they can improve realistic expectations and may do more so for decision-making in more uncertain situations (Lauer and Betrán 2007).

Types of decision-making

Waterworth and Luker (1990) explored patients' perceptions of involvement in decision-making concerning treatment and nursing care. The authors provide insight about how patients view collaboration with their care provider and suggested that participants presented themselves as 'not keen' to participate in decision-making; reluctant to ask questions; expressing real concerns to stay out of trouble and do what was right to please the nurse. There was evidence to support how positive associations between active patient participation can improve outcomes and better patient adjustment (Waterworth and Luker 1990). Both Montgomery et al (2007) and O'Conner et al (2006) have highlighted the effects of active patient decision-making and the positive influences that can be drawn from this in practice.

Montgomery et al (2007) conclude patients seem willing to relinquish their responsibilities and accept the situation. Accepting of the situation, termed 'toeing the line', was an integral part of hospitalisation and demonstrates how patients are willing to comply with routines. Hart (1977) associates this with feelings of dependence upon the expert, largely because of the patients' condition, associated experiences such as pain, and the reliance upon staff for pain relief. A limitation of the study is its age. This is important because today, the general public have greater awareness of their rights and choices as well as having high expectations around the standards of care and choices. Findings from Hart (1977) may not transfer to midwifery care where women centred care is integral. Nevertheless this does highlight how service users may not always desire choice about care, its advocacy by professionals and policy (DOH 2007), and demonstrates a different representation of patient decision-making where some patients are happy to 'toe the line'.

Moffat et al (2007), explored mode of delivery among pregnant women who have previously had a C/S. Whilst there were limitations such as sample eligibility, recruitment was undertaken by clinic staff and not by the researchers, hence it is not possible to guarantee that all women who potentially could have been included in the study were approached. Incomplete data with diaries not being returned and women being unavailable for interview also limited findings. However, findings did demonstrate a perception that professional groups viewed merits of care differently and in agreeing with one professional group such as doctors, the women felt they had to hide their decision from the other group, midwives. This lucidity highlights the tension for

individuals' in their care choices and the related reflection of what others' actually think, and potentially 'judge' about their decisions. It raises the question about the level to which and how individual practitioners have the ability to influence care choices and highlights that women recognise the differing philosophies that underpin maternity care.

VandeVusse's study (1999) analysed instances of control. She demonstrated four types of decision-making interaction between caregivers and women through women's expressions of emotional use of feeling words. Her methods of reanalysing 33 birth stories to clarify how decisions were made in labour she claims, is a more recent phenomenon of scientific analysis. She indicates how practitioners have previously been encouraged to listen to women's birth stories directly as a way to help woman make sense of their experiences, but rarely have practitioners been instructed to do this as a part of exploring practices in ways that could benefit women. She believes that this would not only allow for practitioner understanding of such accounts of birth care, but that this knowledge could be used to improve women's experiences.

She categorised decision-making between caregivers and women by four corresponding methods of interaction. These ranged on a continuum from unilateral decisions made by the caregiver to joint/shared control between women and the caregiver. VandeVusse's results are summarised in figure 2 overleaf as a model of patterns of control and women's expressed emotions.

Findings demonstrated how women were 'accepting' of suggestions and this was due to them feeling their opinions and requests were listened to and they were able to make informed decisions following adequate information and discussion. This is somewhat at odds with Waterworth et al's (1990 p972) earlier study which declared 'accepting' as 'toeing the line', with patients complying to be seen as doing what is right. However, VandeVusse (1999) concludes that women were more likely to accept interventions when given explanations and allowed simple choices even about uncomfortable interventions. What such inconsistencies in findings highlights, is that further research in analysing women's birth stories is called for to draw wider conclusions and learn about labour from experiences.

Figure 2 Model of patterns of control and methods of decision-making related to emotions expressed in women's birth stories. VandeVusse 1999 p48.

Control of decisions   **Women's expressed emotions**

+

Joint: Caregiver and Women
Shared: Through requests   Confident, comfortable

Shared: Through explanations   Appreciative, honored

Suspended while waiting: Through no active decision   neutral, reassured

Uncontested: Through agreement   Surprised, resigned

Contested: Through adaptation   Sad, angry, devalued

Contested: Through refusal   Unsettled, punished

Unilateral: Caregiver to woman

−

The above figure shows how the more unilateral the decision, the more negatively the woman would express herself, conversely, more positive emotions were expressed as decision-making was increasingly shared. As caregiver control during labour increased, women felt excluded from participating in decisions regarding their bodies and as caregiver's exerted unilateral control, adverse situations developed with no active co-operation toward a common goal to fulfil healthy birth outcomes. Within this study the theme emerging is one of 'control' and who has 'control' in a given situation. The more critical the situation, the more the caregiver exerted control and the more the women were happy in certain situations, to let that occur. If practitioners are aware this can occur, it is reasonable to suggest it could potentially be manipulated to how a situation is presented, addressed and the language used within it.

Skea et al, (2004), explored women's decision-making relating to hysterectomy. They showed how women described aspects of the decision-making process with caregivers as suboptimal. Reasons cited were, being given too little information about advantages and disadvantages of treatments, and being put on the spot about decision-making and being hurried to make up their minds. The way in which some participants were recruited for this study is a serious limitation. In some cases, questionnaires were sent pre-operatively, allowing time for consideration whether they wanted a hysterectomy or

not and time to discuss their options with family and friends. Those who were recruited on the day of admission, or the day prior to surgery, were denied the same time scale opportunities in which to make up their minds. Clearly not all women had the opportunity to discuss issues with family and friends and are a variant in some women's experiences. Findings suggested communication with doctors did impinge upon views about treatment choices with some women having residual doubts about the appropriateness of treatments. The authors suggest that there is a "substantial minority of women do not feel adequately informed to make or fully understand the decision for hysterectomy" (2004 p139) and shortcomings in patterns of information and communication relating to decision-making.

Their results demonstrated a high percentage of women wanting to work out treatment options with the doctor. This equates to the joint decision-making VandeVusse describes in her model (VandeVusse 1999). A small percentage of women were happy for the doctor to make the decision about treatment options, again reflective of VandeVusse's (1999) model of unilateral methods made by the caregiver. There were a small percentage of women who wanted to make decisions by themselves. Although this reflects the unilateral method of decision-making, the unilateral method from the perspective of the service user has to date not been addressed, only in respect of the caregiver. It could be argued that the woman's decision method may simply be due to resigning herself to the intervention such as conforming, rather than a refusal to opt for different treatment options. Coupled with some women (Skea et al. 2004), feeling they had inadequate support in their decision-making in describing doctors as being abrupt, uncaring and hurrying them in this process, this remains a contemporary issue in light of dignity and compassion and professional values today (Department of Health 2012), and worthy of further inquiry. Skea et al (2004), suggest that women felt they could not make informed choices when put on the spot, which led them to seek further additional information to what was initially provided by the doctor. Women acknowledged decision-making to be provisional and that final decision's might change if the situation necessitated (Moffat et al. 2007).

Satisfaction with decision-making

Women like to have their thoughts and feelings heard (Moffat et al. 2007) and there are close ties with the satisfaction women experience and the decision-making process.

Blix-Lindström, Christensson and Johansson (2004) found that even though some women were invited to participate in the decision-making process, they refrained, but remained satisfied with their decisions made. Harrison et al (2003) found women do experience increased feelings of responsibility for their and their babies' health, but women differed in their responsibility to decision-making and wanted either passive or active involvement in the decisions about care. For women who wanted active involvement, this was achieved through different processes; struggling for; negotiating or being encouraged. Women wanting passive involvement or those facing a health crisis utilised the process of trusting in the professionals to make decisions about care. These notions are supported through the models presented by VandeVusse (1999). Women satisfied with passive involvement, or those whose pregnancy complications gave them limited opportunity for involvement, relied on the expertise of the practitioner and were content to do so. It is worthy of note, that potentially this could be more to do with situations involving decisions and choices under uncertainty or in fast changing situations (Lauer and Betrán 2007).

Findings looking at satisfaction with decision-making regarding augmentation of labour (Blix-Lindström, Christensson, and Johansson 2004) illustrated how the support and guidance given by midwives was decisive in explaining how women experienced involvement in decision-making. Though midwives were seen as comforters, information and advice providers and fulfilled roles as emotional supporters (Blix-Lindström, Christensson, and Johansson 2004), the satisfaction women felt was emphasised by the importance of the feeling of acquired support and encouragement from midwives, in order to become confident about decisions regarding care. Midwife support and guidance appears to be a crucial factor in this study, irrespective of women's knowledge and expectations. The findings of Blix-Lindström et al, (2004), demonstrated that participation in decision-making is not the most important factor for women's satisfaction, but empowerment from midwives seems to be of great importance for women's experiences in childbirth. Furthermore, a previous study concurs with this suggestion (Lundqvist, Nilstun, and Dykes 2002). Empowerment and the value of this phenomenon has also been described by authors in women's health (Lundqvist, Nilstun, and Dykes 2002), nursing (Gilbert 1995, Skelton 1994) and in exploring practitioner views relating to empowerment (Fulton 1997).

In contrast to Blix-Lindström et al (2004), VandeVusse's (1999) demonstrated, more positive birth experiences were had when women were involved in decision-making and more negative experiences when they were not. VandeVusse's (1999) study explored a range of experiences, one third of participants having home births and one third having C/S births. Whilst Blix-Lindström et al's study (2004) relates to decision-making solely from the perspective of an increased risk situation. Increased risk or anxiety situations are emotive and the literature has illustrated how women either use the expert practitioner in a health crisis or passivity in their decision-making. This has the potential to change how practitioners and women conceptualise and interpret control and the associated role they play as decision makers within it.

Opportunities to participate and degree of choice

Four studies focused upon opportunities to participate and degree of choice in decision-making. All were in relation to intrapartum care, two regarding C/S as mode of delivery (Moffat et al. 2007, Weaver and Statham 2005) and therefore in an increased risk situation. Galotti et al (2000) explored whether the ways women go about making decisions were different if they did not see a midwife. Hindley, Hinsliff and Thomson (2008) investigated the degree of choice women of low obstetric risk had in making informed decisions on the use of intrapartum fetal monitoring techniques.

Galotti et al (2000) established that women who selected a midwife in preference to a doctor for care, felt more knowledgeable about birth attendants; felt more in control in their birth attendant's decisions and more agreeable towards 'alternative birth' philosophies over more 'conventional birth' philosophies. It could also be argued therefore, that women were agreeable and therefore potentially influenced by midwives ways of thinking. Women felt more likely to use 'gut' instinct and previous experience to make pregnancy decisions than women who had not selected a midwife as their primary birth attendant. Participants were paid to participate and this raises questions as to what were the influencing motives for participation. There is no way of knowing if being a paid participant influences the information given and what impact there may be on women's feelings and responses.

Galotti et al (2000) explored experiences of American women within a USA model of obstetric care. Women accessing maternity services in England have a choice of

antenatal care and depending upon their circumstances and level of risk, women and their partners are able to choose between midwifery care or care provided by a team of maternity health professionals including midwives and obstetricians (DOH 2007). In care overseen by obstetricians, it is ultimately the obstetrician that has professional autonomy even though care is carried out by midwives under the obstetricians' instructions. Midwives have ultimate professional autonomy and decision-making in normal midwife led care is with the women they care for. A key consideration seems to remain therefore, around whether the difference in caregiver change women's perceptions of their care and influences more conventional birth philosophies.

The use of informed decisions regarding intrapartum monitoring techniques, by Hindley, Hinsliff and Thomson (2008) is interesting. Fetal monitoring in low risk normal intrapartum care should be intermittent auscultation of the fetal heart rate following a contraction either by doppler ultrasound or pinnard stethoscope (NICE 2007). Hindley et al (2008) asked 'low risk' women in the antenatal and postnatal period, about their views on choice of intrapartum monitoring. The antepartum survey revealed 56% of women wanted to receive electrofetal monitoring (EFM) in labour even though there was no medical/obstetric indication for this and no assumptions were made by the authors in supposition of preference. The postnatal survey revealed 61% had some form of EFM. In asking women in the antenatal survey about their preferences for decision-making about monitoring method, results revealed women wanted to make final decisions after considering their midwives opinions. Despite this choice, being in control in labour was seen as important to all these women, almost all participants said the midwife had not given them the choice of monitoring method even though women felt they had received informed choice overall. This is interesting because NICE (2007) states that changing from intermittent auscultation to EFM should be advised for a number of increased risk situations and whilst advocating maternal request as being one reason also, they highlight "appropriate use of electro fetal monitoring" (2007 p2) should be undertaken. Low risk is arguably not appropriate use for EFM.

Midwives in this study should have been engaging with the evidence base to inform their practice in the appropriate use of EFM (NICE 2007 p2). Therefore it was not a necessary care option to inform the women of choice for EFM. Hindley and colleagues (2008), conclude, women still expect EFM as a chosen method of fetal monitoring, and fetal monitoring practices for women with normal pregnancies do not reflect current

evidence. Nevertheless, the findings clearly show that women expect certain practices in labour. This is important and suggests how practitioners communicate choice and decision-making remains a complex issue. Moreover, this exemplifies the struggle holistic midwifery care is faced within the biomedical model of medicine where technology takes precedence (Edwards 2010a).

Despite strict criteria for inclusion in this study (Hindley, Hinsliff, and Thomson 2008) the authors reported that all women who received EFM, all chose epidural or narcotic analgesia and as this was different from their original intentions of actual preferences in labour, the authors state that such factors were likely to have been influential. These are key findings that clearly demonstrate the impact decision-making has on interventional care practices. Conclusions drawn are that midwives can undoubtedly influence women's in decision-making.

Intrapartum care is increasingly dominated by the use of EFM and its application, as a routine measure regardless of risk, is not based on either expert opinion or best evidence (Hindley, Hinsliff, and Thomson 2008). Effective midwifery decision-making should take into account women's' preferences and values as well as best available evidence (Cioffi and Markham 1997) and one explanation could be that midwives do take into account best available evidence and in so doing, this appears to women as not being offered certain options such as EFM. Women may simply not understand the reasoning why something may not be offered to them. This reflects how the meaning of 'normal process' and the 'perception of risk' may be different for midwives and the woman in labour (Thorstensen 2000). Women almost without exception in Weaver and Statham's study (2005) positioned C/S as safer for the baby than vaginal birth. This illustrates that it could be women's perceptions of potential risk that is key to understanding why they choose some options over others. The difficulty with women focusing upon risk is highlighted by Edwards (Edwards 2005) in her research with home birthing women. She found that the women believed focusing on risk during pregnancy and birth generated fear that is both unsubstantiated and undermines women's self confidence and paradoxically increases risk.

Women do not always have the relevant information to make an informed choice, especially where fetal monitoring is concerned (O'Cathain et al. 2004), but Green (2005) highlights, despite the increased emphasis on evidence based practice

initiatives, this emphasis has not had an impact on reducing levels of intervention that take place in the UK. The reasons for this remain unclear; Green (2005) argues that uncertainty and risk are key issues that underlie the medicalisation of childbirth, reflective of previous claims (Richens 2002).

Kirkham (2004) suggests women are not always offered an equal choice between options, especially by the time of labour and birth and this is clearly contra-indicative to women's inclusion in decision-making. Maternal request for changes in care management for example, EFM, may be seen as contra-indicative in normal birth since women should be encouraged to be upright, mobile, free to adopt positions of comfort in labour and not be restricted by any means for any length of time. The situation is paradoxical in normal childbirth as EFM is not necessary, yet due to years of medicalised discourse women see this as synonymous with the childbirth experience. Moreover, women have become socialised to require it, predominantly because of its links to fetal wellbeing and reassurance, despite evidence to the contrary.

Discussion

Whilst some want to adopt some degree of control over decision-making (Skea et al. 2004, VandeVusse 1999), some patients may not want to be involved in decision-making (Waterworth and Luker 1990). Waterworth and Luker (1990) suggest, even when patient involvement is encouraged, patients who do not want a collaborative role about care decisions are happy to comply with the 'toe the line' approach. This has been contested by Davis (2001) who suggests the way information is presented, consciously or unconsciously, can be weighted towards specific choice and that women move from their comfort zone into an environment that perceives the professional to have all the power and authority. This might mean women may simply conform to treatment and 'toe the line', with professional groups creating a context of coercive, albeit unwitting compliance (Williamson 2010).

Women have shown a desire to be involved in the decision-making process (Moffat et al. 2007, Santalahti et al. 1998). However, some do not participate actively and others are uncomfortable with having the responsibility for it. There is accruing evidence within the work of Moffat et al (2007), Levy (1999a) Santalahti et al (1998) and Waterworth and Luker (1990) to suggest compliance with caregivers and as women look for information and guidance from professionals (Moffat et al. 2007, Seibold 2004, Skea et

al. 2004), this has an impact on their decision-making process. A possible answer may lie in creating awareness for practitioners of the types of decision-making individuals might use. In encouraging informed choices, this knowledge could foster further understanding between women and caregivers enabling for a more shared understanding of each others' expectations. This could lead to a new coalescence of decision-making for both women and professionals and the potential to feel comfortable with decisions made; where both service users and those providing care feel empowered (Murrell 1985) and supportive relationships between them are improved.

Some women want to be active decision-makers whilst others wish a passive role. Passive or active decision-makers can equally be satisfied or dissatisfied with the decision-making process. Passivity is particularly pertinent in a maternity or obstetric crisis. It could be argued that potentially women wish to hand over responsibility in fast changing situations. Women trust and use the expertise of the health professional and feel more satisfied if care from these professionals is congruent with how they wanted to be involved in the decision-making process (Harrison et al. 2003). The most important factor seems to be the ability of the professional to support them in their preferred role in the decision-making process. This provides strong evidence to suggest individual practitioners can have an impact on women's individual decision-making processes in all situations, for example in emotive decision-making situations such as antenatal screening, in a high risk pregnancy such as C/S, and as changes occur in care options such as augmentation of labour. The ideology of practitioner impact on decision-making is illustrated further by others who write authoritatively within midwifery and childbirth (Hunter 2011, Edwards 2010a, Edwards 2005) and decision-making with patients in healthcare (Williamson 2010).

An interesting notion with respect to EFM and assessment of fetal wellbeing including 'appropriate use of electro fetal monitoring' (NICE 2007), is who deems appropriate use? Monitoring practices during birth, Edwards (2005) highlights, is integral to obstetric practices and hence midwifery care. NICE guidelines are developed for care providers, doctors, midwives and women. However, it is the care provider who is more likely to have engaged with the guidelines and understand the underpinning rationale. This may be in contrast to women's' expectations or choices for her labour experience (Edwards 2005) and can carry with it implications for the midwife-mother relationship.

EFM can be used both intermittently and continuously and whilst this review does not aim to discuss the advantages and disadvantages of continuous EFM, even in intermittent use, this can have restrictions for the woman and so its costs and benefits must be weighed up (Anderson 2010). The EFM process affects natural labouring behaviours as in climbing onto the bed for monitoring to occur. The woman does not then wish to mobilise as she feels more comfortable. As pain increases and she is tired she may soon begin to re-evaluate her choice of pain relief. If intervention occurs as a result of care actions in labour, at what point can it be traced back to certain behaviours, actions and decisions undertaken by the care giver or herself with the knowledge she has on which to base that decision at that time.

Risk and abnormality within childbirth has been associated within the litigation culture of society (Thomson 2011). The threat of litigation is an important aspect of decision-making for midwives and is associated with increasing uncertainty about birth outcomes (Green 2005) and maternal request may influence the situation. Even within evidence based practice, the situation remains complex. The culture is one of a policy context of choice; choice can be from a number of available options, not all options (Jomeen 2012, Jomeen 2010, Jomeen 2006). If a woman makes a choice not perceived as safe or sensible, professionals may attempt to veto or influence that choice, restricting decision-making, hence choice is a fallacy in some circumstances but also then, difficult for practitioners to offer. In consideration of the evidence on women and decision-making, with few studies, most of which have major limitations, an adequate picture does not provide any real understanding and many questions remain unanswered. What is implicit is that choice and decision-making are clearly complex issues and healthcare professionals and midwives clearly play a significant role in the process of women's decision-making.

Influences affecting decision-making

Introduction

This section aims to examine the central themes that emerged from 17 studies relating to factors influencing decision-making in a maternity context. A pragmatic decision to collectively analyse the influences that relate both to women as service users and midwives as practitioners was undertaken because studies that held women's perspective were found to be minimal. Table 2 overleaf illustrates the studies included in this review.

Date	Reference	Country	Design	Sample	Setting	Focus of study	Limitations of study
					Table 2 Influences affecting decision-making		
1992	Cartmill & Thornton	UK	Qualitative: hypothetical cases, descriptive analysis of case management	19 junior obstetricians	Medical study. Setting not referred to	The way in which medical information is presented may affect doctors' decision-making.	Purely hypothetical therefore no certainty size of effect would be the same in practice.
1996	Jackson, Schmierer & Schneider	Australia	Qualitative: survey using 5 point Likert scale Piloted in a modified Delphi technique	705 midwives	21 major public and private midwifery hospitals	To develop a reliable questionnaire to assess attitudes of pregnant women and appropriate educational experiences for them.	Sample size not justified, 702 females / 3 males.
1998	Tinkler & Quinney	England	Qualitative: antenatal/postnatal individual interviews (core pilot) group interviews antenatal/postnatal	68 women core pilot/ peripheral pilot no change groups	Community setting	Explores women's descriptions of their maternity care experiences in England specifically focusing on their experiences of communication; being informed and making choices; being involved in the process of care and their own perceptions of care.	Main route of information gathering at booking appointment, not much time, potentially rushed, participant pressured. Could feel pressured by interview venue and time.
1999	Kirkham	England	Qualitative: in-depth semi-structured interviews. Grounded theory approach analysis	168 midwives	5 different sites, different in geographical and social settings	Culture in the NHS was examined in order to foster understanding of the context of midwifery practice	Geographical areas and types of social settings not mentioned.
2002	Stapleton, Kirkham & Thomas	Wales	Qualitative: non-participant observations in antenatal consultations. In-depth interviews.	886 midwife-woman consultations. 883 women	13 maternity units	To examine the use of evidence based leaflets on informed choice in maternity services.	Required a revised sampling technique mid study to ensure good representation. Original sampling by staff on duty who expressed time constraints, potentially affecting recruitment.

2004	Mrayyan	UK, USA, Canada	Qualitative: Comparative descriptive survey design (internet data collection). Electronic questionnaire	317 Hospital nurses	Hospital employed nurses from Listserv internet mailing lists. Own Listserv addresses most responded while working in hospital	To examine the role that nurse managers have in enhancing hospital nurses' autonomy	Computerized Listserv problems, delivery failures/returned emails. 23% were undeliverable. Potentially sample not a true representation.
2004	Hollins Martin, Bull & Martin	England	Quantitative: Postal SIS M questionnaire. 65% response rate	209 midwives	7 hospitals in the North of England	Investigate the factor structure of the social influence scale for midwifery (SIS M), gain insight into conformity behaviour of midwives in the practice environment and the relationship of such behaviour to maternal and neonatal outcomes.	Limited evidence for the study to draw upon and the reader to draw conclusions about.
2004	Hollins-Martin & Bull	England	Quantitative: random selection postal private workbook	60 midwives	7 regions of North Yorkshire	To ascertain whether decision changes were caused by social components (interview-interviewee relationship) or education shared through discussion.	Approximately 30-35% of workbooks were returned. Not clear whether these were all completed fully.
2004	Hoffman, Donohue & Duffield	Australia	Quantitative: one group prospective correlation survey 58% response rate using postal questionnaires	96 Registered nurses convenience sample	Medical/surgical areas in 1 teaching hospital and 2 district public hospitals	Determine relationships between occupational orientation, educational level, experience, area of practice, level of appointment, age and clinical decision-making, to determine the predictive ability of each factor on clinical decision-making.	Cannot generalize to UK. Not transferable to midwifery context and the nature of fast changing situations. Convenience sample rather than random sample narrowing clinical field.
2005	Hollins Martin & Bull	England	Qualitative; Interviews Quantitative; survey	60 Midwives. 20 E grades, 20 F grades and 20 G grades.	7 regions of North Yorkshire	Considers whether midwives' decisions are influenced by a senior midwife	Likert scale may have influenced the respondent by suggesting answers that they may not have thought of without the fixed choice alternatives.

2005	Kamel, Dixon-Woods, Kurinczuk, Oppenheimer, Squire & Waugh	England	Qualitative: semi structured interviews	25 midwives and doctors. (13 midwives, 12 doctors).	Acute hospital trust. (2 maternity units and community midwifery service).	Explore the views of health professionals on the factors influencing repeat caesarean section	Only based on one city, cannot necessarily generalize to other settings. Participants could demonstrate impression management and giving answers that demonstrates the correct qualities.
2006	Hindley, Hinsliff & Thomson	England	Qualitative: semi structured interviews	58 midwives	2 hospitals in the North	To evaluate midwives attitudes, values and beliefs about the use of fetal monitoring for women at low obstetric risk	Prior knowledge /preconceptions may have affected data collection.
2006	Barber, Rogers & Marsh	England	Quantitative: cross-cultural survey. 43% response rate. Qualitative: 7 focus groups 5 were groups of maternity users and 2 were midwives groups.	398 women returned questionnaires. 20 service users and 16 midwives took part	Routine antenatal appointment session. Service users invited via community clinics, GP surgeries and antenatal classes.	To identify factors that influence women's decisions about where to give birth	43% response rate. Could be due to recruiting methods.
2006	Freeman, Adair, Timperley & West.	New Zealand	Quantitative & qualitative: questionnaires with open- ended questions	104 midwives. 100 low risk nulliparous women	Various independent, team and hospital based settings.	Examine how the settings in which midwives practice (the birth place) and models of care affect midwives' decision-making during the management of labour.	Questions set did not yield equal responses to draw assumptions.
2007	Handfield, Turnbull & Bell	Australia	Quantitative Qualitative: survey with pre-specified categorical options and questions requiring open ended replies.	216 current practicing obstetricians. Voluntary participation.	Public and private sectors within obstetrics	Perceptions of sources of patient information about pregnancy and birth	Data collection methods. No indication of target population; not sure all were targeted. Incomplete data.

2007	Van der Hulst, Van Teijlingen, Bonsel, Eskes & Bleker	Holland	Qualitative: questionnaire survey of women and their midwives. 98% response rate.	625 women participants	Stratified sample 25 Dutch independent midwifery practices, rural/urban locations.	A national study of midwives' perceptions of women's decision-making in the technical interventions. How independent midwives perceived the relative influence on obstetric decisions of their clients, themselves and their obstetricians.	Random approach of women at appointment. 98% responded to study. Unclear if women may have felt coerced.
2008	Blix-Lindstörm, Johansson & Christenson	Sweden	Qualitative: Focus groups	20 labour ward experienced midwives. Purposeful sampling technique	Representing all labour wards 6 hospitals including midwife led ward.	To explore and understand how midwives perceive and experience decision-making about augmentation of labour.	Small sample. Different units/wards some midwives may have felt difficulties in speaking in the groups.

The Studies

Studies ranged from 1992 to 2007 with a steady flow of research in this field being undertaken from 2002 onwards. This highlights the increasing acknowledgement of this important area. As the preponderance of the studies was English, this could be reflective of the political agenda and the foundation of choice in childbirth at the time. The majority of studies were undertaken within the UK (Barber, Rogers, and Marsh 2006, Hindley, Hinsliff, and Thomson 2006, Hollins Martin and Bull 2005, Kamal et al. 2005, Hollins Martin and Bull 2004, Hollins Martin, Bull, and Martin 2004, Stapleton, Kirkham, and Thomas 2002, Kirkham 1999, Tinkler and Quinney 1998, Cartmill and Thornton 1992), two were European studies (Blix-Lindström, Johansson, and Christensson 2008, van der Hulst et al. 2007) and five were from the rest of the world (Handfield, Turnbull, and Bell 2007, Freeman et al. 2006, Hoffman, Donoghue, and Duffield 2004, Mrayyan 2004, Jackson, Schmierer, and Schneider 1996). The study by Mrayyan (2004) provided cross continental research incorporating data from UK, USA and Canada, allowing potentially for a wider understanding on peer and hierarchical influences on nurses autonomy.

Fifteen studies relating to influences in the decision-making process focused on the practitioner perspective, whereas just two studies had the woman as the central focus (Barber, Rogers, and Marsh 2006, Tinkler and Quinney 1998). Studies were predominantly qualitative in nature and based within the interpretive philosophy (Gerrish and Lacey 2006), aiming to explore through shared interpretation, assumptions about how individuals understand and interpret interaction in a given situation. Some used quantitative methods (Hoffman, Donoghue, and Duffield 2004, Hollins Martin and Bull 2004, Hollins Martin, Bull, and Martin 2004, Mrayyan 2004), and the remaining studies were of mixed method design (Handfield, Turnbull, and Bell 2007, Barber, Rogers, and Marsh 2006, Freeman et al. 2006, Hollins Martin and Bull 2005), covering the cross section of emerging themes.

Once more deep engagement with the literature meant that themes did emerge. The themes in this section are listed below. What determined these was the focus of each study. Practitioner influences are critiqued followed by the influences on women.

Overall there were 3 emerging themes relating to influences on practitioner decision-making:

- Presentation and sources of information

- Beliefs and views

- Hierarchy

The two studies relating to influences on decision-making and the childbearing woman had just one emerging theme.

- Social Influence

Presentation and sources of information

Cartmill and Thornton (1992) demonstrated how the way in which medical information is presented may affect decision-making. The hypothesis they tested was that doctors would be more likely to intervene in labour care when the scale of the partogram led to a flattened cervical dilatation curve, or when the latent phase of labour was drawn on the partogram, as a flat partogram and a long latent phase would imply an impending difficulty in labour and need for intervention (Cartmill and Thornton 1992 p1520). The results from these hypothetic presented labours, illustrated how doctors were more likely to intervene and actively manage labour if the progress of labour curve appeared flat and the latent phase was included.

It is possible to argue that potential intervention in obstetrics relates to and relies on documentation of events rather than actual events and holistic observation, such as labouring women and her behaviours. This is comparable to a midwife in practice viewing a CTG recording to establish intensity of uterine contractions. The only way to assess uterine contractions is through palpating the woman's fundus, and not simply by observing a 'line' recording on paper. The implications are that understanding of the physiology of normal labour by all practitioners is paramount in making assumptions about labour progress, with the latent phase not mistaken as established labour and the obstetric clock set ticking. This can only be done by knowledge and observation in practice. Doctors may not necessarily engage in this normality as part of their normal obstetric practice and is most likely due to the legacy of the medical model that looks from a risk perspective. There are limitations to this small medical study in that there is

no certainty that the size effect of results would be similar in actual practice as decisions assessed were purely hypothetical. It does highlight importantly, the influence that practitioners face in both obstetric and midwifery practice and has implications for the clinical context and for midwifery and obstetric educators by ensuring this is addressed as part of routine education practice.

Stapleton, Kirkham and Thomas (2002), explored the use of evidence based leaflets in maternity care. They present evidence showing acceptance of something does depend on how this is offered or presented to women. Findings illustrated participating midwives had generally positive feelings toward the potential of the leaflets to assist women in making decisions. Pressures within the clinical environment however, impacted on their effectiveness meaning they were rarely discussed by midwives with women at the antenatal consultation. Furthermore, they demonstrated that choices were not always available to women and this was sometimes as a result of certain professional groups' defined norms of clinical practice in limiting choices available.

The authors declared limitations to this study. An opportunistic sampling procedure determined by staff on duty was undertaken initially, but this led to a mid-study review being required which resulted in a more selective sampling approach being undertaken by the researchers to ensure all childbearing women from all minority groups and social classes were represented. Pressures and constraints within the working environment, and a change in sampling technique, means we cannot assume all participants were recruited with the same intention. Further, we cannot assume potential cases such as higher risk or complex cases weren't disregarded due to being more time consuming. Conclusions illustrated how dissemination of leaflets affected promotion of informed choice in maternity care. Women's trust in health professionals was highlighted, but trust ensured compliance with professionally defined choices, with women rarely observed to gain clarity by questioning or making different requests in the process.

Handfield, Turnbull and Bell (2007) show how societal changes mean women are gaining knowledge through the internet. There were issues with data collection techniques; incomplete data; and whether data did truly represent the target population. However, some interesting findings were raised. The authors suggest women source their information and knowledge through the internet and use this as a way of verifying opinions, even accessing second opinions in the context of anonymity.

There is much knowledge women can access via other means beyond communicating on a one to one basis with their caregiver. Contemporary practitioners must be aware that their clients will seek out clarity to the questions they want answering. It is not always within our control to assure the quality or accuracy of information women access, but it is within our control to ensure that the continual building of practitioner-women relationships are in place to ensure women and their families feel they can seek the clarity they require in an unconditional manner with their individual practitioner.

Beliefs and views

This theme referred to how midwives view women as decision-makers and how they perceived women's decision-making around technical interventions in the birth process (van der Hulst et al. 2007), such as repeat C/S (Kamal et al. 2005), EFM (Hindley, Hinsliff, and Thomson 2006), birth environment (Freeman et al. 2006) and augmentation of labour (Blix-Lindström, Johansson, and Christensson 2008). Freeman et al (2006), found birth place setting did influence midwifery practice and medical models of care dominated practices, influenced by intervention and the need for technology. They suggest that pregnant women comply with, rather than choose how they want to give birth. These findings concur with others previously documented (Kirkham 1999, VandeVusse 1999). Kamal et al (2005) suggest that professional attitudes to repeat C/S, could influence and 'convince' women to try for vaginal delivery which is perceived as positive but asserts authority over the woman. C/S was seen as a social practice, though participants did identify evidence as important in making a decision about repeat C/S, the organisation of care and professional boundaries also played an influential role. In conclusion, they suggest that attention needs to focus on the multiple parties that are involved in the decision-making processes. There is no guarantee that these findings can be generalised to other areas of practice or different practitioner groups as this study incorporated a single city. Participants only choose to give the information they wish to (Nagel 1987), and they may have been concerned with management impressions and wish to demonstrate they were conscientious, well informed and compliant with best practice.

Literature surrounding beliefs and views focuses further on midwives' own ideologies and how they view themselves in the culture of midwifery. Jackson, Schmierer and

Schneider (1996) illustrated how negative attitudes can be held by societal members who interact with certain groups. They highlighted a sizeable minority (30%) of registered midwives who had negative attitudes to women's ability to learn and remember information during pregnancy. The study investigated the hypothesis based on a theory of self-fulfilling prophecy (Rosenthal 1976). Rosenthal (1976 p129) describes how 'one prophesises an event and the expectation of the event can change the behaviour of the prophet in such a way as to make the prophesised event more likely'. Applied to the work of Jackson, Schmierer and Schneider (1996), it demonstrates how midwives as societal members who interact with pregnant women have the belief that pregnant women cannot learn and therefore adequate learning opportunities are not provided for these women. Given inadequate learning opportunities to acquire the appropriate knowledge in pregnancy, women will not be able to learn; this lack of knowledge is recognised by the same health professionals and thus reinforces their beliefs that pregnant women cannot learn.

Jackson et al (1996) provide evidence from other researchers who have demonstrated that professionals holding negative attitudes towards patient groups will change their behaviour in line with their attitudes, leading to discrimination. They suggest in light of this, such discriminatory behaviour presents a set of opportunities for the target patient group, which leads to changes in their behaviour, reinforces the professional's negative attitude and thus, the self-fulfilling prophecy. They concluded that midwives, who do believe women can learn, will develop adequate programmes of education to teach them relevant skills and information and suggest that although it is not the majority who hold negative stereotypes about learning in pregnancy, those who do are clinically significant.

Van der Hulst (2007) explored perceptions midwives' have of women's decision-making around technical interventions in the birthing process. The sample group of women were approached randomly on an assigned day; the study had an excellent response rate of 98%. Fowler (1993) recommends a minimum of 75%, where as Bowling (2002) declares 75% as good. Their findings illustrated midwives' views about influences relating to midwifery care practices. Midwives felt they had certain influence over decisions relating to care, for example in referring women to obstetricians, yet felt obstetricians had more influence in other decisions such as induction of labour. Despite caring for women in labour, midwives reported they felt they had less influence when it

came to decision-making around pharmaceutical pain relief and decisions such as in membrane sweep, it was women themselves that had most influence. Blix-Lindström et al (2004) have already highlighted decision-making in an increased risk situation is highly emotive which shows women use the expert practitioner in a health crisis. Women may see induction of labour or referral to obstetricians as increased risk situations, hence, are happy to accede to expert practitioners to take the decision-making lead.

Factors considered by midwives that influence decision-making whilst caring for women undergoing augmentation of labour were identified by Blix-Lindström and colleagues (2008). These included regulations and guidelines; shortage of delivery rooms; influences of obstetricians; women in labour and midwives professional selves. In discussing such environmental factors that influence midwives' decision-making, the authors make brief reference (Wittmann-Price 2004) to patients themselves being able to choose what is best for them. This provides an interesting link to a concept of emancipated decision-making that remains unexplored within childbirth decision-making. This will be discussed later in this chapter.

Blix-Lindström et al (2008) illustrated that midwife job satisfaction can result from a sense of professional power over the possibility of navigating factors that influence decision-making during the augmentation process. Consequently, this sense of power influences co-operation between obstetricians and women during labour.

Kirkham's (1999) ethnographic study examined dilemmas in the culture of midwifery within the NHS to understand the context of midwifery practice. Findings revealed that culture was seen essentially as a service of sacrifice, where midwives lack the rights as women which they are required to offer to their clients. Moreover, not only is there a lack of mutual support and of positive role models of support, but a considerable pressure to conform and experienced feelings of guilt and self-blame were commonly expressed. This is reinforced with the findings of others in this literature review (Hollins Martin and Bull 2005). The impact and the implications for midwives as women on their professional lives and practice, needs to be understood as these directly impact upon practice (Redwood 2008). Kirkham (1999) suggests how a culture where midwives are not seen as women but as lead professionals, directs an imbalance in needs for personal and professional support and results in them feeling stressed and burnt out.

Negative feelings amongst midwives may lead to feelings of oppression (Wittmann-Price 2004) that will impact upon the decision-making process about health care issues and the care midwives give (Kendall 1992). A potential concept that describes the phenomenon in nursing, when caring for women in the decision-making process about healthcare issues is one of emancipation (Wittmann-Price 2004) this is derived from a long standing history of social oppression and is addressed critically by both social and feminist theories. Emancipation is a process that promotes both humanistic patient care and professional growth in clinical decision-making about women's health care issues. Wittmann-Price (2004) aims to define it in application to practice, firstly to promote free choice of women about health care issues and secondly to promote professional growth.

Lavender and Chapple's (2004) later work exploring midwives working in maternity services concur with Kirkham's findings (1999). Despite these studies being the age they are, there has been nothing evident within this literature review to dispute this is any different today. In highlighting midwives' views from across different settings, midwives in all maternity units believed there was a fundamental problem with the culture and ethos of maternity care in England and highlighted poor communication, feeling undervalued and a lack of effective management and clinical support as some of the issues. Midwives expressed lack of confidence to care for women during an uncomplicated pregnancy, whilst acknowledging an effect on their own morale and care for women. One midwife reported, shift leaders as the main barriers to normality, but felt that blame was often shifted to obstetricians. This suggests a fairly intrinsic problem for clinical midwives and one where they do not feel able to assert autonomy in decision-making in conjunction with the women they care for. Kirkham (1999) outlines that working within a culture of caring and self-sacrifice may not equip midwives with the skills to support and care for each other and there was realisation between midwives that the culture of midwifery could not acknowledge or promote that need. Kirkham (1999) further suggests that there are close parallels between the experience of midwives and that of childbearing women, but despite those parallels, professional and employer pressures prevent midwives from identifying closely with their clients.

Hindley, Hinsliff and Thomson (2006) establish that midwives do subscribe to the belief of women centred care, but because of the complexity of factors experienced in their

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daily working lives, they felt a vulnerability when implementing certain evidence based practices, especially in events using indiscriminate technological methods within practice. They conclude that institutional culture and available resources in practice are mitigating factors affecting implementation of care processes based on best evidence. They suggest midwives paradoxically feel difficulties in practising confidently without such technological methods and in a culture where technology becomes more sophisticated, this may not become resolvable. Despite the study being undertaken in only two hospitals, these settings do reflect national standards (RCOG 2008, NICE 2007). Whilst more junior midwives would have a different model of education, that emphasises non-technological focus in a culture that promotes normality, they may feel unable to implement that practice (Henderson 2008). What is noteworthy is that in any study asking midwives their attitudes, values and beliefs, prior knowledge and preconceptions of midwifery practice, may have affected the data collection process. This is due to the relation we have to the culture in which we work or live and is reflective of how we are and behave within that culture, in the language we use, the social practices that we undertake, and the conventions we accept as being the norm.

Hierarchy

Four studies explored others' influence over actions and decisions in practice. Three studies focusing on midwifery research was undertaken by one key researcher, making it reasonable to assume that this area has not been widely investigated. It therefore remains an interesting, valid and insightful concept that warrants further investigation.

Mrayyan (2004) examined the role nurse manager's play in enhancing nurses' autonomy. Findings suggested a strong relationship not only in deciding on patient care, but in the wider context of operational decisions. Positive aspects of nurses' increased autonomy resulted due to supportive management, education and experience; these were found to be important factors. Autocratic management styles, doctors and workload were found to negatively influence nurses' autonomy. This resonates with Kirkham's (1999) findings regarding cultural influences of the NHS and in midwifery practice. Mrayyan (2004) concludes that effective support from managers can increase hospital staff nurses autonomy. Nurse-managers have a role in building, nurturing and maintaining unit culture. This is crucial to autonomous decision-making and is reported as being important in enabling autonomy (Kramer et al. 2007).

Seminal research investigating a midwifery perspective was undertaken by Hollins Martin, Bull and Martin (2004). In developing a social influence scale for midwifery, the aim was to investigate and gain insight into conformity behaviour of midwives in a practice environment. A ten item self report scale (SIS-M) was devised in order to assess impact of senior authority figures on midwives clinical decision-making (Hollins Martin, Bull, and Martin 2004) to illustrate implications for maternal and neonatal outcomes. Conformity and obedience as used in the context of Hollins Martin et al's study (2004), was informed by the psychologist Milgram (1974). Milgram (1974 p113), describes conformity as having a very broad meaning relating to the "action of a subject when he goes along with his peers, people of his own status, who have no special right to direct his behaviour". Obedience is restricted to "the action of the subject who complies with authority" (Milgram 1974). Hollins Martin et al (2004) conclude a considerable potential for the SIS-M in providing insight into conformity behaviour of midwives.

In a further study, Hollins Martin and Bull (2004), examined whether decision changes were as a result of social components of interviewer/interviewee relationships or the education shared during discussion. Results indicated that social relationships caused a large social influence effect during interviews, suggesting that a senior midwife is profoundly capable of influencing decisions that junior midwives make and that educational content plays little part in this process. Moreover, in studying communication processes, Hollins Martin and Bull (2005), demonstrated how senior midwives can not only influence decisions, many of which should be women centred, but 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 and ideas about birth.

Social Influence

Studies relating to influences affecting childbearing women in decision-making are clearly limited. Two studies related to midwife-woman relationship and women's beliefs. These are discussed under the theme of social influence.

Tinkler and Quinney (1998) explored women's descriptions of maternity care experiences. In examining communication and making choices, being informed and involved in the process of care and overall perceptions of care, findings demonstrated

the nature of the midwife-woman relationship. The authors considered how this relationship influenced experiences and perceptions of care. In affirming that the midwife-women relationship is an important aspect of satisfaction, trust is just one factor that affects satisfaction. Others have found women implicitly trust the midwives who care for them and even when their own wishes were disregarded, trust is maintained (Bluff and Holloway 1994). This notion is reflective of findings by Moffat et al (2007), who also established satisfaction with decision-making. They highlighted how types of decision-making can foster close ties with satisfaction experienced. Additionally, even though women are invited to participate in the decision-making process, they refrain and still remain satisfied with decisions made (Blix-Lindström, Christensson, and Johansson 2004).

Barber, Rogers and Marsh (2006), explored whether significantly designed information and educational initiatives increase women's knowledge of choices for place of birth. Their aim was to identify factors that could influence this. Findings exemplified how midwives had the greatest influence over women with regard to choice of birth places, but did not use their influence effectively to ensure that all women were aware of all their birth place options. Evidence from Tinkler and Quinney (1998), further suggests, how women receiving one type of service provision over another, have been more likely to be offered different and possibly a greater range of choices relating to choice of birth place. Barber et al (2006) found how the information women were given on which to base their choices was very often limited and the least likely group of women likely to be offered a homebirth were primipara women. It seems feasible that 'professional gate-keeping' (Levy 1999b) could be highly influential and related more to practitioner's own beliefs; in turn leading to manipulation of women and the situation which arguably corresponds with Milgram's (1974) description of obedience. It is possible this behaviour then becomes an inherent norm in a culture of practice. However, the Barber et al (2006) study is not without limitations. The cross-cultural survey yielded just 43% response rate. In a response rate of fewer than 50%, a study cannot say responses represent the views of all whom the questionnaires were sent out to (Rees 1997 p81), and in this particular study, this could well have been down to recruitment methods. Despite this limitation and in light of a paucity of studies relating to what influences women, it remains relevant.

Discussion

The focus in the literature is predominantly on how and what influences practitioner's decision-making. Women do trust their health professionals (Edwards 2005), but this trust may mean women comply with professionally defined choices where women may be afraid of alienating their caregivers and frightened of the consequences if they do not comply (Bewley 2010, Edwards 2005). The literature is suggestive that pregnant women comply with rather than choose how they want to give birth and this is reflective of competing demands and time pressures of health professionals (Kirkham 2010b) even in a maternity culture where the focus is on developing maternity services that aim to offer real choice to women (Department of Health 2007, Jackson-Barker 2006, Kirkham 2004).

Birthplace setting influences midwifery practice and medical models of care dominate obstetric hospitals which are influenced by intervention and technology. This is widely documented within the maternity discourses (Kirkham 2010b, Edwards 2005, Kirkham 2004). Midwives' own ideologies and how they view themselves within the midwifery culture is illustrated by how some midwives' hold negative attitudes about women's abilities to learn and retain knowledge in pregnancy. Holding negative attitudes changes midwives behaviour in line with their attitudes and in that process they potentially discriminate against the women they care for.

Obstetricians, midwives and women all influence certain technical interventions. Obstetricians have more influence over strategic decisions regarding care planning and technical and medical decisions that have more uncertainty surrounding them, for example, induction of labour. Women have more influence about care decisions that have more flexibility involving them as the overall determinant of that decision, for example, stretch and sweep at full term. Women are happy to use the expert in what they may see as uncertainty or in an increased risk situation, for example, referral to an obstetrician. Midwives however, perceived themselves in the middle of these two groups, effectively having to navigate between them from a degree of definite power but under pressure to conform to both groups.

Midwifery culture is seen as 'women centred' and one that emphasises the true value of caring and real commitment to role irrespective of the personal sacrifice midwives feel they make (Kirkham 1999 p734). This creates a pressure for midwives where they

are seen as lead professionals and not women. Furthermore, they struggle to maintain a personal and professional balance (Kirkham 2010b), but paradoxically feel potentially shamed back into compliance through the oppressive ethic of caring in the existing midwifery culture (Kirkham 1999 pp734-735). Here, parallels can be drawn between the experiences of midwives and that of women, and Kirkham (1999) suggests that pressures within the ethos of midwifery prevent midwives from closely identifying with the women they care for.

One proposed phenomenon when caring for women in the process of decision-making relating to themselves about healthcare issues which may be worth communicating is that of emancipation by Wittman-Price (2004). A concept that has been addressed critically by both social and feminist theories, the process of emancipation promotes both humanistic care and professional growth in clinical decision-making in women's health (Wittmann-Price 2004). Such theories are both pertinent and applicable to midwifery practice. Williamson (2010) explores this from a healthcare perspective in combining new academic theory and empirical evidence in looking at healthcare from an emancipatory perspective, the rise of the patient movement and emancipation of patients. The concept of emancipation proposed by Wittmann-Price (2004) remains a highly interesting phenomenon, especially when empowerment, an element of emancipation is a term widely used in midwifery practice (Fields 2008, Rogers 2008, Symon et al. 2008, Gould 2007, Hyde and Roche-Reid 2004), yet to date no definition of empowerment is offered. When such a concept lacks a clear definition, Gibson (1991 p354) warns "each person defines it within the context of his/her personal experience to give it meaning, therefore exactness of concepts in a scientific sense is thwarted".

Emancipation is broken down into antecedents, attributes and consequences, empowerment being identified as one such attribute (Wittmann-Price 2004). The key concept lies behind understanding the phenomenon of emancipation for application to women's decision-making in birth choices and to discover what impact this might have for them. This concept undoubtedly impacts upon midwifery practice. Whatever the concept of empowerment is argued to be, it is simply a characteristic of emancipation. A common sense starting point lies within exploring the phenomenon of emancipation from a woman centred perspective, to expand our understanding of what these concepts mean for women and for practice.

Hollins Martin (2006) clearly addresses the aspects of social influence, obedience and conformity of midwives within practice. She described how research on obedience highlights subordinate relationships in which people become "agents of a legitimate authority to whom they relinquish responsibility for their actions" (Hollins Martin 2006 p11), in this, their actions are no longer guided by their own values but by the desire to fulfil the authority's wishes. She highlights the implications that arise between midwives in practice and the practitioner's view of what is or is not morally appropriate. The effects however, may be quite profound upon whether the woman is allowed particular birth options, regardless of whether she actually might comply with health professionals.

The body of evidence from section two and three provides empirical knowledge about what influences affect both practitioner and women's decision-making. This is not a thesis on how human beings arrive at judgements; but whether decision-making as an end product makes it possible for women to exercise autonomy over pregnancy and birth decisions. This in turn may be dependent on practitioner decision-making, in a myriad of different contextual influences. Some studies were mutually intertwined in section two and three and concepts were not always tangible. Studies from these two sections did not sit clearly in the one section, but interlinked between influences that affected women's decision-making and the decision-making that affected women, and highlighted the experiential concepts within empirical data.

Conclusion and aim of this thesis

In devising a tool to investigate and measure conformity behaviour of midwives in practice, Hollins Martin and colleagues (2004) concluded that its use as a multi-dimensional measure of distinct conformity dimensions, gives insight into the relationship of such behaviour to maternal and neonatal outcomes. This research into social influence, conformity and obedience within decision-making in midwives' practice was the first of its kind and is highly relevant to midwifery practice. Furthermore, this model directs investigation into how the concept of social influence might cause an effect on women exercising autonomy in choice and decision-making. In light of this, this thesis considers how this theoretical model of social influence, conformity and obedience might translate to women and impact on their decision-making about childbirth options. Quintessentially, do women become 'agents of a legitimate authority'

(2006 p11) as Hollins Martin claims midwives do, and in so doing relinquish responsibility for their actions? Indication by Moffat and colleagues (2007) suggested that this is the case and that women often conform to the 'suggestions' of their midwife or doctor.

A particularly interesting group of women are those who challenge professional advice on birth options; for example woman who choose to free birth, birthing at home with no professional help (Nolan 2008); woman who decline augmentation of labour or women having had a previous C/S who want to birth in water or at home, when there are perceived increased risks for mother and fetus. These women may potentially be labelled awkward, or out of the ordinary for going against perceived safety and professional advice (Anderson 2004, Anderson 2002). This group are juxtaposed with other women who don't have highlighted risk conditions, who are perceived free to make choices in this same culture that is dominated by guidelines and protocols and where medicalised models of care often dominate and influence practice. It is feasible that women feel pressured to conform to maternity practices due to risk and safety (Symon 2006) in a culture where current evidence suggests, certain birth options for some women, could threaten maternal and fetal outcome. While other women feel liberated, emancipated, to make autonomous decisions about birth options in light of increased risk, and gain the birth experience they desire, and are entitled to within the concept of women centeredness. Exploring the differing experiences of these seemingly dichotomous groups would present an original and revealing contribution to the existing body of evidence by exploring the conceptual issues surrounding the influence practitioners have upon a woman in relation to the process Wittmann-Price (2004) proposes, in promoting both humanistic care and professional growth in clinical decision-making about women's healthcare issues.

Exploring from a woman centred perspective, what influences surround them in their decisions about birth; whether emancipated decision-making is possible and its relationship to conformity could determine how a continuum of women may be socially influenced. Based upon the original search criteria, the literature has shown that no information exists on social influence relating to women and decision-making in a childbirth context.

Updated literature review 2007-2013

The original search terms were reapplied as the writing of this thesis commenced. Whilst some papers focused on impact of birthplace and factors influencing choice in birth place (Houghton et al. 2008), no new research has come to light that bears any real significance to the aims of this thesis. However, Ashley and Weaver (2012a) performed a literature review on factors that influence multipara women who choose a home birth. Their follow on study did explore the factors of eight multipara women who had chosen a homebirth following a previous hospital birth (Ashley and Weaver 2012b) and demonstrated choice was complex and highly individual and influenced by, positive and negative previous birth experiences; life experience; and others within the social field.

Research question and central aims

There is in general a deficiency of literature that provides any tangible theoretical understanding about women's decision-making and a distinct lack of focus on women in this process. The link to a promising theoretical perspective not previously used in relation to birth and childbearing decision-making is Wittman-Price's (2004) concept of emancipation. Emancipation is congruent with autonomy (Duchscher 2000) and has even been reported as a state of autonomy (Grundy 1987). Used in women's healthcare decision-making this concept was identified from its brief reference in Blix-Lindström and colleagues' study (Blix-Lindström, Johansson, and Christensson 2008) into midwives' navigation and perceived power during augmentation of labour, in relation to patients themselves being able to choose what is best for them. Related to the notion of patients being able to choose what is best for themselves, it can be assumed to be logical for women to make decisions based on what they see as best for themselves and for midwives to facilitate this concept. Yet the literature does not acknowledge this notion in the decision-making process of women or in midwife facilitation of these decisions.

In the absence of any theoretical explanation about women's experiences in this area, a dearth of knowledge limits understanding of how women effectively deal with decisions about their desired birth outcome. Exploring from a humanistic stance how women effectively deal with the childbirth decision-making process regarding birth choices, this study will explore the concept of emancipation in a context of childbirth.

This study will aim to determine what influences surround women as decision-makers, making choices, and whether they are socially influenced and conform to professional advice. The study will explore whether emancipation and conformity are linked and whether this affects birth experience to determine whether emancipation in birth choices reduces pressure to conform.

The questions this research will ask are:

- Are women socially influenced about their birth choice options?

- Does social influence link to emancipation for women in decision-making about birth options?

- Does emancipation in birth choice reduce the pressure to conform?

It has the following objectives:

- Using a qualitative interpretive methodology explore the relevance of the concepts of social influence, emancipation and empowerment to women's decision-making about birth choices

- Explore what are the relationships between social influence, emancipation and conformity for women's decision-making about birth options.

- Identify whether, emancipation and conformity affect birth experience.

- Contribute to the development of research in midwifery studies in the UK.

- Inform developments in services, through improved research evidence based knowledge.

How the aim, objectives and research questions are to be addressed will be discussed and explored more fully in the following chapters.

Chapter 3: Conceptual framework

Introduction

The aim of this chapter is to combine the theoretical models of social influence, empowerment and emancipation that are fundamental to this inquiry, apply them to the context of women's decision-making in maternity care and propose a new theory that surrounds social influence and women's decision-making in a maternity context.

The literature provided a catalyst to explore the relationship between these existing theories which underpin this study's questions, rationale, purpose and significance. These concepts bind together the theory of social influence, conformity and obedience and the work of Stanley Milgram (1974) in relation to Caroline Hollins Martin's application of conforming to authority in a midwifery practice context (2004). This in turn coalesces to the wider context of social influence and the work of Elliot Aronson. The process of women's decision-making in relation to the concepts of emancipation and empowerment, interrelate with the theories and structures that encompass the work of these individual concepts and are relative to women's decision-making about what they want for themselves. What figuratively is developed and described later in this chapter, represents a macrocosmic structure that encompasses the broadest structure of human social representation, explicitly the cultural system of authority within which we all exist and the microcosmic structures of a contextual culture of midwifery. It illustrates these key concepts as a plurality of social influence, empowerment and emancipation within a maternity culture that perceives the decision-maker surrounded by these cultural and social structures. As revealed in the introduction to this thesis, the audible voices of women are significant in underpinning the interpretive methodology and in their ability to illuminate real understanding and give meaning to existing theory. In essence this combines philosophical knowledge to midwifery knowledge through an interpretive methodological lens of the lived understanding and women's knowledge. Their narratives are used within this part of the thesis to illuminate conceptual understanding and although unconventional they are central to the theoretical development within this thesis. Their voices became naturally intertwined in a process of interplay between theory and practice within this qualitative

research process. Table 5 in chapter 4 on page 132 provides the demographic data of all participant women within the study.

Safety and women exercising autonomy in choice and decision-making

The conclusion and aims of this thesis set out in the previous chapter pointed out the concept of social influence and its potential for causing effect on women exercising autonomy in choice and decision-making. Furthermore, in how emancipation is said to be congruent with (Duchscher 2000) and reported as, a state of autonomy (Grundy 1987). Within midwifery discourse, autonomy is described as 'the right of the individual to decide upon the integrity of his or her own body" (Symon 2006 p25). Williamson (2010) informs that autonomy is variously defined but largely means self-determination and freedom from coercion. An individual's autonomy is in western societies a basic value (Jenson and Mooney 1990). This unites the ideology of emancipation in an individual choosing what is right for them and for midwives' autonomy (Wittman-Price) by enabling them to exercise their clinical skills, and as apposite to women's individual circumstance this builds relationships with the women they care for (Kirkham 2004).

Edwards (2005 p17) suggests:

> midwives and women can be autonomous, women can grow and midwives can develop the knowledge and skills to make birth safer while enhancing women's self-esteem

Autonomy in decision-making about birth situates this as relational to both women and midwives interactions. Anderson (2010) brings to light skilled and sensitive midwives can create feelings of safety and calm for women whilst an insensitive and intrusive midwife can obstruct a woman's sense of being able to feel this and can undermine her self-confidence in her own body to achieve her experience.

Safety is undoubtedly important (Kirkham 2004). Women are concerned about safety surrounding birth and do not put themselves or their babies at risk (Edwards and Murphy-Lawless 2006, Edwards 2005). Edwards (2005) highlights this with regard to her study with home birthing women. In her experience women do not refuse transfer to hospital from home, but disagreements with the reasons for transfer and who makes

the decision to transfer (Edwards 2005) did surround transfer issues. This she explains is more to do with the women protecting own integrity, self-esteem and autonomy. For the women in her study home symbolised being in control, a connection to her baby, her body and her spirituality, whilst the hospital symbolised the loss of this control and separation of what they believed in (Edwards 2005).

Smythe's (1998) unpublished doctoral thesis explored what it means to be safe in childbirth and searched to uncover the complexities and meaning of this phenomenon. She is informative in describing the phenomenon of safety. The meaning of 'safe' is complex (Smythe 1998 p11). Smythe (1998 p122) explains:

> Safety is not a commodity to be bought from a practitioner, although a practitioner can make childbirth experiences safer. Safety is more than that. Safety 'is'. It exists as experiences. Safety is already in the experiences of pregnancy, in the progress of the labour, in the birth of a healthy child. Nobody can make that safety or take it away. It is constitutive of the experience. It has a being in its own right.

This is interpreted as 'safety' exists just as much as 'unsafety' does. It is already 'there' by the time we come to notice it, we are thrown into situations that are already there by the time we come to notice it. Smythe continues (1998 p241):

> The meaning of being safe in the maternity services would be of no consequence if it were not for the thrownness of childbirth itself, and the world in which it takes place. Things go wrong. Death is always a possibility. Thrownness simply happens. It is beyond our knowing until it happens. It may be beyond our understanding and our skills. If that is the case, the safest of care will make no difference. 'Being' safe does not guarantee safe outcomes. Thrownness must always be considered when sitting in judgement on the safety of practice.

Smyth (2010, 2003, 1998) writes authoritatively with regard to safety as do other prominent authors within a maternity care context (Kirkham 2010a, Bewley and Cockburn 2004), within midwifery practice regarding risk and choice (Symon 2006), midwives supporting women's autonomy (Edwards 2010b), and the consequence of restricting women's autonomy (Edwards 2005). Edwards (2010b) highlights how decreasing autonomy diminishes women's self-esteem, self-worth self-trust and confidence. Trusting relationships between women and midwives are crucial for

safe care; however both midwives and women need to be supported in this context (Edwards 2010a).

Choice is connected centrally to personhood (Edwards 2010b) and Edwards (2010b) suggests threatening or undermining choice threatens and undermines autonomy. Edward's (2005) advises whatever women define safety for themselves as, should be valued and respected, it is they who have the most concern for their and their babies well-being and they who need to decide what being safe means. Smythe (Smythe 2010) concludes that safety is not a thing but an interpretative act and through interpretation, we question, listen, watch and be attuned to each situation. Moreover, practitioners should take the time to elicit woman's own interpretations and be willing to believe these, even if there is nothing to see at that time (Smythe 2010). This trusts and supports women's autonomy in choice and decision-making about what she wants for herself.

Social influence

Social Influence was the single dominant theme arising in the literature on influences that affect women's decision-making. Predominantly how and what influences practitioners' decision-making, the nature of the relationship between women and midwives and how this relationship could influence experiences and perceptions of care.

To gain insight and begin to understand how this relates to women's decision-making as they make decisions about where to birth, it is necessary to make clear what is meant by social influence. Clarity is drawn from social psychology and the work of Aronson (2008) specifically because he is an eminent twentieth century psychologist with a long and distinguished career in social psychology. Social psychology is understood as "the scientific study of the ways in which people's thoughts, feelings and behaviours are influenced by the real or imagined presence of other people" (2008 p437). This makes him an authority to give an insightful, stimulating and simple introduction to the concept of social influence and a socio-psychological analysis that allows understanding to be gained for this inquiry.

What is social influence?

Human beings are socially gathered in a state of living, in organised communities and are considered to be social beings. Aristotle is regarded to be one of the first thinkers to have formed notions about the nature of human beings and to have formulated some of the basic principles of social influence (Aronson 2008, Law 2007). In simple terms, social relates to human society or organisation (Summers and Holmes 2006 p1142) and influence is the effect of one person or thing on another, and the power of that person or thing to have such an effect (Summers and Holmes 2006 p613).

For the purpose of this thesis, I define social influence 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"

I wanted to define this for my own purposes within a midwifery perspective in acknowledging that a complexity of features exist in a maternity culture and not just individuals that can have the capacity to cause effect on one's behaviour, for example, previous experience; protocols and birthing practices (Smythe 2011, Kirkham 2010b, Edwards 2005, Kirkham 2004). This definition is in accordance with Aronson's own definition (2008 p6) as the:

> influences that people have on beliefs, feelings and behaviour of others.

Social influence is a common factor existing in socio-psychological situations that causes an effect on an individual's behaviour, beliefs or feelings (Aronson 2008). Changes in an individuals' behaviour is as a result of social influence, either by conformity or obedience; obedience being a form of compliance (2008). These terms will be discussed later in this chapter. Aronson, (2008) illustrates the common feature of social influence by way of a collection of hypothetical, socio-psychological, different and diverse situations demonstrating how behaviour and judgements can be changed or altered as a result of interaction with other forces, such as individuals, mass media or general attitudes of a population. Forces such as these are evident in a maternity context (Taylor 2010, Hollins Martin and Bull 2005). Hollins Martin and Bull (2005)

demonstrated how a senior authority figure, in this instance a midwife, is capable of influencing more junior midwives in their decision-making in maternity care.

Aronson (2008) illustrates how the fear of rejection and humiliation can shape an individuals' behaviour and how, for example, being rewarded (even by verbal encouragement) or encouraged every time certain behaviours are expressed, can shape self-image (Nordenfelt and Edgar 2005). Moreover, how this can be shaped by mass media or changes in attitudes of the general population especially that of minority group members.

Applying this theory to the Hollins Martin and Bull study (2005), the junior midwife wants to feel she provides care in line with the woman's wishes whilst maintaining professional autonomy and in line with evidence based care and usual protocols and guidelines. Conversely, this situation may not be seen in the same mode by the senior midwife who may imprint her own ideas and courses of action on her junior counterpart and influence the pattern of care. This typifies the 'tightrope walking' (Levy 1999b) midwives do in practice culture (Kirkham and Stapleton 2004, Levy 2004, Kirkham 1999), one where the junior yet autonomous midwife, does not wish to be seen as either inexperienced or perceived negatively in decision-making and where she may need to justify her actions (Cheyne, Dowding, and Hundley 2006) publically to this authority figure.

The implications of social influence on behavioural change as a result of mass media can be exemplified by way of a maternity care context in the following section.

Behavioural change

The idea of general attitudes or media influencing opinions and affecting behavioural changes in maternity care can be illustrated by the Peel report (Department of Health and Social Security Welsh Office 1970). In reviewing midwifery and maternity bed needs at this time, 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 this objective (1970 p60).

This demonstrates the implications social influence has for changing judgements on mass. The changes implemented at this time influenced maternity care provision for women and has remained influential ever since. Not only did this remove choice for women, as we understand choice provision today, but recommendations under the pressure of 'greater safety', only attained by giving birth in hospital (1970 p61) dominated policy and gave rise to a mass cultural shift from home to hospital birthing.

Changes in attitudes as a result of mass media filters down through populations; policy to obstetric and midwifery staff who deliver services based upon the current healthcare policies of the time. This cascades down to service users, their families and to the general population and cultural shift occurs. Birth under such a premise becomes perceived as something technical and risky and needs to be undertaken in hospital under the watchful management of the obstetric team. Consequently, what the Peel Report (1970) did, changed how society largely views birth in that the hospital provides the greatest safety for mother and child. Continuing attitudes promote the notion that hospital birth is the safest option (Vedam 2003), despite evidence to the contrary (de Jonge et al. 2009) still exist and accounts of far-reaching journalism remain ever present in fuelling this type of social influence which implies women who give birth at home, are selfish and reckless (Fraser 2010) and have no right to put their babies lives at risk (Lancet 2010).

The concomitant effects on an individuals' behaviour change, due to factors of social influence that exist in any situation are as a result of either conformity or obedience (Aronson 2008).

What is Conformity?

Aronson considers that as social animals we live in a state of tension between our individual values and values associated with conformity (2008). He defines 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). Conformity within maternity care is illustrated by Tricia as she discusses her thoughts on a scenario of another woman:

> *"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". [Tricia]*

This exemplifies how people conform without question, without even knowing the reason why and change their behaviour in line with the pressure from this individual as expert advising what is best for her. In comparison conformity because someone is viewed as an 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." [Denise]*

The degree between advice from an individual and imagined pressure from an individual could well be a fine line and what one person views as advice another may view as pressure to conform.

Conformity is observed on a much larger scale in the western world from the second half of the 20th century where an automatic culture of birth taking place in hospital, and the pressure to conform to this culture is reinforced to women through mass media and journalism (de Jonge et al. 2009). Aronson (2008) considers whether conformity in some situations is 'good' or 'bad' and indicates that words carry evaluative meaning. This can be understandable in pregnancy when women are faced with decision-making about the safe birth of their babies (Edwards 2010b, Edwards 2005). Aronson (2008) further considers that a person labelled as individualist or non conformist, often implies they are good and often portrayed as heroes or revered. Conversely, within our western culture Aronson (2008) advises that the label conformist is designated to someone who is inadequate. If this principle is applied to the context of midwifery and women's decision-making, it raises the important question of how women are perceived in making choices; as showing individualism or as being nonconformist (Edwards 2005). Moreover, this concept is reliant on how certain individuals, for example, the mother or the midwife perceive this in a given situation. Aronson (2008) believes there is inconsistency in the way society considers conformity seeing it from a

positive stance as being a team player or more negatively as non-conformity and deviance.

Conformity and decision-making

There are situations in which conformity is highly desirable and non-conformity constitutes an unmitigated disaster. As Aronson (2008) contextualises in driving down the street the wrong way into oncoming traffic, would be non-conformist behaviour and undoubtedly disastrous. Moreover, explaining this concept from the real life disaster of the space challenger explosion in 1986 and how even knowledgeable and sophisticated decision-makers can fall victim to conformity pressures that are intrinsic in making group decisions. This demonstrates how decision-makers conform to making decisions, which later can be shown to be flawed. The expert decision-makers in this example were caught up in the enthusiasm of the launch for a number of reasons, the effects of mass media surrounding the first civilian into space; an orientation to 'go' because of previous successful launches; the need to ensure the funding commitment to cost effective productivity and drive to demonstrate technological capabilities. Aronson (2008 p17) deemed they were "victimised by their own wishful thinking" as the 'decision to launch' had become more desirable than a 'decision to delay', even in the light of concern from engineers who objected strenuously to the launch for safety issues. Despite this advice to delay being voiced the expert decision-makers conformed and the decision was made that the launch should go ahead.

This demonstrates how such cohesive groups can be "isolated from dissenting points of view", and decision-makers fall prey to 'groupthink' (Aronson 2008 p18). Groupthink is "the mode of thinking that persons engage in when concurrence seeking becomes so dominant in a cohesive group that it tends to override realistic appraisal of alternative courses of action" (Janis 1971 p43). This is indicative of shared illusions observed in encounter groups or friendship cliques when the members simultaneously reach a peak of "groupy" feelings (Janis 1971).

Brown (2000 p4) suggests that "groups can be characterized as a collection of people bound together by some common experience or purpose, or who are interrelated in a micro-social structure or interact with one another". As individuals, we can often choose which groups we want to join, a chess group, or a political group, yet in some circumstances the decision is made for us, for example the group of pregnancy. A

maternity group could be argued as a cohesive group that may consist of service providers, healthcare professionals including midwives, midwifery supervisors, paediatricians, GP's, consultant obstetricians and user representatives in which the woman and her partner come to join in the event of becoming pregnant.

Janis's (1971) work involved studying group dynamics and discovered how groups of ordinary people displayed typical phenomena of social conformity. He demonstrated how powerful social pressures are tolerated by the members of a cohesive group whenever someone who opposes official policy or begins to voice objections to a group consensus. This exemplifies what Hollins Martin and Bull (2005) conclude about the junior midwives who in having a clear plan of care with the woman, change their behaviour and become socially obedient to authority figures. Janis (1971) clarifies that there are many indications, pointing to the development of group norms that reinforce morale at the expense of critical thinking; in particular in remaining loyal to the group by adhering to what the group have already committed to, even if these policies are obviously working out badly and having detrimental and unintended consequences that disturb the conscience of each member. Such behaviour is a key characteristic of groupthink. Although Janis's (1971) work is limited to decision-making bodies in government, groupthink symptoms he argues, appear in any field where small cohesive groups make decisions. Even in maternity care where practitioners work within statute policy and guidelines it is reasonable to suggest that practitioners will not be exempt from groupthink.

In a midwifery context a cohesive group of women; service providers; doctors and midwives all display and tolerate the typical phenomena of social conformity. A particularly good example of the role of social conformity might be a pregnant woman, and a member of this cohesive group initiates her desire by requesting a home birth, yet she is of higher obstetric risk. With an average of 1.6% home births regionally and a UK national average of 2.39% (Birth choice UK 2012) women who access this care provision are in the minority. Metaphorically speaking, there are midwives who stand alongside her in support of her request, but in desiring this in the context of a risk status, she is perceived by the majority of this cohesive group as a dissenter and a non-conformist. The cohesive group espouse powerful social pressures through group norms, on her not to make certain choices as birth options. In voicing her desire to give birth at home under such circumstances, the woman is non-conforming to the majority

as this situation is not observed to be the norm in practice. In voicing her request she may be perceived by group members as objecting to the provision of safe care by giving birth at home (Fraser 2010). Further, the situation may be portrayed by the cohesive group as turning out badly in a situation of elevated risk particularly if a bad outcome actually occurs.

Such group norms do little to reinforce morale at the expense of individuals' critical thinking. Critical thinking, involves the analysis of all the ideas and opinions of all group members and not just those of the majority. Everyone has a voice and should be heard, and the confidence and feeling of well being of every member should not be ignored at the expense of such critical thinking. Members cannot remain loyal to a group by sticking with adopted principles of action the group has already committed itself to, and override alternative courses of action, if these adopted principles are obviously working out badly. Denise illustrates the process of sticking to plans all ready committed to, in her discussions with the consultant in light of the recent possible risk situation, in determining whether the principle action of home birth should continue or change:

> *"we'd have to talk it through and see whether we thought that the risks were worth, yeah, see whether we thought it was safe". [Denise]*

Working out badly positions a premise of risk, developed and endorsed through a fear of litigation in practice, or protection of the woman's well being, as practitioners aim to save from harm.

Denise illustrates this point and how this impacts on adopted course of action by members of the cohesive group:

> *"I think she might have explained why I think it was all to do with if anything went wrong 'cos I was already, my waters had already broken, I was in hospital I think it was all to do with that, their safety if they let me come home if anything had gone wrong it would have been on their backs". [Denise].*

It seems feasible that a woman may express a desired choice that could be seen as going against normative service provision. By Janis's (1971) definition of groupthink,

some women disturb the consciousness of members of the cohesive group in voicing objections to the group consensus in this case not birthing at home. Hence, the cohesive group perceive her desire for home birth as contrary to group norms. Social pressures may be displayed to her by group members as a result (Freeman et al. 2006, Kirkham 1999, VandeVusse 1999, Levy 1999b) and social conformity is displayed between members as she opposes the 'group norm'. Lisa's experiences illustrate this:

> *"No she said 'no, you're not having it'. It was never, I was never given the option of feeling like I could actually say, 'well, I'm sorry I want it'. It was, if you have a low-lying placenta you do not have a home birth...she said that she wouldn't be able to do the home birth or progress with the home birth with the placenta low-lying and the consultant would feel the same." [Lisa]*

Groups that engage in this maladaptive decision-making strategy of groupthink, perceive themselves as invulnerable and are blinded by optimism that is perpetuated when dissent is discouraged, and in the light of conformity pressures, individual group members come to doubt their reservations and refrain from voicing opposing opinions (Aronson 2008). Aronson (2008 p18) indicates "consensus seeking is so important that certain members of the group sometimes become *mindguards* – people who censor troublesome incoming information". This imitates the aforementioned concept of gate-keeping (Levy 1999a) highlighted within practitioner decision-making. Katie illustrates the process of voicing what was viewed to be opposing opinions by the two midwives in her home:

> *"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...there was another lady with her...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 as well, [husband], hearing all of these facts...was getting a little bit, sort of are you sure we should be doing this." [Katie]*

Lisa demonstrates the consensus of other group members due to the midwife acting as a mindguard:

"what happened then was we went back to see the midwife and I said just that...I still wanted her to continue with the home birth and plan the home birth and look forward to the home birth...and she said no again and we had a bit of a conflab about it and I cried...and eventually she agreed to run it past a consultant and see what he said. And then there was some confusion because she did get a consultant letter to sign me on for a home birth eventually...but she said she hadn't mentioned the possibility of a low-lying placenta because he would have said no straight away. That's what she said, she said, 'if I tell him that you've got a low-lying placenta he won't agree with it' and she actually told my husband that that consultant didn't agree with home births anyway." [Lisa]

Janis describes how symptoms of groupthink arise when decision-making group members become motivated to avoid being too harsh in their judgements of their leaders' or their colleagues' ideas and assume "a soft line of criticism, even in their own thinking" (1971 p43). The perception of groups being invulnerable could be a key element in a maternity care context, one where it is exemplified by risk. This may be illustrated by a group scenario of a woman, midwife, senior midwife and an obstetrician. The midwife who is junior to the obstetrician and midwife in charge, knows the woman's desired choices, yet may not challenge the judgements of these other professionals and refrains from voicing her opposing opinions to this group. In conforming to the notions of the group rather than the woman she is caring for, she comes to believe in her own mind that this line of treatment is for the best. Hence, she adopts the soft line of criticism as Janis proposes, and protectively steers the woman into making 'safe' choices rather than the desired choices. Midwives conform to the 'group' by situating their opinions with other group members, the junior midwife with the senior midwife (Hollins Martin and Bull 2005); even when as autonomous practitioners, they should respect the woman's right to refuse any advice given (Nursing & Midwifery Council 2004 p17), and her wishes for her birth experience. The midwife may show signs of groupthink, through a desire not to show a disloyalty to her senior colleagues' opinions or practice. In this however, the midwife is not 'with woman' in her decision-making. Midwives, working within cohesive groups, often feel a great amount of group pressure experienced within their everyday working lives (Cheyne, Dowding, and Hundley 2006, Kirkham 1999). To understand this in the context of the phenomenon of social influence within a maternity context it is necessary to explore the work of Asch and his theory surrounding group pressure.

Group pressures

Understanding the affects of group pressure and the effects of social conditions on forming and changing opinions and judgements, has largely been the work of Asch (1963, 1956, 1955, 1952). His objectives were to study the social and personal conditions that persuade individuals to resist or yield to group pressures where the latter are perceived to be "*contrary to fact*" (Asch 1963)*.* The issues which this problem raises are of decisive importance to whether or not a group under certain circumstances, will submit to existing pressures. Moreover, the consequences for both individuals' and our understanding of them is of equal importance, since it is the decisive factor about a person, whether he possesses the freedom to act independently, or whether he/she characteristically submits to group pressures (Asch 1963). Taylor (2010) and Hollins Martin et al (2005) have both found submitting to group pressures occurs when a hierarchy exists.

Asch's (1952 p387) inquiry starts from his general observation of 'truism', that "people in the same field alter each other's ideas, feelings, purposes and actions" and that it is not possible to remain in a social field and be free from its effects upon us; the actions of others wield distinctive intellectual effects upon us and they introduce us to correct or erroneous ideas. He contests that social conditions determine the formation of interests and purposes and under given social conditions, individuals do what they would not do in their absence. Moreover, these effects can be astonishingly strong.

Each society produces a high degree of regularity and uniformity of practices and beliefs. Members of society speak the same language, observe the same holidays and those belonging to a group eat and dress similarly, follow the same customs and according to Asch (1952), this is fact. He maintains that those who hold these beliefs are almost never those who have invented them and that in essence we believe very much what our friends and neighbours do. Evidence of belief in what our friends and neighbours do can be observed in Lorraine's account about deciding where to have her first baby and Mary's account regarding feeding her baby:

> *"I hadn't really thought about it but I'd just discussed with people who had had children...you know...what their experiences were with both [birth centre] and [hospital] I've had quite a lot of pregnancies with my friends recently". [Lorraine]*

"so I can decide myself whether I'm gunna be able...to breastfeed or not...I felt like I really wanted to do it cos my sisters all breastfed apart from one she couldn't do it either, my mum, breastfed all of us". [Mary]

In pregnancy a degree of regularity and uniformity may mean that women might all share similar anxieties or fears, they all share the desire for a safe birth and a healthy baby. Professionals may believe very much the norms of what their colleagues and peers might do in similar situations. In such maternity contexts women may feel under pressure to make certain choices; ultrasound scan provides a good example. Ultrasound is a routine pregnancy procedure (Garcia et al. 2002), perceived by women as having health benefits (Gudex, Nielson, and Madsen 2006), yet it remains a woman's choice whether she has this procedure (Midirs Informed Choice 2010). Ultrasound scans have clinical utility, they can notify practitioners of an expected due date of birth and may be used to prompt certain care pathways in the event of the pregnancy becoming overdue (Gardosi, Vanner, and Francis 1997). Depending upon how this procedure is discussed in pregnancy, there is potential for this procedure to be perceived as *given care* and prescribed as is best for you and your baby, rather than a procedure of choice for women. Hence, women almost unilaterally conform to this, either because of adhering to the group of individuals they belong, or they feel they should, because it is designed with their best interests in mind and that they may not feel able to decline. The confounding factor with ultrasound scanning is that women often perceive them in a pleasurable context (Harris et al. 2004) that adds to the embodied experience of pregnancy.

Asch's (1955) research followed a straightforward technique in which subjects were asked to give their opinions or preferences about various matters. Subjects were later asked to state their opinions, but were informed at this point, of the opinions held by authorities or large groups of their peers on the same matters. Subjects undertaking these experiments alone and under no group pressure were able to make a series of judgements with almost a complete absence of errors. However, when subjects were confronted with opinions contrary to their own for example with a majority agreeing on the same incorrect response three quarters of subjects shifted their judgements towards those held by the majority (Asch 1955). Aronson (2008) considers the possibilities for this behaviour as either subject's became convinced in the face of unanimous majority that their own opinions were wrong; or they went along with the

crowd whilst inwardly believing their initial judgements were correct in order to be accepted by the majority or to avoid fear of rejection.

Asch (1955) indicates that those members who strike out on a path of independence do not, generally succumb to the majority, while those who choose a path of compliance are unable to free themselves as the ordeal is prolonged. The subjects were interviewed at the end of the experiment. It appeared that those who were independent individuals were those who held fast their decisions because of staunch confidence in their own judgement. Asch (1955) believed the most significant fact was not that they showed an absence of responsiveness to the majority, but a capacity to recover from doubt and to re-establish their equilibrium. Amongst the compliant participants, there was a group who quickly reached the conclusion that they were wrong and the others were right and some simply yielded in order not to spoil the results. Many of the participants either viewed the majority as 'sheep' following the first responder, or that the majority were victims of an optical illusion, nevertheless, their suspicions failed to release them at the moment of decision. Participants who disclosed they had simply yielded in order not to spoil the results may exemplify a certain parallel with Janis's (1971) theory of groupthink, in not wishing to show disloyalty in their judgements of fellow participants. Asch (1955) found that in some of the reactions of subjects in constructing their difference from the majority, saw this as some sort of 'deficiency' in themselves which at all costs they must conceal and were desperate in their attempts to merge with the majority.

Factors affecting conformity

Asch (1955) wanted to discover which aspect of social influence was more important, the size of the majority or the unanimity. He modified his experiment to answer this question and designed a series of experiments to explore the size of opposition. He varied this using between 1 – 15 persons in opposition to the subject. Findings demonstrated a clear trend. If a subject was confronted by a single individual who contradicted his answer he was swayed a little but continued to answer independently and correctly in nearly all trials. When the opposition increased to two people, the pressure became substantial with minority subjects now accepting the wrong answer 13.6% of the time. Under the pressure of a majority of three, the subjects' errors jumped to 31.8%. In fact when this majority consists of only three, the tendency for an

individual to conform to group pressure is about the same as it is when the unanimous majority is fifteen (1955 p34). Hence, the size of the opposition is important but only up to a point. Though these percentages may appear low they are quite significant and show a salient effect.

If a subject is joined by an ally who gives a correct response, the pressure to conform is reduced and the subject is likely to give the correct response. The presence of a supportive partner depleted the majority of power. Even if unanimity is broken by a non-ally, the power of the group is diminished. A fellow opponent therefore allows a freeing effect from the influence of the majority. What this indicates, is if there is unanimity, the actual size of the majority need not be great to draw out maximum conformity from an individual.

Scenario's where size majority could draw out maximum conformity may be witnessed in an antenatal clinic appointment where two or three health professionals and a woman may be in consultation about birth options. From past personal and experiential accounts, of working within a midwifery clinic environment and recent anecdotal evidence, it is very often the case in an antenatal medical clinic, such as with diabetic women, that there can be a number of professionals in this consultation with her. Very often these include a consultant obstetrician or registrar; an endocrinologist; diabetic specialist midwife; a dietician; midwifery assistant and sometimes a medical student accompanying the medical doctor. The circumstance of having this many professionals within a consultation has been questioned in the clinical setting by staff locally, though not documented in an official context. It seems feasible to suggest that with a significant number of health professionals present in situations and Asch's theory of social pressures, there is potential to influence a woman in her decision-making as the situation promotes a strong urge to conform to the majority. Interview text with Louisa demonstrates this point:

> *Louisa: so she set up for me to go and see Dr x and when I got [there] there was Dr x, there was this lady who was head of...and...like a paediatric...the one's that look after the babies*

> *I: paediatrician?*

> *Louisa: yes paediatrician one of them so there was like 3 of them*

I: was there a midwife in the room as well?

Louisa: no there was there was an auxiliary type nurse [Louisa]

There is already a body of evidence to support midwives influence women in choices about care (Levy 1999b), that women conform under these circumstances (VandeVusse 1999) and women unquestioningly accept decisions made by those who they see as professional (Moffat et al. 2007). Moreover, the role of the Supervisor of Midwives (SoM) may offer in a maternity context what Asch's refers to as an ally; SoM's act in the capacity to offer guidance and support about any aspect of midwifery care and all women receive notification of this support in their pregnancy (Nursing & Midwifery Council 2012).

Asch's (1955) investigations were directed by underlying assumptions, that people submit uncritically and painlessly to external manipulation by suggestion or prestige, and that any given idea or value can be 'sold' or 'unsold' without reference to its merits. This implies a strong urge to social conformity. Asch (1955) advises a degree of scepticism must remain of the supposition that the power of social pressure necessarily implies uncritical submission to it. Independence and the capacity to rise above group passion are also open to human beings and we should question whether it is possible, due to mental and emotional states, to actually change a person's judgement of a situation without first changing his knowledge or assumptions about it (1955 p32). He concludes, that the tendency to conformity in a society of strong, intelligent, well-meaning people who are willing to call black white or vice versa is concerning, especially about our ways of education and the values that guide our conduct. What is more concerning is Asch's (Asch 1955) final remark that all who participated in this experiment (and subsequently showed the power of social power) believed without exception that independence was preferable to conformity. What this implies is that although they agreed independence was preferable to conformity, they underestimate the ability within themselves to remain independent of their actions – a case of agreeing, but not practicing what is preached.

Self-esteem

Self-esteem is one factor that can increase or decrease conformity (Aronson 2008, Asch 1955), someone of low self-esteem is more likely to conform to group pressure

more than someone with high self-esteem. Since low self-esteem in pregnancy has been reported to have a significant negative impact on a variety of health outcomes (Jomeen and Martin 2005), this could mean that women maybe more likely to have a medically managed pregnancy and birth; be less able to make pregnancy and birth related choices; and hence conform to group pressure. What is relevant in Aronson's (2008) examination is the significant factor of how a group of experts or members of a high social status are more effective at inducing conformity. Conformity works in much the same way when the source of influence is an individual rather than a group (Aronson 2008), with individuals being more likely to conform to the behaviour or opinions of an individual who is either similar to us; important to us or appears to have expertise or authority in a given situation. Women do trust their midwives (Kirkham 2010b, Edwards 2005, Bluff and Holloway 1994) and therefore hold them in a status of expertise. Conformity behaviour to practitioners was highly evident as the women have shown and conformity to expert advice unquestioningly, is illustrated by Sue if she was to be told she needed another caesarean section:

"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 and...obviously they deliver, you know, hundreds of babies every year, thousands probably, and if they think that there is a problem and it's got to be done that way, then I would always go along with it, I wouldn't challenge it at all". [Sue]

Conformity to the experts is increased in individuals demonstrating low self-esteem as Becky illustrates in these narratives in her willingness to hand over herself and conform to what the experts suggest:

"I've always been like, I'm not very confident and I'm not very em, I wasn't very outgoing". [Becky]

"Just allowed them to take control which I'm really glad, obviously they know what they're doing because I didn't have a clue. But even at the same, if I did know what I was planning or I did know what I wanted to do, it wouldn't happen that way, because I can't speak and I can't come to terms with things. I just can't do anything, so, it's a good job obviously that they do...know what they're doing because they just took me step by step through it." [Becky]

Whereas in high self-esteem individuals such as Anna, conformity is decreased and expert opinion questioned:

"I definitely think it was because of my age. I do feel like I was looked, sort of controlled, told what to do and also confidence because I was young, whereas this time round I know what I want, I'm not frightened to say what I want. So you've got a lot more confidence and I think people pick up on that". [Anna]

"she said because of intervention because [birth centre] doesn't have anything like that...it wouldn't be on offer and I did say to her 'well, I didn't think because you'd had ventouse you'd have ventouse again' and she said 'no, but because there was intervention it's more likely you'll need other intervention' Well I thought that it doesn't feel right to me. I don't understand just because I've had a ventouse why, I did everything else right, by the book so yeah, I was questioning that and I questioned the next midwife and she said, 'I don't think that's right". [Anna]

Responses to social influence: compliance, identification, internalization.

Aronson (2008) distinguishes three kinds of responses to social influence: compliance, identification and internalization. Table 3 summarises the main aspects of these responses.

Table 3 Responses to Social influence (adapted from Aronson 2008)	
Compliance	Is the behaviour of a person who is motivated by desire to gain reward or avoid punishment and is only long lived as the promise of reward or threat of punishment.
Identification	Brought about by an individual's desire to be like the influencer and puts us in a satisfying relationship to the person/persons with whom we are identifying. This is different from compliance because we come to believe, though not very strongly, in the opinions and values we adopt.
Internalization	The most permanent deeply rooted response of one's values and beliefs. The motivation to internalize beliefs is the desire to be right and this becomes intrinsic. If we believe the person who provides the influence to be trustworthy and to have good judgement, we accept the belief being advocated. This then becomes integrated within our own system of values, and as part of our own system; it becomes independent of its source and becomes resistant to change.

By identification, with a group or person, we may find their ideas are appealing and we will be inclined to accept influence from them. We adopt similar values and attitudes, not to obtain rewards or avoid punishment as in compliance, but to be like that person or group. This might occur if opinions of people we respect are encountered. It becomes easy to appreciate how the positive influences of an admired figure (a doctor, midwife or obstetrician) or someone elevated in terms of social status could have either a positive or negative influence on a pregnant woman. Susie exemplifies this in her identity as a professional working in health, rather than as a pregnant woman since she identifies with other professionals in health as equal and as being a part of this group:

> *"I mean cos I do work a bit on the neonatal unit [doctor] had just caught me and she'd you know spoke to me about it informally and it would just be anything different from the norm so like you say not feeding well or anything...I suppose...in the sense I haven't obviously got knowledge and experience of being a first time mum but then I've got a little bit extra peripheral knowledge through my job...I think I could have probably discussed it but I'm sure I would have been probably advised it wasn't the best thing I knew myself with working...quite a few years ago with one of the modern matrons on some stuff when they were setting up the birth centre and we worked on PGD's and things and I knew". [Susie]*

All that is needed is the individuals' desire to be like that person and it is possible that as a group, pregnant women could cause positive effects on other group members, influencing control of individual decision-making and making the choices right for their individual experience. This type of positive influential effect on group members can be illustrated by how they perceive their experience. This is positively expressed by Lisa:

> *"It was just amazing...I was just amazed at how well everyone coped with it including myself and really really thankful that I couldn't have written a better birth if I'd have tried it was just beyond everything I'd dreamt of, it was just so wonderful and it was a really enjoyable experience I really enjoyed it and if I could pop a pill and do it again every night I'd do it, it didn't hurt unbelievably I was completely with it the whole time I remember reflecting during a contraction do you want to do this again, is this too much, could you cope with this again at your age?" Yeah, sure I could, it's like having a big pooh [laughs out loud] it was just lovely". [Lisa]*

By exploring the terms compliance, identification and internalisation, Aronson (2008) demonstrates how compliance, being the least enduring, has the slightest effect on the individual. This is because people comply merely to gain reward or avoid punishment. Lisa illustrates her compliance at this point to avoid the ongoing negativity of the midwife:

> *"I didn't want her to just lay a load more stuff on top of me to give her a reason to fight the home birth. So I just went very much down the route of well let's cross that bridge if we come to it let's carry on with the home birth plans and we'll cross that bridge if we come to it would that be okay...'would that be okay would that suit you if we could just carry on with this dream of a home birth for now...she gave the impression that it was across the board a professional thing that there was absolutely no choice at all."* [Lisa]

Compliance merely to gain reward or avoid punishment was observed in Waterworth and Luker's (1990) study where patients simply 'toed the line', complying, because the nurses had the power to give them pain relief. This is reflected further in Asch's (1955) studies where the reward or punishment was acceptance or ridicule. Rewards and punishments are important means of inducing people to learn and perform specific activities, though these remain limited techniques of social influence because they must be ever present to be effective unless the individual discovers some additional reason for continuing the behaviour (Aronson 2008). Hypothetically, this could be illustrated by a midwife or doctor informing a woman she will endanger her baby's health if she maintains certain choices and goes against the advice given. The punishment is the threat of a damaged or dead baby and may be perceived by her as a continuous punishment until the birth of her baby so she complies with the advice given to her. A threat of further punishment is observed in her putting others at risk as Katie experienced:

> *"And they said, obviously, you've got to put yourself in the situation, you know, 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]

By the process of identification and the opinions and values we adopt in having desires to be like the influencer, the influencer does not need to remain always present. If the

influencer has not been seen by the individual for years for example, the individual will still continue to hold beliefs similar to those of the influencer provided; a) the influencer still remains important to the individual, b) the influencer still holds the same beliefs, and c) that these beliefs are not challenged by more convincing counter opinions (Aronson 2008). This can be illustrated by a midwife caring for a woman in her first pregnancy, as an influencer, the midwife makes impressions on her and the woman identifies with the midwife. She is cared for by the same midwife in a subsequent pregnancy and the woman still regards the midwife as important to her even though some years have passed since any interaction with her. This is illustrated by Janet:

> *"it's very nice it's very personal there's only 3 midwives I could have seen and 2 of them I've known for a long time...so it feels a lot of the time...more like a social visit it's all very nice and comfortable and it's ...nice to catch up with them and see how they are getting on and stuff as well as them checking up on me...[midwife] I've had through all 3 of them she's been here all that time...and it was [her] who delivered [child] so it was lovely for me...the chances of getting her on call...were few and far between so that was absolutely brilliant as far as I was concerned". [Janet]*

And Denise:

> *"they remembered me because it's the same midwives from when I had my older children...lovely, yeah she had all the home birth leaflets out ready for me, 'cos she knew and she was like, 'oh, third time lucky this time'...so they knew straight away cos obviously it's...nice that they remember you...our midwives are lovely around here". [Denise]*

Beliefs can be changed if; the influencer changes their own beliefs or the appreciation for the influencer fades; if a person or group of people is deemed to be more important; or a different set of beliefs is preferred. Aronson (2008) indicates that the effect of social influence through identification can also be dissipated by a person's desire to be right. For example, in having taken on a belief (through identification) where an individual is later presented with a convincing counter argument by an expert and trustworthy person, the individual will probably change their belief.

This is illustrated by Katie as she began to change her set of beliefs in accepting of a situation she was not happy with:

"they were telling us...it was really busy and, you know, obviously we'd have to go up to the labour ward eventually...so, you know, they said that that was the actual sort of plan of action...so we sort of accepted it...and I was just put in a room with four other women and you know there was an examination going on with one of the women who was rather loud and a bit outspoken and you know when you just look and think my God, I don't want this, this is horrible, you know. It started making [me] feel stressed and a bit anxious. I thought I'll be damned if I start having doctors coming in here in front of other women examining me and speaking so openly...about what's going on with me..and it made me start getting a bit anxious and upset and I said to [husband] I don't want to stay here, I want to go home...and I did get very upset at that point...so at that point from being moved from downstairs where I was happy to be staying in hospital, then going up there and being put with the other ladies, all of a sudden I started you know, going back to the home birthing sort of situation, thinking no, I just want to be home".[Katie]

As the motivation to internalize beliefs is due to a desire to be right, this is the most permanent response to social influence. This is the most powerful self sustaining response and does not depend upon a constant promise in the form of agents for reward or punishment as in compliance, nor on continued esteem of another person/group as in identification.

Aronson (2008) describes how specific actions may be caused by compliance, identification or internalization. He illustrates this by the simple behaviour of obedience to the laws of speeding. Society employs police officers to enforce driving laws and people drive within set speed limits if they know officers might be out with speed guns on a specific stretch of road. This is compliance – clearly obeying the law to avoid a speeding fine. If individuals knew the road was no longer being watched, on knowing this, some might increase their driving speed on this stretch, however some might continue to obey the speed limit despite there being no apparent threat and because they know their friends and family would obey it also. This is identification – identifying with others. Finally others might conform to the speed limit because they are convinced that speed laws are good and in obeying this, it helps to prevent accidents and that it is actually responsible behaviour. This is internalization. With internalization Aronson (2008) says flexibility in this behaviour is found, that certain conditions within the environment (situation) behaviour might change. The compliant individual might fear a police radar trap even though they know it's removed and the identifying individual

might be identifying with this very rigid model, hence, both of these would be less responsive to important changes in the environment (situation).

Major components in each response to social influence: power, attractiveness, credibility.

Aronson (2008) outlines the important components of power as the influencing component in compliance; attractiveness as the influencing component in identification and credibility as the influencing component in internalization. These are outlined below and will be explained in relation to social influence.

Power as influencing component in compliance

In compliance, the influential component is power. It is the power of the influencer to dispense the reward for compliance and punishment for non compliance. As a parent we have the power to give love and affections to our children, give sweets or pocket money. An employer has the power to praise and promote employees. Health professionals have the power to praise and reassure patients, to dispense analgesia that controls pain and makes comfortable. Such rewards are a way of producing compliance (Aronson 2008).

Attractiveness as influential component in identification

The influential component in identification is attractiveness. This is the attractiveness of the person with whom we identify. In identification, we want to hold the same opinions that the person holds. For example a woman who breastfeeds her baby, may articulate how wonderful this is, her baby is contented and this makes her feel good as a mother. The listening individual may then see this person with certain attractiveness and adopt these same opinions or a woman declares that she does not want to breastfeed her baby because of certain practicalities, she is returning to work shortly and does not want her baby dependent on her for feeds and it is nice to let others bond with the baby. In essence this freedom allows her to feel in control and confident she is juggling motherhood and work well. The listening individual identifies with this woman with a degree of attractiveness as she too is returning to work, hence, adopts these same opinions. Aronson (2008) points out that the reverse is also true.

Credibility as influential component in internalization

A fundamental component in internalization is credibility, the credibility of the person who is giving the information. Being told something by a person who is expert and trustworthy and who is perceived to be highly credible, has the potential to influence through an individual desire to be correct. For example, a woman who is informed that being upright and mobile in labour is the most effective way to labour because gravity helps the baby descend through the pelvis, the need for pain relief is decreased and it shortens the time for birth (Sutton 2001). The woman would be influenced by this because of her desire to do the right thing. This behaviour would ultimately become internalized and she would maintain an upright and mobile position in labour because she believed it to be true. There is much supporting evidence to confirm the belief that women do perceive professionals as credible, trustworthy, expert individuals (Moffat et al. 2007, Blix-Lindström, Christensson, and Johansson 2004, Bluff and Holloway 1994) hence, have capacity to influence the women they care for.

Obedience as a form of compliance: The work of Milgram

Obedience has been highlighted by Aronson (2008) as a form of compliance. Obedience as a form of social influence and has largely been the work of Milgram (1974). Milgram believed that obedience is a basic element in the structure of human life and that some system of authority is a requirement of all communal living; that it is the psychological mechanism that links individual action to political purpose and it is the dispositional cement that binds men/women to a system of authority. The term authority may have a number of different meanings. It is described as

- the power or right to control, judge or prohibit the actions of others

- a person or group of people having power or a position that commands such a power or right

- the ability to influence or control others

- or an expert in a particular field

(Summers and Holmes 2006 p78).

Milgram (1974) observed the facts of recent history that was suggestive that for many people, obedience may be a deeply ingrained behavioural tendency. His concerns arose as a result of the atrocities of the Second World War and the Nazi extermination of European Jews by the third Reich (Henslin 2007). He considered how the master plan of one individual persuaded ordinary citizens to override moral conduct and be complicit in the carrying out of outrageous acts in the destruction of others; the driving force was the duty to obey orders. He developed a laboratory experiment using a 'teacher' and 'learner' scenario and with the premise of studying memory and learning, Milgram (1974) was able to logically measure obedience.

The experiment was designed to cause a degree of extreme pain, torment and suffering by delivering electric shocks by a subject to a victim. The victim was acquainted with the experiment and suffered no actual shock; but was only perceived to be by the subject. The experiment aimed to show how a genuinely naive subject, would proceed in a concrete and measureable situation in which they would, when ordered by the experimenter, inflict increasing pain on the victim. The aim was to investigate at what point a subject would refuse to obey the experimenter. Milgram emphasized the enormous difference between carrying out orders of commanding officers during times of war and carrying out orders by an experimenter, yet the essence of certain relationships remains the same; for example, how does one behave "when he is told by a legitimate authority to act against a third individual" (Milgram 1974 p4). Whilst his theory is drawn out of experiments using sensitive methods that stimulated intense feelings, his attempt was to understand the broader concept of what makes ordinary people so obedient. Milgram (1974, 1963) argued that principal findings from this study demanded urgent explanation into the extreme willingness of adults to go to almost any lengths on the command of an authority (1974). Hollins Martin provides insight into Milgram's work on obedience to authority from the perspective of a midwifery practice.

Own contextual representation

A system of authority is a requirement for communal living and this is the very basis in the structure of human life (Milgram 1974). Obedience and conformity are both powerful forms of social influence and we are open to the influences in the social context of living within the macrocosm of social organisation. This is part of the

complex structure that links action to purpose that binds us to a system of authority (Milgram 1974).

Figure 3 overleaf illustrates my own conceptual representation of this social structure and demonstrates a midwifery culture within. This mini culture is made up of its own social norms, the individuals encountered within, dominated by belief systems and guiding principles. These are all bound together within, and influenced by, the wider social field that is, in addition, guided on a broader scale by guiding principles and societal norms.

The arrows illustrate the direction of influence within the social structure that causes effect on social conditions and the individuals bound within. What this aims to illustrate is the broader social field as a macrocosm that represents the complex structure of social organisation. Contained within this are microcosms that represent mini-cultures in contrast. Midwifery culture is one such representative microcosm within the overall system of social organisation. This broad social field influences the enclosed microcosms largely due to the existence of powerful forms existing within it that have the capacity to cause effect on the enclosed microcosm. As social organisation and culture changes, this affects the mini-cultures existing within, causing contributory affects that are fed down into its central part, having the most consequence for the women of our society who feed and nurture our nation and are the "absolute core to social value" (Oakley 1993 p48).

Midwifery practice of the 1940's and 50's for example, reflected cultural norms of that time for example in women being confined to bed for a period of time following birth (Forty Leading Specialists 1948). These practices begin to change over time as a result of evidenced based health and medical knowledge that occurs in the wider social field, such as advances in technology or pioneering medical developments and treatments. Therefore cultural norms and professionals no longer practice what was once seen as the norm. Equally so for example in divisions of labour by gender and gender roles (Oakley 2005) where women were once seen in culture as home makers and men perceived as bread winners, this is less apparent today in the wake of feminism and equality.

Social field alters our ideas, feelings, purposes and actions

Made up from members of the wider social structure

Women/ Doctors/ Midwives /Policy makers/ Collaborative Partners

Social conditions determine the formation of interests and purposes

Macrocosm of Social organisation represents

Culture of maternity care

The miniature culture in contrast

Microcosm of Social organisation represents

What effect do these structures have on the choices control, decisions experiences of their members?

Dominated by beliefs

How do these affect control power empowerment emancipation and oppression?

The broad complex structure that binds us to a system of authority

Dominated by policy and guidelines

Figure 3 Representation of social structure encapsulating the culture of midwifery

Concluding social influence, compliance and obedience

In Asch's (1955) conformity study social pressure induced conformity of participants to untrue statements of the group (1955). It demonstrated how when responses were made in private, conformity all but disappears. Hence, participants comply with the unanimous opinion of the group to avoid rejection or punishment. Conversely, when identification or internalization behaviours are adopted this conformity behaviour (Aronson 2008) is changed and power is no longer the important component but attractiveness of the person we identify with. In identifying with this person, we want to hold the same opinions as them, such as, the truthful partner, the ally in Asch's experiment. In a scenario of a midwife caring for a woman in her subsequent pregnancy for example, the woman identifies and internalises with the midwife because of her admiration she has for her as midwife and expert (Kirkham 2010b, Freeman et al. 2006, Kirkham 1999, VandeVusse 1999, Bluff and Holloway 1994) and the woman's behaviour changes, adopting conformity behaviour because she is identifying and internalizing with the attractiveness of the midwife as expert rather than the power as expert being the most important component.

Milgram's (1974) obedience to authority theory argued that obedient behaviour may be perceived differently in different circumstances; by means of a superior officer during war, and that of an experimenter in a laboratory. It may be considered that the experimenter would have less power over participants than the officer would have since the experimenter has no power to enforce necessary participation in a psychological experiment. This does not evoke the same urgency or dedication as participating in war. The fact remains that in the experimental scenario, the participants were there of their own free will, making it easier for them, we can assume, to walk away if they so wished. Additionally, actions of causing extreme pain, torment and suffering in war by a soldier, under the guise of protecting one's own society and the structure of social life from which one belongs, are more understandable than an individual causing this degree of suffering to another individual in a laboratory experiment, as this act may not disturb an individuals' conscience in quite the same way. Obedience as understood and explored by Milgram (1974), has been utilised to demonstrate obedient behaviour in healthcare (Hofling et al. 1966) and in a maternity context (Hollins Martin and Bull 2006, Hollins Martin and Bull 2005, Hollins Martin and Bull 2004, Hollins Martin, Bull, and Martin 2004). Hollins Martin et al's (2004) seminal

research applies Milgram's theory of obedience in a midwifery perspective and demonstrates the impact senior midwifery authority figures have on junior midwives' decision-making (Hollins Martin, Bull, and Martin 2004). Moreover, they suggest how social relationships can cause a large social influencing effect where senior midwives are profoundly capable of influencing junior midwives and lead care (Hollins Martin and Bull 2004) even when there is a clear vision between the junior midwife and the woman she is caring for regarding thoughts and preferences about birth.

The concept of risk in maternity care and the safe delivery of the baby to a mother may embrace the same process in making ordinary people maintain such obedience. Within maternity culture individual practitioners or the policies that prescribe and dictate practice (Kirkham 2010a) which a subject may refuse or obey might be perceived as Milgram's authority figure (Milgram 1974). Consequently, due to pressures of obedience within a hierarchy in the form of guidelines and policies, which they must conform to, practitioners might influence women, dissuading them from certain choices and reinforcing what Kirkham (1999) argues is a fundamental problem with the culture and ethos of maternity care. A policy context compromises the social field (Asch 1952), where people cannot be free from its effects and the degree of regularity and uniformity of practices and belief, means people maintain obedience because of the power of social conditions (Hollins Martin 2006).

Milgram's theory (1974) about how individuals behave when told by a legitimate authority can be made clear in a maternity context. Practicing as an autonomous practitioner the midwife works in adherence to policy and practice guidelines (Levy 2004). If the woman in her preferences decides on care that challenges perceived safe practice that the midwife is not in favour of this, could figuratively create an act in opposition to the woman she cares for. It is questionable therefore how midwives as autonomous practitioners, directed by the system of working to guidelines, might behave when a woman acts in perceived opposition in her resolute decision about where she wants to birth her baby; if this is perceived as not the safest option for her. Policy and procedures are considered to be the legitimate authority and it is feasible therefore to question whether care options consequently may not be offered. This is again exemplified by Anna:

"that was what I wanted and...when I spoke to her, she said to me with him having intervention, [son]...my first one, I would need to go to [Hospital] which I was annoyed about...and she said because of intervention because [birth centre] it doesn't have anything like that..it wouldn't be on offer and I did say to her 'well, I didn't think because you'd had ventouse you'd have ventouse again' and she said 'no, but because there was intervention it's more likely you'll need other intervention". [Anna]

In consideration of Asch's (1952) theory of conformity amid social pressure, an interesting concept is presented for understanding decisions made by women at a time of pregnancy and birth. Asch's (1955) participants were all college students and did not find themselves in a daunting environment, nor were they regarded as vulnerable individuals in a vulnerable situation. A group of pregnant women, exposed to new situations and dilemmas where they must make decisions about themselves and their unborn baby, may feel potentially vulnerable (Edwards 2005). This may be overwhelming (Santalahti et al. 1998) and when presented with influential social pressures from a number of experts, this may draw out maximum conformity and not create a favourable environment where she can discuss her preferences in order to secure the experience she desires.

Social influence shapes all human judgements, practices and beliefs. It seems that it is not possible to remain in a social field and be free from its effects upon us; this is true whether the social fields are clinical or academic practice or simply philosophical thought. It is possible through the process of identification for an influencer to change an individual's beliefs in presenting a convincing counter argument. This counter argument may be convincingly presented in such a way as to have negative impact in part for the woman and positive impact for the practitioner, brought about by the desire to respect the authority presenting the argument, hence, acting in a 'groupthink' manner. It is important that individuals can work through the responses of social influence and internalise their own values and beliefs and that this is motivated from within. Whether this is possible for all individuals to achieve may be reliant upon an influencer to be trustworthy, of sound judgement and where this judgement is from an unprejudiced position.

This summary of Asch's' (1955) concept demonstrating the effects of social and personal conditions on forming and changing opinions and judgements in combination

with Milgram's obedience theory (Milgram 1974) provide a definition of social influence. Both Asch's (1956) conformity model and Milgram's obedience model (1974, 1963) are adopted in the context of this thesis as a definition of social influence in a midwifery context. Moreover, the trichotomy of compliance, identification and internalization responses to social influence (2008), will be adopted when exploring social influence in decision-making in pregnancy.

Research indicates that health professionals do influence women and that it is midwives who have the greatest influence over women with regard to birth place choice (Barber, Rogers, and Marsh 2006). The contextual background under investigation is not whether women are socially influenced, but to what positive or negative extent this occurs, by both the decision made and how this impacts on the outcome of the encounter such as, her birth experience. Asch (1955) suggests those who strike out on the path of independence don't usually succumb to the majority, whilst those who have chosen the path of compliance are unable to free themselves in the process. He proposes that the decisive factor about a person is about whether they possess the freedom to act independently or whether they characteristically submit to group pressures (Asch 1955). There is correlation at this juncture to the concept of emancipation (Wittmann-Price 2004). In using the trichotomy of responses to social influence, alluded to by Aronson (2008) this could uncover new assumptions about decision-making in pregnancy and birth within a system of authority. The phenomenon of emancipation, a concept considered when caring for women in the decision-making process about healthcare issues, is a new theory identifiable from the literature. This phenomenon, together with empowerment, the term used widely in healthcare literature, will now be discussed. These concepts illustrate certain social conditions that make up our social field and the social pressures that influence decision-making for women in pregnancy and birth. These concepts will further inform thinking that help to make sense of our world.

Empowerment and Emancipation

It is not the aim of this thesis to undertake a concept analysis of both of these terms but to highlight the nature of these concepts and argue a natural synergy between them that contends the term emancipation is a more appropriate conceptual model for women's decision-making in maternity care. These concepts clearly link to social

influence, obedience and conformity identifiable through the research on decision-making and women and in relation to women having the ability to choose what is best for themselves' (Blix-Lindström, Johansson, and Christensson 2008); in empowerment from midwives by links to satisfaction in decision-making (Blix-Lindström, Christensson, and Johansson 2004) and in implications with regard to protective steering (Levy 2004, Levy 1999a).

Empowerment is a familiar term used in health care and seemingly constantly on the lips of practitioners (Skelton 1994). It is linked to education and healthcare practices (Duchscher 2000, Harden 1996, Owen-Mills 1995, Hawks 1992); power in nursing (Kuokkanen and Leino-Kilpi 2000, Fulton 1997, Gilbert 1995); power for organisational development in critiquing health promotion (Woodall, Warwick-Booth, and Cross 2012, Murrell 1985) and for job satisfaction in nursing (Ning et al. 2009). Empowerment has been used as a model for practitioners to reflect on practice (Aoki 2002, Fahy 2002, Johns 1999); for student midwives (Kemp and Sandall 2010); models of care in midwifery care (Ingvilda, Dahlberg, and Ingebrigtsen 2011) and is used in empowering patients (Kulik and Megidna 2011) and in questioning whether women can empower themselves (Edwards 2005). Importantly it has been explored within the context of coercion by expert practitioners (Zerwekh 1992). More recently it has been linked to midwifery from experiential perspectives of women (Lundqvist, Nilstun, and Dykes 2002), nurses and midwives (Corbally et al. 2007) and from a disempowerment point of view with regard to language use in maternity care (Leap 2010, Leap 2009).

Rappaport (1984) introduced the concept with the intention of stimulating and influencing mental health policies. Gibson (1991) reports little in the nursing literature existed on this concept back then. Over the last two decades there have been few who have attempted to define it (Hermansson and Mårtensson 2011, Page and Czuba 1999, Rodwell 1996, Gibson 1991) and no clear definition exists. Reviewing the literature in recent times Koukkanen and Leino-Kilpi (2000) illustrated how empowerment is a complex concept with an underlying philosophy that can be classified into three approaches based upon theoretical orientations of critical social theory, organisational theory, and social psychological theory. Within critical social theory empowerment is associated with improving living conditions of oppressed groups such as racial minorities, women and patients in healthcare. Organisational theories and empowerment are concerned with the delegation of power and the

subjects' opportunity to take action. In social psychological theory, it is based on individual's development, suggestive it originates inside the individual and is concerned with individual reflection within environment.

According to Gibson (1991) the difficulty in defining empowerment is that it takes on different forms in different people within different contexts and when a concept lacks a clear definition then each individual defines it within the context of his or her personal experience to give it meaning so exactness of concepts in a scientific sense is thwarted. Rappaport (1984) considers it cannot be defined in a single way, but it needs defining by the people concerned. Perhaps this is why defining such an umbrella term is difficult and why Rappaport argues it has to be defined by those concerned. According to Page and Czuba (1999) it is a construct shared by many disciplines and arenas and is understood differently within them. Yet it is a process by which, individuals, communities and organisations gain mastery over their lives (1984). As Jose exemplifies:

> *"you can kind of gain some control over what's going on and feel a bit empowered to...you can make decisions and...feel that you know if you want something to happen". [Jose]*

Focus on the term empowerment tends to be upon the attributes, related concepts, antecedents and consequences connected to it (Hermansson and Mårtensson 2011, Rodwell 1996, Gibson 1991). There is general consensus that empowerment is something that is rooted in 'social action' ideology of the 1960's and 1970's self help perspectives (Hermansson and Mårtensson 2011, Kuokkanen and Leino-Kilpi 2000, Gibson 1991). It would be reasonable to suggest therefore, the self help perspective has by its own ideology, an existential approach that has the person central to it as a free and responsible agent to determine their own development through acts of will. Rodwell (1996) identifies the concept appears to be about enabling or imparting knowledge transfer from one individual or group to another and that it includes the element of power, authority, choice and permission. Jose exemplifies this point:

> *"probably allowed to discuss and make choices more that you... empower yourself as well...I know that sometimes people make decisions and feel empowered and want to be empowered...think it depends on people's characters some people are stronger and take*

> *control and empower themselves but I think also people need to be empowered...I think hospitals are one of the worst places because we take people out of their clothes don't we...put them into clothes put them into a bed and disempower I've seen people in hospitals who are quite strong people totally disempowered and you sometimes have to stick up for them and you know say come on let's sort this out...I think the hospital's the worst case scenario for that I think you are disempowered in the hospital". [Jose]*

Grace (1991) suggests there is an apparent dichotomy that exists between the concepts of power and empower because systems of health effectively constructs the individual as a health consumer in accordance with the model of consumer capitalism. This gives a different impression to that of a self help perspective. The empowering concept has the person as central whereas the concept of power has the capacity to influence the behaviour of others at core, as the above excerpt of transcript demonstrates.

Enabling people to assume responsibility for themselves remains a shared principle amongst those who write on this subject. Empowerment is fundamentally a process arriving from valuing people (Chavasse 1992), interactions and relationships between two or more seems a core characteristic (Kulik and Megidna 2011) and about the interplay between domination and resistance (Edwards 2005). Page and Czuba (1999) define empowerment as a multi-dimensional social process that helps people gain control over their lives and a process that cultivates power in people for use in their own lives, communities and their society by acting on matters they define as important. As Rosie illustrates:

> *"I don't want to be in that situation...I've never done this before so I don't know how it's going to turn out but hopefully its gunna be...I want it to be a very positive and empowering... experience childbirth I don't want it to be like a cattle market sort of thing where we're all just one after the other just popping them out and being stuck on a ward for however many hours I want it to be a much more sort of calming situation". [Rosie]*

Gibson (1991) alludes to these characteristics of empowerment as a process of helping people to assert control over the factors which affect their lives, encompassing both the individuals' responsibility in healthcare and broader societal responsibilities in enabling people to assume responsibility for their own health. She describes empowerment as a

transactional concept because the process involves a relationship with others that entails helping individuals develop critical awareness of the root causes of their problems, and a readiness to act on this awareness. Skelton (1994) discusses it in the concept of authority and how the roots lie in a political interpretation of the relationship between the individual and authority. This interpretation is as an actual handover or takeover of power about decisions in relation to provision of healthcare. Jose illustrates this point:

> *"they may make decisions and be empowered but sometimes those decisions aren't always the right decisions for them from a medical point of view does that make sense I think it's a difficult one I mean if in this situation the worst case scenario...if for example she was allowed to have a homebirth which you know in some way's would be good if that was what she wanted to do but in this scenario say she had a homebirth and...say something happened and she didn't progress past 9 centimetres again or there was a tear of the scar tissue and it actually you know worst case scenario she and her baby you know...died...then that's a scenario that you want to take away...want to keep it safe, it's a bit of a see-saw it's a real fine balance between empowering people but then making sure they're safe too". [Jose]*

Hermansson and Mårtensson (2011) undertook a concept analysis of empowerment in a midwifery context and describe empowerment as a primary personal process which enables individuals to increase and utilize necessary knowledge, competence and confidence to make their voices heard. Once more the woman remains central to this concept but needing to be heard by those in power. They found the empowerment process to be an intrapersonal process, the intra and inter personal process was described as intertwined. This connects with the intertwined nature of the relationships women have with their midwives (Hunter 2011, Kirkham 2010b, Leap 2010, Hunter et al. 2008) hence, guarantees midwives as being an attribute to empowerment for women in this transactional process as Katie illustrates:

> *"She was always very optimistic and very much, you know, she didn't see it being a problem really 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 and she said, 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...you know, she was always that way inclined to tell you the way it was give you the advice and then obviously let you make the decisions." [Katie]

Hermansson and Mårtensson's (2011 p14) study provides tentative criteria and attributes for the concept of empowerment in a midwifery context and asserts empowerment in this context as 'an ongoing process between empowered midwives and empowered future parents'. This may not be as easy as it sounds as it implies that midwives need to be, or have experienced empowerment themselves, which may be difficult in a disempowering culture (Kirkham 2004, Kirkham 1999). In providing an example from one of their midwife participants who used the metaphor to describe empowerment as 'it's like walking next to the parent-to-be and giving injections that transfer power' (Hermansson and Mårtensson 2011 p14), they inadvertently illustrate how empowerment and power may be perceived by practitioners – that is power is seen as being given by the midwife to the woman. This has consequence in the context of decision-making in pregnancy and birth against a backdrop previously highlighted in how practitioners gate keep women (Levy 2004, Levy 1999b). Knowledge and expertise inherently makes practitioners powerful as Lisa illustrates in her experience:

"she categorically ruled out a home birth there and then.. she got the results and she just said...categorically, you are not having a home birth...she said 'no, you're not having it...I was never given the option of feeling like I could actually say, 'well, I'm sorry I want it. it was, if you have a low-lying placenta you do not have a home birth...she said that she wouldn't be able to...progress with the home birth with the placenta low-lying and the consultant would feel the same". [Lisa]

Power subsists within the context of relationships between people or things not in isolation and not inherent in individuals (Weber 1948); as power is created amid certain relationships. These relationships have an ability to change and be broken down. Power is perceived and understood according to Lukes (1994) differently by individuals who hold positions in power structures. This resonates with the work in midwifery of Hollins Martin (Hollins Martin and Bull 2006, Hollins Martin 2006, Hollins Martin and Bull 2005, Hollins Martin and Bull 2004, Hollins Martin 2004) in conforming to authority. Who has the power to give to another, no one does. Leap believes we cannot give women power, "by its very nature, power is not given but taken" (2010 p19).

The notion of self; self help; self-esteem and self-efficacy (Gibson 1991) is an essential attribute that is reflected in the literature on empowerment. No one can value others unless they value themselves (Chavasse 1992). Power originates in self-esteem that has been developed through love and affirmation (Zerwekh 1992) and is fostered through a mutual-participation relationship in which patient and nurse has equal power as Janet demonstrates:

> *"two of them I've known for a long time...so it feels a lot of the time it feels more like a social visit for all you're doing all the other bits and pieces like the blood pressure checks and everything". [Janet]*

Relationship with a mutual-participation appears to be an essential key. Empowerment is argued to be a process that not only challenges our assumptions about the way things are and the way things can be but it makes us challenge basic assumptions about power (Page and Czuba 1999).

Empowerment demonstrates a multi-dimensional social construct that exists within in a context of power that presents within, and involves changes in, inter-relational circumstance between self and others, through a state of valuing self in affairs of self importance. The context of empowerment clearly cannot be explored in isolation but its existence within a structure of power, and how power is perceived within micro social systems such as midwifery practice should be to ensure women know they are at liberty to make the decisions that are right for them within their personal social contexts.

Emancipation and decision-making

Decision-making must start with the person whose situation is changed by the decision. As Page and Czuba (1999) detail, the assumptions we have about the way things are and the way things can be, should make us challenge basic assumptions about power in order that we alter our view of things. Literature in the debate of empowerment discusses the antecedents, attributes and consequences of this concept. Emancipation is an antecedent to empowerment, and a term that was identified from literature with reference to a study relating to women's decision-making (Blix-Lindström, Johansson, and Christensson 2008). No other reference to emancipation as an antecedent to empowerment materialised. Emancipated decision-making remains unexplored in

paradigms where shared decision-making is paramount such as in midwifery practice. This requires attention so that new understanding contributing to the central debate can be made. In undertaking a search of CINAHL and Ebscohost database using the term 'emancipation' (academic journals and gender specific) 32 articles were identified. Wittmann-Price's (2004) work was primary and no further studies emerged that could bring anything further to the emancipation and decision-making process debate in health, nursing or midwifery.

Williamson's (2010) work writing within healthcare focuses upon the patient movement as an emancipation movement. AIMS (Association for Improvements in the Maternity Services) is just one example of such a patient movement, hence emancipatory movement working to improve the quality of healthcare within a context of maternity care (Williamson 2010) to support and inform women about maternity choices. Williamson (2010) further highlights how new academic theory combined with empirical evidence can inform and change focus in how healthcare is perceived and by looking at healthcare from an emancipatory perspective improvements in quality as patients experience it is explained.

Emancipation in decision-making in women's health care is a conceptual model that Wittmann-Price (2004) developed to describe a phenomenon witnessed in nursing when caring for women in decision-making processes about healthcare issues. Like empowerment it is a term used in a variety of ways but Wittmann-Price (2004) found no previous concept analysis and few references to an emancipated decision-making process. She explains a paucity of information exists within nursing research and practice disciplines and that emancipation has mainly been discussed in the paradigm shift in nursing education or inconsequentially in its use as patient education to facilitate emancipation of patients. Wittmann-Price's (2004) intention in analysing this term was to define it theoretically and operationally as a process that promotes humanistic care and professional growth in the area of decision-making for women about health care issues.

As a nursing concept emancipation is drawn from a long-standing history of social oppression addressed by both critical social theories and feminist theories. Oppressive health practices relating to women have not only always been present, but these continue to develop (Wittmann-Price 2004), with evidence of oppression existing within

midwifery culture (Anderson 2002). Williamson (2010 p14) highlights how we can see in society certain "groups or categories of people as institutionally oppressed and pervasively disadvantaged" but often we are slower to see that patients too can be subjected to institutional domination and can experience oppression. Dominant ways of doing things become 'dominant' because others just accept them (Alford 1975). This is akin to the groupthink concept in social conformity where critical thinking does not readily occur and people simply become accepting of something.

Wittmann-Price identified how emancipation is broken down into antecedents, attributes and consequences, oppression being the antecedent to emancipation. Rationally an oppressive force must precede emancipation. If oppressive forces did not exist there would be no need for emancipation to occur. Therefore:

> the outcome of emancipation is to equalize power between dominant and deprived groups, enabling free choice and promoting true humanistic paradigms in society and healthcare (Wittmann-Price 2004 p440).

This concept can be witnessed within the experimental groups involved in the social influence studies of Milgram (1974) and Asch (1956) where subjects would comply with the dominant group majority, rather than being able to voice themselves against the oppressive force.

This makes clear the relevance of the concept for midwifery practice both as highly relevant for women in midwifery culture making decisions about what they want for themselves but also for midwives in their relationships with women in providing informed choice. Further as autonomous decision-makers within the culture of midwifery where there is clearly oppressive forces (Hollins Martin 2004) that can cause effect. Scarry (1999 p424) asserts 'oppressed nurses deliver oppressed care, thereby compromising the physical, emotional and social well-being of the client'. As Janet illustrates:

> *"I do get the impression...I sometimes wonder if midwives are very cautious of leading somebody into making a decision so unless you fire the questions at them, that discussion can just not take place and I think..that some or quite a few women assume that their options are [birth centre] or [hospital] and forget about the home birth because*

the midwives feel that they can't push that home birth as an option...I think it's just one of those kind of...in their job you can't lead someone into making a decision...you can't have a midwife then accused 'well she told me the best option for me was' and I think it's a very fine line for the midwives that they can advise based on what you ask them". [Janet.]

Scarry (1999) highlights further that the oppression of nurses and the nursing profession is acknowledged by both societal and organizational forces. Midwifery culture (Kirkham 1999), is synonymous with nursing and midwives are synonymous with the women they care for. The need to understand this has previously been emphasized for the impact this has upon practice (Redwood 2008) and for the culture that binds women and midwives (Kirkham 1999).

Wittman-Price (2004 p439) defines emancipation as "an evolving concept". She explores five identified attributes that must be present for emancipation to exist; reflection; personal knowledge; empowerment; awareness of social norms and a flexible environment. Table 4 overleaf provides a synopsis of these attributes (Wittmann-Price 2004). These five attributes are highly relevant to the concept of social influence. They indicate a degree of independent engagement an individual must maintain to reach a point of emancipation. The concept of social influence, conformity and obedience imply these attributes aren't engaged routinely with in practice by individuals; moreover, they are disregarded under the premise of control from another.

These attributes encourage independent thinking as individuals begin to engage in decision-making. Consequently, these dominate the concept of social influence, by increasing the ability to remain strong in ones conviction against coercion and obedience by others, as by exploring them, the decision-maker works through them as a methodical process of decision-making. Since it promotes critical thought about issues that are important to an individual, it may be argued that thinking what is right for them occurs as a result of exploring it in further depth.

Table 4 Attributes for emancipation (Wittmann-Price 2004)		
Reflection	Develop a perception of questioning practices based solely on tradition/authority. Reflection in action, stepping out of oneself/freeze frame the moment to understand it better. Stop and think about what we are doing. Develop critical consciousness. Reflection-a necessary tool for understanding groups/individuals	Dialogue promotes reflection. Action may be taken after true reflection may lead to a person or group to deter intentional judgement. Reflection is cognitive or interactive process in which a woman consciously engages when considering alternatives in healthcare
Personal Knowledge	A type of knowledge with elements of self-awareness. Personal knowledge influences everything one does, it is being aware of one's own feelings. Personal knowledge is objective, it makes people aware of how knowledge affects situations	Personal knowledge defined as awareness by a woman that she has thought about alternatives presented in healthcare in relation to herself
Empowerment	Professional knowledge imparted to patients within nurse-patient relationships. Positively promotes autonomy and independence. Implies some type of power is shared or transmitted. The process provides the resources, tools, and environment to develop, and increase ability and effectiveness of others to reach goals. Is a component of emancipation process, alone may not ensure freedom of choice. Where there is power there is knowledge. Power begets knowledge. Knowledge as power can be used to liberate or oppress depending on delivery/intent	Empowerment is interpreted as the information and resources that health professionals provide to women about healthcare alternatives
Awareness of Social norms	Awareness that social norms set standards and establish paradigms that may be difficult to change and social norms have sanctioned one of the possible alternatives as more acceptable than others. Emancipation involves knowing knowledge development always occurs in a social context and exerts influence over information transfer therefore influences individuals perceptions	Awareness of social norms is defined as awareness of how society places more value on one or more of the alternatives being considered
Flexible environment	Non-judgemental environment that supports freedom of choice is imperative, if the chosen alternative attracts any sanctions this simply elicits another type of oppression. Flexibility should enable patients to make choice; flexible environment is one responsive to change leading to personal benefits Increases choice, enhances self-esteem and understanding.	A flexible environment is defined as one that allows women unopposed enactment of a chosen alternative.

Wittmann-Price's (2004) seminal work identifies the need to better understand emancipation by referring to the existence of oppression as a negative phenomenon within the caring professions. Williamson (2010 p1) considers emancipation is used figuratively to mean

> setting people free from the coercive control or constraint of a more dominant or powerful other or social groups, from subjection to them from their intellectual, moral or spiritual fetters.

Williamson (2010 p1) emphasizes the word emancipation "calls to mind harsh and unwelcome ideas like oppression and injustice". These terms can seem irrelevant to healthcare as patients, clients or service users experience care and as health carers we signify our concern for others (Williamson 2010). Additionally, oppression identifies with the terms coercion, repression and domination and the potential for individuals to be dominated, coerced or influenced by authoritarianism (Hollins Martin and Bull 2006) or by gate-keeping decisions about care (Levy 1999b). A simple definition of emancipation is said to

> free from restriction or restraint especially social or legal restraint; to free from the inhibitions of conventional morality; to give independence to (Summers and Holmes 2006 p381).

Moreover, synonyms of emancipate are liberate; set free; freeing; release; unshackle and untie. Oppress is the direct antonym to liberty, with coerce, dominate, repress, subjugate and afflict being synonyms of the verb oppress.

Importantly what Williamson (2010) does highlight is how patients are in many ways less powerful than doctors and other autonomous health professionals and politically speaking subordinate to them. Furthermore:

> they are often subjected to both obvious, more subtle, open and hidden, coercions and restrictions to their opportunities and abilities to act autonomously in accordance with their views of their interests and of their responsibilities to themselves and to other people (2010 p1).

As Louise illustrates:

"it felt like they didn't try lots of different things it was just like let's just go for the...like well she wants an epidural just give her an epidural, can't get the baby out just cut her it felt very much like...there was just no other options there was no choice no discussions, there was no like, they didn't even say right let's just try pushing a bit more or you know trying to talk me into the pushing just..cut me".[Louisa]

Wittman-Price (2004) is in agreement that oppression can be overt or insidious and this brings about dehumanization because of the culture it produces – a culture of silence and fear of freedom (Moore and McAuliffe 2010, Gibson 2006). Williamson (Williamson 2010) explains how patients, "people in clinical relationships with clinicians receiving care from them" (2010 p1), can feel or experience overt coercion as oppression and they can often accept it as just the way things are. Moreover, it is overt coercion that persistently potentially works against an individual's autonomy (Williamson 2010) especially if this comes during certain procedures or when a woman cannot resist it. Williamson (2010) affirms maternity care, through professing to meet the needs of women can simply slip into routine practices, this suits staff because routines are desirable in complex care because they can provide a basic level of safety. However, these become so taken for granted by staff that they forget to ask for consent and so become routine unless individuals either refuse them, evade them or ask for something else (Williamson 2010).

Wittmann-Price (2004) highlighted how emancipation theory is based upon the critical social theories of Marx and Hegal (Paley 1998) and how oppression is maintained by social institutions associated with negative, patriarchal and authoritarian concept of power, in order to control individuals (Kuokkanen and Leino-Kilpi 2000). Power is not used as a tool of control or subjection but is generated through an individual's behaviour, interactions, language and relationship towards another. This is witnessed in the use of power and language has in our social world (Walton 1995), evidential in midwifery culture (Hunter 2006, Walton 1995) and still remains today (Leap 2012). The power professionals have over women in their use of language and interactions can be exemplified by Katie:

"she said there's a number of things here preventing you from actually progressing into your labour properly so she said...it could take a long time for him to actually get into the position correctly after she'd broken the waters and for things to actually progress to where

we need to be to push him out...she said...I'm going to give you options now because once I've broken your waters these options are going to go and she said obviously I want you to be prepared for everything that's going to come, she said to me, you know, 'have you considered having the epidural then' and I'd said...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". [Katie]

"I think they can be unsympathetic in the sense that they can sometimes sound a bit too sort of outspoken sometimes...like they've got the attitude of...we're the experts, we've seen it, we've been through it...they should be a little bit sympathetic towards each individual case...you know, it's a case of...the minute 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...because of course they're the ones...with the experience you always believe...they're the ones that..are there to give you the actual proper advice, and, you know, if they say something to you, you're taking it that, wow, they must mean this then so I best follow their advice then, when it's a situation of an emergency. But, obviously my situation of emergency didn't seem to be that much of an emergency now, does it, looking back?" [Katie]

The purpose of critical social theory is to expose constraints on individual or social freedoms. Emancipation sets free from oppressive social structures and replaces them with a humanistic philosophy based on the value of freedom. Free will is a synonym of autonomy, choice, self-determination or lack of restrictions. Foundations of critical social theory rest on the assumption that individuals are capable of self-reflection and that all people have a basic need to act independently in different social situations (Kuokkanen and Leino-Kilpi 2000) for example, between midwives, midwives and women or midwives and other health professionals. Wittmann-Price (2004) tells how human behaviour is inseparable from environmental influences and society has imposed disadvantages on some groups. This is exemplified by the theory of self-fulfilling prophecy and midwives believing women cannot learn so they do not provide learning environments for them (Jackson, Schmierer, and Schneider 1996). She states further how the whole social structure cannot be changed without political action. This kind of collective autonomy is one of the primary values of critical social theory.

Kuokkanen and Leino-Kilpi (2000 p239) report "empowerment connotates influence rather than striving to enhance one's power by taking it from others". Janet illustrates this point in discussion with her midwife whose encouraging behaviour empowered her in her decision-making, now the birth centre where she had booked to have her baby was closed:

> *"I'd sort of discussed it with the midwife and said 'closed how long for' and they said we don't know, possibly for the duration because it was Christmas coming up and you're on skeleton staffing anyway...and there was this kind of 'ooh well' if it's over Christmas and you know I deliver over Christmas what would I prefer...I said to the midwife cos I'd actually got to 37 weeks then how about booking in for a home birth...is that still an option and she said yeah course it is we'll get your paperwork so they literally just sorted the paperwork out about 3 days after I'd made that decision."* [Janet]

Emancipation is freedom and the right to choose without restraint. The consequence of emancipation is free choice. Choice is emancipating if the person is free to choose what is right for them but this decision must be enacted without consequence because if it carries with it negative consequences it is still bound by oppression (Wittmann-Price 2004). Nicola demonstrates this point:

> *"to be honest...I was a bit scared then, because I didn't know, obviously, I'd never heard of it before, I didn't know anybody who'd... ever experienced it before, and then one lady come in and basically just blatantly outright said 'Oh, if we don't get your baby out in so many days your baby could die."* [Nicola]

Current policy advocates choice and aims to provide this for women. Choice however, remains a highly contentious issue with some women clearly confined because of personal health circumstance (Department of Health 2007). This does not represent free choice; in spite of current rhetoric suggesting this is the case (Department of Health 2012a, Department of Health 2010).

Asch (1963) investigated independence and submission and social and personal conditions that induce individuals to resist or yield to group pressure. What is a decisive fact about a person is "whether they possess the freedom to act independently or whether they characteristically submit to group pressure" (Asch 1963 p177). This

implies a certain freedom that enables an individual to resist definite constraints put on them and does not submit to group pressures, indeed pressures from individuals who are viewed as an authority over them. This may be seen in women who are recognised as out of the ordinary and perceived to be making choices in maternity care that are deemed as going against professional advice. This is illustrated by Louisa who this time, because of her previous experiences, was quite prepared to give birth at home alone if the professionals would not grant her permission to birth at the birth centre:

> *"I think that they'd have been supportive and understood why I wanted to do that...they would have tried to of persuaded me not to not to do it probably because...if it is high risk it's not really...it's not right to say I mean I know if it was me in my role and someone's going against what we were saying you would advise them not to do it I think...I would have put them in a very difficult position to be honest...I wouldn't have wanted to do that but I would have you know... I would have made it clear to them I am not going to [hospital] so...you come and help me...or you don't... I wouldn't have told them...just rung them after...not going against what they've...advised...but I've read up a lot about home births but I just knew I wouldn't be going."* [Louisa]

Emancipation is an equalization of internal and external demands (Wittmann-Price 2004) where an individual chooses what is best for them even if this is not the most accepted alternative sanctioned by others or by society's norms; the consequence is free choice with or without an associated intentional action. In order for emancipated decision-making to be achieved women must feel it is the best alternative for them in their individual circumstance and is free choice. It is this Wittman-Price (2004) declares is the ultimate goal of emancipated decision-making.

Conclusion

Within the context of this thesis, I define social influence in midwifery in relation to women's decision-making as:

> *"A practitioner in maternity care who has the capacity to affect maternal decision-making positively or negatively that causes change or alters maternal behaviour".*

The importance of Asch (1963, 1955) and Aronson's (2008) social research into conformity lays foundations for interpreting choice and decision-making in maternity care and consequently understanding the pressures women face as a consequence of these tensions associated with behaviours and opinions. This research takes what is already known conceptually from the work of Milgram (1974) and human behavioural psychology, and elements of Hollins Martin's (2005, 2004) theoretical model of social influence in a midwifery context, and uses it as a conceptual lens to make possible a new field of exploration from women's perspective, that creates new understanding of existing issues of social influence and conforming to authority in childbirth.

It illustrates how these concepts of social influence, empowerment and emancipation are bound within a wider social structure and how the nature of the relationship amid them, contributes to the complexities of decision-making. In linking these three theoretical concepts of social influence, empowerment and emancipation with women's narratives, underpins the true essence of experiences from which realistic conclusions can be drawn informed by the voice of women. This is fundamental for further development of existing theory that aims to offer explanation regarding the impact of social influence on women, their experiences of decision-making and explains what the implications of this might be.

Kuokkanen and Leino-Kilpi (Kuokkanen and Leino-Kilpi 2000) affirm the Latin word *Potēre* is to be able to have the ability to choose. Further dictionary definition (Summers and Holmes 2006 p932) of *Potēre* illustrates this originates from Latin *Posse* - to be able. Moreover, the word power originates from the Latin *Posse* (Partridge 1966) and indicates power from the very starting point, implies this is about having one's own ability to choose something. Power is understood as central to meaning; it is perceived as a positive rather than negative concept in Kanter's (1979) account of organisational empowerment of individuals. In organisational and management theories of empowerment what remains different from that of social empowerment is how theories do not account for oppressed groups but focus on the position the person occupies within the organisation, however not from power that creates dominance, control or oppression but power that represents efficacy and capacity that organisational managers require to move to organisational goals (Kanter 1979). Power is distributed top down through a hierarchy to the workforce (Kuokkanen and Leino-Kilpi 2000). Whilst a hierarchy still exists, the focus is about individuals having the

power to create the consequence of increased productivity and effectiveness (Kanter 1979) in the position held within and recognising them as effective members within and central to the organisation.

Empowerment for decision-making in maternity care can draw on these consequences of increased productivity and effectiveness where the maternity hierarchy focuses on women and their position within the maternity culture to create increased productivity and effectiveness. Productivity could imply more efficient birthing options and experiences where women choose what is best for them as they empower themselves from knowledge and understanding about risk and safety (Symon 2006). Effectiveness includes better outcomes for mother and baby; less morbidity in the reduced use of technological applications such as epidural and hence need for CTG, reduced incidence of assisted births and more effective use of resources within the organisation.

Power, as the Latin meaning implies is about one having the ability to choose. This identifies what might exist in a social world that is uncontested and free. However, social norms, individuals' behaviour, coercive natures, risk and fear indicate our social world is not uncontested and free. Hence, in this state, ownership of power switches from the individual where it originates in the truest sense; is given up or taken by such factors from a state of unawareness as we naturally engage in our social world. We are all free agents yet not conscious of this state as we are bound up in the social field of everyday existence. Moreover, the social influences that surround us; conformity; group pressures; self-esteem, can increase this and perception of this *freeness* is lost.

The resultant fact is exemplified in how decisions are made by women. Women, in the sense as being free agents and not constrained by certain choices could result in behavioural change and either conform as a result of imagined pressures from those they come into contact with, persuaded to yield to group pressure or resist and remain free to act independently having confidence in personal judgement and maintain the capacity to recover from doubt and re-establish equilibrium.

Chapter 4: Research Design

Introduction

The literature illustrates a gap in knowledge regarding what we can or cannot claim to understand about what influences women's birth decisions, and how this affects their birth experience. A lack of understanding implies a need for exploration in light of the maternity care women receive and the choices that are provided for them. The conceptual framework drawn from the literature provides a frame for combining sociological theory that can be usefully applied to the context of women's decision-making in maternity care. This frame helped conceptualise the context and justifiably led to ask the specific questions in this inquiry. To recap, the questions this inquiry aims to ask are whether

- Women are socially influenced about their birth choices?

- How does this link to emancipation in decision-making?

- Does emancipation reduce the pressure to conform?

The aim of this research design chapter is to connect the methodological approach and the theoretical underpinning of this thesis to the questions being asked and sets out the approach the inquiry undertook. The research design provides the concrete understanding that bridges the gap about what we do not know and transforms it into something we can legitimately come to know.

As researchers, there is a responsibility, not only to ourselves but to those who have become part of our inquiry, those who invest time and support in us to produce trustworthy accounts and to the research community we engage with. It is essential to think carefully about the philosophical views we bring to an inquiry; the strategy that relates to our view and the methods we apply to transform the approach into practice (Creswell 2009). Our philosophical views influence the decisions we make in how we think, feel and undertake our research.

Creswell (2009) considers in planning research projects researchers need to firstly identify the research design approach with which they will engage. This foundation brings together their assumptions, specific strategies and decisions about choice of methods best employed to do this. These are influenced by what we will study, our personal experiences and typically the disciplines who consider such methods (Mason 1996). This chapter will explore the elements that comprise the design of inquiry and provide justification for choices made. This inquiry is qualitative in design, philosophically proposes a social constructionist perspective and utilises an interpretive phenomenological strategy. This chapter is written from both a theoretical and reflective perspective and diary excerpts will be used for illustrative purposes where appropriate. Reflective first person accounts are in keeping with the qualitative paradigm where reflexive practise is seen as fundamental to inquiry (Webb 1992, Swanson-Kauffman 1986) and essential to the intersubjective nature of this inquiry.

Qualitative research design

The nature of research inquiry concerning the 'softer' human and 'harder' natural sciences has both research paradigms at opposing ends of the research spectrum in continual battle for paradigmatic hegemony. The incongruence between these qualitative and quantitative fields of application is linked to different theoretical positions within the research spectrum (Flick 2009).

Paradigms represent fundamental questions based upon ontological, epistemological and methodological assumptions. These questions represent the ways we analyse and justify in a particular paradigm of choice with regard to informing and guiding research. Paradigms represent a worldview that characterizes the nature of the world, our place in it and the many possible relationships to it (Guba and Lincoln 1994). Such beliefs are basic in the sense they must be acknowledged simply on faith as there is no way to establish a definitive truthfulness (Guba and Lincoln 1994). Whatever an approach an inquirer may advocate as preferred therefore, a key understanding is that each progressively moves on our understanding of the world and our existence within it allowing for critical examination, exploration and analysis of it.

Ontological assumptions question the form and nature of reality and what can be known by it. If a real world is assumed, the inquirer aims to determine assumptions that relate to matters of a 'real' existence and 'real' action, how things really are and how

things really work (Guba and Lincoln 1994). Epistemological assumptions are made by asking what the nature of the relationship between a 'would be knower' and what can be known (Guba and Lincoln 1994). Guba and Lincoln (1994 p108) indicate the answer to this is already constricted by the ontological question that is:

> *not just any relationship can be postulated...if a "real" reality is assumed then the posture of that knower must be one of objective detachment or value freedom in order to be able to discover 'how things really are' and 'how things really work'.*

Methodological assumptions ask how an inquirer can go about judging what is believed to be known about a phenomenon. Guba and Lincoln (1994 p108) consider this is also constricted by both epistemological and ontological assumptions and that:

> *not just any methodology is appropriate...a 'real' reality pursued by an 'objective' inquirer mandates control of possible confounding factors whether the methods are qualitative or quantitative*

It is not simply a case of reducing the methodological question to a set of methods but rather the methods must fit to a predetermined methodology.

Qualitative research traditions consider that knowledge is based upon a theory of assumptions and examination of such phenomena is from a subjective position, one where a researcher's own views and personal experiences may be legitimately employed in interpretation of knowledge. This epistemological perspective considers that there is more than one way to understand a phenomenon and attaining knowledge. This position is in opposition to traditional analytical methods which assume the world is predictable and that measureable fact and outcomes can only be scientifically verified by observation (Lambert, Jomeen, and McSherry 2010).

Each of us has our own paradigm, the way we view the world through our own eyes. Different paradigms each provide a set of basic beliefs that enable judgements about what we understand to be true; a 'truth' about reality. The concept of truth Lincoln & Guba (Lincoln and Guba 1985) argue is intangible, it has a number of meanings but all can symbolise truth. Furthermore, they exemplify how, truth can be taken to be true; can be claimed by a person of moral or professional standing; can be a logical or

mathematical claim that is known to be true; can be an empirical scientific claim of truth by hypothetical affirmation or denial of something consistent with nature (Lincoln and Guba 1985).

Amid all forms of truth, metaphysical truths are the basic taken for granted truths that cannot be tested against external norms of nature, or logical, deductible measures and professional benchmarks, but must be accepted at face value because they can never be tested (Lincoln and Guba 1985). This is what Guba and Lincoln (1994) have since referred to as requiring a basic acknowledgement on faith as there is no way to establish a definitive truthfulness about something. Metaphysical truths Lincoln and Guba (1985 p15) explain:

> *represent the ultimate benchmarks against which everything else is tested for if there were something more fundamental against which a test might be made, then that more fundamental entity would become the basic belief whose truth must be taken for granted.*

These systems of ideas give us

> *some judgement about the nature of reality or a reason why we must be content with knowing something less than the nature of reality, along with a method of taking hold of whatever can be known* (Lincoln and Guba 1985 p15).

This systematic set of beliefs and associated methods are what Lincoln and Guba (1985 p15) define as a paradigm:

> *paradigms represent a distillation about what we think about the world (but cannot prove). Our actions in the world, including actions we take as inquirers, cannot occur without reference to those paradigms: as we think, so do we act.*

Debate for intellectual legitimacy within paradigms is observed to be a continual and contentious issue (Denzin and Lincoln 2000). Despite being different in focus and purpose, both qualitative and quantitative approaches remain legitimate methods of inquiry into how we perceive and come to understand our world. Qualitative research is often considered as a less scientific approach (Cutcliffe 2000), and because of its

subjective nature, it can often mean it is misunderstood (Pope and Mays 1999) yet is a legitimate way of attaining knowledge about practice issues (Lambert, Jomeen, and McSherry 2010) and in maintaining effectiveness and efficiency for the needs of women (Hunter 2008).

Willig (2008) explains a positivist epistemological position implies that research produces an objective knowledge and that understanding is gained through impartial and unbiased means utilising an external, impartial view of the researcher. Moreover, empiricism assumes that the knowledge of the world must be derived from facts of experience and perception through a process of systematic collection and classification of observations and this basis of knowledge, results in creating complex theory. Despite different paradigms and approaches of any inquiry whatever we believe, these remain assumptions and:

> *are not open to proof in any conventional sense; no way to evaluate one over another on the basis of ultimate, foundational criteria* (Guba and Lincoln 1994 p108).

On this basis, Guba and Lincoln (1994 p108) argue that any given paradigm is simply a representation of complex views of inquirers who formulate chosen responses to these ontological, epistemological and methodological questions and argue the:

> *sets of answers given are in all cases human constructions because they are inventions of the human mind and hence open to human error... no construction is or can be incontrovertibly right; advocates of any particular construction must rely on persuasiveness and utility rather than proof in arguing their position.*

Women's health studies according to Mason (1996) rely on qualitative ways of knowing. An inquiry into women's decision-making requires an approach that studies women's real world situations. This promotes a natural unfolding of rich and illuminative understanding of their perceptions and experiences, and has adaptability to inquiry that allows for deeper exploration as the frame of mind allows. In qualitative research the researcher situates themselves in the participant's worlds to understand their subjective experiences. These personal experiences are turned into representations

that allow interpretation which reveal insights that apply more generally beyond the individuals studied (Lambert, Jomeen, and McSherry 2010).

If our epistemological position determines how we perceive the world, then we position ourselves according to our ontological assumptions in the way we come to understand the reality of that world. We are individual in experiencing the world differently and therefore there cannot be a way of determining a straightforward or simplistic knowledge of reality for human experience. What the experience of love feels to you does not necessarily evoke the same meanings of love for me. I have my own understanding of it, of what it is, and how it makes me feel as a human being, experiencing in the world. In communicating as two experiencing individuals, about our perceptions of love in a social context, we can move towards gaining some shared understanding and knowledge about some truth of reality of what love might be. This knowledge is not gained in isolation as individuals, but through our interactions with each other and is reflective of our experiences of the world in which we co-exist.

Objective knowledge is obtained by means of impartiality by the means of the inquirer. Impartiality is not possible in co-constructed existence where meaning making and understanding between people is inter-subjective.

Social Construction

The constructivist paradigm assumes an ontological relativism and differs from an ontological realism as is the belief in positivist and post-positivist theories. Constructivism follows the ontological principle that knowledge and truth exists in relation to a cultural, societal and historical context and these are not absolute (Guba and Lincoln 1994). Realities and what we come to understand are understood as being mental constructions that occur as we co-exist naturally. These are socially and experientially founded and shared between, individuals, groups and cultures. Guba and Lincoln (1994 p110) explain these are:

> dependent for their form and content on the individual persons or groups holding the constructions; constructions are not more or less 'true' in any absolute sense, but simply more or less informed and/or sophisticated.

Having this ontological assumption, constructions and their connected 'realities' are alterable.

Willig (2008) argues that social constructionism positions human experience and perception as mediated historically, culturally and linguistically, and what we perceive and experience is never a direct reflection of environmental conditions but must be understood as a specific reading of these conditions. What she determines by this is that experience and perception is temporal to circumstance and susceptible and explicit in social context. Affirming this, Willig (2008) does not mean we cannot really know anything, but suggests there are multiple typologies of knowledge rather than knowledge. Knowledge comes from different places and people; it is our beliefs backgrounds and lifestyles that shape it (Savage 2006). Language does however remain an essential element of socially constructed knowledge and the same thing can be illustrated in different ways, giving rise to how we might come to understand and perceive it differently. Willig (2008) exemplifies this with positive optimism of a 'glass half full' or with a negative lacking perception of the situation in a 'glass half empty'; both are equally accurate ways of interpretation of a situation through the means of language. Language is a form of social interaction where meanings are communicated and in how knowledge is created.

Social constructionist approaches provide a way of constructing reality rather than just simply reflecting on it, because it allows for ways of constructing social reality that are available in culture to explore conditions of their use and trace their implications for human experience and social practice (Willig 2008). This position allows for exploration of the components of women's social worlds. A feminist perspective gives women a voice to connect their social lives and construct their own knowledge through experiences. Women's epistemological assumptions, even if they have no conscious awareness of their own theories of knowledge, can be explored and understood, furthermore are central to their perceptions of themselves and their social worlds (Belenky et al. 1997). By exploring the social constructions of women's knowledge, from their personal experiences, a truth can be established. These social descriptions represent their social understanding of reality that establishes a reality that can be taken for granted.

Within a constructivist paradigm the inquirer and the object of investigation are interactively linked so that the findings are literally created as the investigation unfolds (Guba and Lincoln 1994). The nature of these 'intra-mental' social constructions mean that individual constructions can only be elicited and refined through interactions between and among the inquirer and participants (Guba and Lincoln 1994). Hermeneutic process is employed as comparative to this dialectical interchange of constructions between both parties (Guba and Lincoln 1994). What is aimed for in this process is a consensus construction that becomes a new and complex enlightenment to that that existed prior (Guba and Lincoln 1994). The nature of the midwife-woman relationship has already been highlighted in the literature review as a tapestry and the relationship women and midwives have is warp threads that hold the fundamentals of care as its foundation (Hunter et al. 2008). As such, inter-subjective knowledge that includes experiential, contextual and intuitive are legitimate ways of knowing if care is to be both humanistic and holistic and enhanced by both midwives and women's ways of knowing (Hunter 2008).

Guba and Lincoln (1994) inform that constructivist belief is relativist and that social reality as a product of human intellects that can change as their constructors become more informed. Knowledge between these co-constructors is a transactional process, where subjective assumptions are the foreground for this interactional knowledge creation that aims to take previously held notions about a phenomenon and reconstruct these into new constructs.

Social constructionist approach focuses on the inter-subjective nature of knowledge and as such is an appropriate epistemological perspective in coming to understand the assumptions women have about themselves in the context of decision-making in their worlds. The stories women construct are representations of their experiences and perceptions of the different forms of knowledge they have and use to inform their decision-making. Social constructions, communicated through language have already been identified as a means of influencing practice in midwives' interactions with women (Hunter 2006, Walton 1995)

Hermeneutic Interpretive Phenomenology

Hermeneutic Interpretive Phenomenology is situated within the qualitative paradigm and method chosen for this inquiry. This aims to identify the essence of the human

experience as described by the women themselves. It is an ideal strategy for understanding their personal experiences and revealing perceptions based on their 'life world' descriptions. Phenomenology is concerned with the theory of interpretation of human behaviour. There are many forms of phenomenology and this inquiry adopts a Heideggerian interpretive perspective (Fleming, Gaidys, and Robb 2003) focusing on the lived experiences as they are experienced, understood and consequently socially constructed by the women experiencing them.

The method of exploring the lived experience is a well-used method in healthcare to draw out experiences of patients (Ortiz 2009, O'Mahony 2001, Annells 1996), moreover for understanding experiences of pregnancy and childbirth (Savage 2006, Lundgren 2004, Lundgren and Dahlberg 1998). Patricia Benner is the most notable phenomenologist writing in nursing (Chan et al. 2010, Benner 2001, Benner and Tanner 1987, Benner 1982, Benner and Wrubel 1982). Smythe, (2011) formerly a clinical midwife utilizes Interpretive Phenomenology within her research and provides insight into this methodological approach that links understanding with action from a midwifery perspective. Midwifery practice she voices (Smythe 2011) is situated in a context where anything can happen at any time and is a mix of situations that are always unique amid the physiological processes of both mother and baby, where the unknown is naturally present and what follows is always unknown. This she argues is "the phenomenological world of practice" (Smythe 2011 p36). Moreover, due to knowing the lived nature of these encounters this draws the hermeneutic interpretive phenomenology as an appropriate approach to exploring and understanding the lived experience. Understanding of something is informed by experience, unique in context and the uniqueness of human experience resonates with others where truths are uncovered (Smythe 2011).

Heidegger (1962) emphasized the existence of the person as a free and responsible 'being' in the world, in a world not of our own choosing but in time and a socio-historical setting that we create through our own actions and that there is no certainty to it (Heidegger 1962). Phenomenology according to Heidegger (1962) is based within the humanistic paradigm and aims to gain insight into a phenomenon in question. This approach has at its ontological core what it means to be human, the nature of being and being in the world as opposed to being separate from it (Heidegger 1962). His interest in the possibilities of being, in which existence knows itself only by its relation

with others and objects, believes a diversity of direct experiences in consciousness exists. This is in opposition to Husserl's understanding (Fleming, Gaidys, and Robb 2003) who viewed consciousness as an object that could be gazed at in an objective way.

Phenomenology as a humanistic approach makes a most fitting method from which to explore the essence of decision-making about birth choices. It embraces the individual as being part of, and not separate from the world in which they exist, one that is co–constructed through our inter-subjective dealings with others. This was influential in choosing this paradigm as an inductive approach in which to study the lived experiences of those who directly experience such essences, develop and constructs understanding and knowledge of it. Only those who have experienced internally can communicate it to the external world. It is the lived experience of the world of everyday life that remains the central inquiry in this method (Speziale and Carpenter 2007).

Schultz (1970 p320) describes the world of everyday life as:

> the total sphere of experiences of an individual which is circumscribed by the object, persons, and events encountered in the pursuit of the pragmatic objectives of living. It is a "world" in which a person is "wide awake" and which asserts itself as the "paramount reality" of his life.

Phenomenological method not only aims to provide insight and answer questions about understanding human experience, but through interpretive analysis of these experiences, and the perceptions women attach to them, new ways of knowing can develop.

A person's perception is a given phenomena, and a lived experience of this phenomena is the essence. An essence is expressed by van Manen as "a linguistic construction of a phenomenon" (1984 p43). Phenomenology is the study of these essences and asks what the nature of the phenomenon as meaningfully experienced is (Van Manen 1984). Dahlberg (2006) believes we need to layout the idea of essences and see how an understanding from an empirical point of view could make the original meaning useful for empirical purposes. It is this lived experience that presents to the individual what in their life is true or real. It is this that gives meaning to our perception

of a particular phenomenon that is influenced by everything internal and external to the individual (Speziale and Carpenter 2007).

Qualitative approaches give meanings and descriptions personal significance. Phenomenological inquiry allows for such exploration of women's experiences of influence and decision-making, and what the potential impact of this phenomenon might mean for individual lived experiences of birth. Through the linguistic constructions of women's narrative, the essences of their perceptions and the meanings they attach to them become evident to the external world. Analysis of such meanings can only be made through interpretation of these others' lived experiences by another 'being'. Consequently the approach is one of hermeneutical inquiry, the theory of interpretation.

Van Manen (1997) distinguishes between description and interpretation; phenomenology is the description of the lived-through quality of lived experience but it is also a description of meaning of the expressions of the lived experience. Van Manen (1997 p25) clarifies that these descriptions are different. The first is a direct description of a life world that is lived and the second is a transitional description of the life world expressed in symbolic form, moreover, that this form contains a stronger element for interpretation and that this is the distinction between phenomenology as a pure description of the lived experience and hermeneutics as interpretation of experience via some symbolic form.

Interpretive phenomenology of Heidegger differs from the school of Husserl's descriptive phenomenology (Fleming, Gaidys, and Robb 2003). Descriptive phenomenology asks the researcher to suspend personal beliefs and prejudices whilst describing participants' experiences so as not to influence the interpretation of the participant's experiences and to 'bracket' one's own beliefs and preconceptions. Some argue it is not possible to remain outside of the subject matter because the researcher has been involved in the process of research and the data (Parahoo 2006, Nightingale and Cromby 1999). Asch (1952) previously highlights this point, in how it is not possible to remain outside the social field and be free from its effects upon us. It is not impossible to be inside someone's head as they problem solve and decision make. The human nature of decision making is by no means a static event. Women make decisions within a temporal social context of pregnancy and birth that is in a constantly

evolving state of flux. As researcher and inter-subjective other, this can only be understood through the method of hermeneutic analysis.

Bernasconi (1986) highlights that Gadamer, makes distinction between phenomenology and hermeneutic phenomenology. Interpretation he reports (1986 p68) in its original meaning:

> is both a *pointing to something*; and is a *pointing out* of the meaning of something. *Pointing to something* is a kind of indicating that functions as a sign, *pointing out* what something means relates back to the kind of sign that interprets itself, and when we interpret the meaning of something, we are actually interpreting the interpretation.

Intuitively I was drawn to this approach (Smythe 2011), this tradition felt appropriate to begin exploration into the lived experiences of women experiencing decision-making about where to birth. Strength is given to this argument further from the literature which demonstrates how women like to be asked about their experiences (Moffat et al. 2007, Garcia, Kilpatrick, and Richards 1990), especially in decision-making (Tinkler and Quinney 1998). The literature was fundamental to the research design and reinforced early notions regarding what methods best suited this inquiry.

For example, a grounded theory approach it was concluded did not feel a 'realistic fit' for this particular inquiry. Researchers utilizing a grounded theory approach gather data, analyse this and build theory from this (Nieswiadomy 2012). Comparable to phenomenology, grounded theory is an inductive process and one where concerns are with generating theory (Mason 1996). However, the phenomenon worthy of inquiry was already known from reviewing the literature and uncovering the gap in existing knowledge. There was no existing theory evident in which this could be extended or modified as is understood in a grounded theory approach. Elements of Grounded Theory and Phenomenology have similarity. Grounded theory uses a constant comparative in data analysis technique with development of a core category (Nieswiadomy 2012). The hermeneutic cycle of analysis used in this inquiry was a technique that undertook such a process where data was consistently and constantly analysed in much the same way.

Reviewing the literature confirmed that research methods utilized in the reviewed studies (Barber, Rogers, and Marsh 2006, Tinkler and Quinney 1998), aimed in some

way to explore influences on women's decision making in pregnancy and birth but to date this has not been explored from the *lived experience* perspective. These studies endeavoured to either describe women's descriptions of their perceptions of communication and maternity care experience (Tinkler and Quinney 1998), or identify factors that influence women's decisions about where to give birth (Barber, Rogers, and Marsh 2006). Both studies sampled women in group interview or focus group format to supplement cross cultural data thus, using a multiple perspective to generate data. This kind of perspective does not uncover deep meaningful stories such as the personal lived experience seen in phenomenological inquiry. Participants will only bring forth to a group what they want to share (Cluett and Bluff 2006) and so these studies did not intend to uncover meaning as *individual* but as a *collective group* in the social context of life.

To date, there remains no research that utilizes qualitative research methods using an Interpretive Phenomenological Analysis (IPA) approach in an attempt to understand women's *lived experiences* in relation to social influences upon decision-making about birthplace choices. Moreover, how these are perceived and understood by women and what consequence this might have on them in being truly liberated to make choices freely. To date this area has not been explored. It is proposed that this research inquiry, in an attempt to seek understanding from the interpretative phenomenological perspectives of women, remains unique in doing this and was both instrumental and influential in the research design. This thesis presents founding knowledge with regard to the essence of the lived experiences and the social influences women face both in pregnancy and decision-making about where they birth their babies.

I have identified the characteristics of qualitative inquiry that best suit the nature of exploring the human experiences of women in their social context. The inductive nature and epistemological perspective of social construction as the lens in which to 'gaze through', gives voice where interpretation of the lived experiences of these women can be achieved through a hermeneutic frame and legitimate knowledge increased.

Research methods

I wanted to understand this element of women's life experience and how they navigate decision-making about where they birth. The literature demonstrated a paucity of women's voices and so I set out to foreground the voice of women. I knew that to do

this the inquiry needed to be qualitative utilising an inductive paradigm and interpretive methodology in order for women to speak out. For this to be achieved I needed a method that allowed open dialogue with women that could facilitate their narratives, yet allowed for space to think and recall memories. A method where I could prompt and explore where appropriate, to draw out their perceptions and life/birth stories where these could be represented utilizing an interpretive hermeneutic frame.

What is evident from reading this thesis thus far, are the voices of women. These voices are the fundamental central essence to providing knowledge about and acquaintance with, a phenomenon and facilitate guidance in an interesting and meaningful way. This signposts theoretical understanding in what we already know about something, for application of it in a consequential way that provides authentic understanding and forms strong foundations of new knowledge discovery. This knowledge guides us as we weave our way through the conjectural and intellectual minefield of research methodologies we employ as inquirers.

As women construct their experiences and types of knowledge this can be applied to human understanding and how it is co-constructed in our social world. I thought deeply about how to write this chapter. Something that is built upon strong and justified foundations gives credibility and it is where methodology and approach has to be demonstrated as the most appropriate. The most apposite method for undertaking this research is in the truest sense phenomenological. The methodology and methods *showed themselves*. As Heidegger says (1962 p58)

> phenomenology means to let that which shows itself be seen from itself in the very way in which it shows itself from itself.

What I understand from this can be illustrated through my experience of reviewing the literature. The review essentially showed me the way of choosing the research design and methods. I *learned* to see the literature as it *appeared*, and *saw it 'from itself'*. Seen in such a way *shows itself* as how it really is or rather how it really is not, that is, what is absent in how *it appears*. The paucity of women's voice, the paucity of knowledge on influences on women in decision-making showed themselves as absent. This absence *shows itself* as how *it really is.* This was instrumental in what I wanted to

discover, why I wanted to discover it and how it needed to be discovered - a voyage of discovery of and 'from itself'.

Rigour in qualitative research

As with conventional inquiries rigour is just as important within the naturalistic paradigm. Often within the naturalistic paradigm naturalistic researchers can have their enquiry called into question for how much their interpretations can be justified as trustworthy (Lincoln and Guba 1985). What constitutes quality or rigour criteria in interpretive inquiry, has largely been debated by Lincoln and Guba (1985), Lincoln (1995) and Denzin and Lincoln (2000). The importance of measures for adopting rigorous approaches is seen in the steps health researchers undertake to ensure trustworthiness of findings as a paramount part of their inquiries (Hayter and Harrison 2008, Hayter et al. 2008, Lo et al. 2008).

Lincoln and Guba (1985) illustrate criteria for meeting trustworthiness of inquiry within the naturalistic inquiry and consider the criteria of credibility, transferability, dependability and confirmability as an approach to achieving this. These steps were applied within the process of this inquiry and addressed in justification of reasons undertaken for certain practices throughout the methods and analysis chapters. The authors suggest techniques that make credible findings more likely, for example prolonged engagement and peer debriefing (Lincoln and Guba 1985). My role previously as a midwife has meant I have spent time in learning the culture of maternity care and affords me to build trust with the women participants. This is addressed later within this section. The nature of IPA ensures prolonged engagement with participant data where the investing of sufficient time to achieve certain purposes can, in what Smith et al (2009) consider as a researchers commitment to the depth and richness of analysis. Peer debriefings, a further activity suggested by Lincoln and Guba (1985) can be utilised as a means of providing an external check on the inquiry process. This can and was in this inquiry maintained through academic supervision to ensure the quality of interviews and completeness of the analysis undertaken (Smith, Flowers, and Larkin 2009). Member checks of data from research participants is a most crucial technique for establishing credibility (Lincoln and Guba 1985), and this was maintained within this research process to ensure credibility of the data obtained.

The nature of transferability in naturalistic inquiry is different to that in the positivist paradigm, and is the researcher's responsibility to "provide the *data base* that makes transferability judgements possible on the part of potential appliers" (Lincoln and Guba 1985 p316). Lincoln and Guba (1985) argue if in using techniques in relation to credibility to show a study has quality it ought not to be necessary to demonstrate its dependability separately, but propose the technique of auditing as a method to authenticate dependability that can provide a fairness of representation for accuracy. Dependability was demonstrated by Lo et al (Lo et al. 2008) in their study by maintaining a peer review coding process whereby the research team members sought to establish accord around emerging themes. Within this inquiry as a lone researcher, this was maintained by supervision where supervisors provided the same peer review process advocated by Lo et al (Lo et al. 2008).

Lincoln and Guba (1985) determine confirmability the fourth technique for establishing trustworthiness within naturalistic inquiry can be maintained through practices for example by triangulation or by keeping a reflexive journal. This technique is the ability of the researcher to maintain an audit trail where confirmability within a study will be seen to dovetail in this process. This is illustrated in this study by the comprehensive analytical process demonstrated in the hermeneutical analysis of interview data, clearly identifying the process carried out enabling the reader to follow the chain of evidence that lead from initial documentation through to the final report (Smith, Flowers, and Larkin 2009). The process of auditing can be conducted by supervisors who can conduct mini audits of their student's work for example in looking at the first interview transcript annotated with initial themes. Moreover the supervisor can check the annotations have some validity in relation to the text being examined and the approach the student employs in the codes, categories or themes applied (Smith, Flowers, and Larkin 2009). This practice was undertaken with supervisors at various stages of the process. For studies undertaking interpretive phenomenological analysis Smith et al (2009) consider that it is important to remember it is a creative process and the criteria for validity must remain flexibly applied as what may work for one study could have less suitability for another. For novice qualitative researchers knowing what might constitute demonstrating a study as trustworthy can be difficult and the role the supervisor plays within this process can be crucial in ensuring something is a balance between being of very high quality and when it is good enough (Smith, Flowers, and Larkin 2009).

Reflexivity

Reflexivity is used within qualitative approaches as a method to validate research practices (Kingdon 2005, Pillow 2003, Cutcliffe and McKenna 2002) and ensures trustworthy inquiry (Lambert, Jomeen, and McSherry 2010). It is essential for a continuous reflective process and awareness on how one's own values and perceptions, alongside those of respondents can shape data collection and analysis (Gerrish and Lacey 2006, Parahoo 2006). Morrow (2006) adds the approach can be used by inquirers for the purpose of understanding the phenomenon under exploration, resulting in accurate portrayal of the meanings made by participants and where self-examination allows assumptions that could affect the study to be understood. In appreciation of the reflexive process, the inquirer is encouraged to reflect on the assumptions that have been made about the world while the research activity continues (Willig 2001).

Researcher position

I am conscious of my position as a woman, mother and midwife in having presence within both my midwifery and research practices and what impact my interactions might have on others. As a midwife, mother and researcher, I am a socially engaged individual within my social field. Recognising this, it felt an instinctive method by which to explore human essences in an inductive manner by inter-subjective engagement. We do not exist in isolation, meanings of situations are created by our interactions together (Weber 1948). I consciously aimed to put my experiences of these aspects of my life to one side, in both midwifery and research practice and in the language I would use so I did not say anything that I felt might construct insecurities in the decisions women might make. For example, by my personal choice to breastfeed my own infants I did not want to imprint my own ideas onto women so they might perceive this as a right and proper thing to do, however I do promote this as the healthiest option for babies and mothers (World Health Organisation 2013, Renfrew et al. 2006).

During this research inquiry I have reflected on a time before I was a midwife. I expressed my choice to my GP to birth my baby at home. I wanted my baby to be born at home because it felt the right thing for us as a family; the ease in not needing childcare; not interrupting my position as a mother in our family unit and that an uninterrupted flow of family life would continue. I was 'told' in 1993 'homebirth was not

safe, it was something the midwives had taken on themselves, we do not advocate it and we will not look after you.' The profundities of my GP's words have stayed with me and are as clear to me today as 20 years ago. I complied with my GP's suggestion and went in to hospital to have my baby. I now recognise I was socially influenced by him as he caused an effect on my behaviour, and obedient, as I complied with his authority over my birth choice and being 'told off' by him for contemplating a home birth with my second child. This was obedient behaviour because of pressure from him in the threat of not being looked after and obeying him because I complied with his suggestion to have my baby in hospital. My behaviour was not one of conformity because as expert, doctor or man, he is not viewed as the same status as me as a pregnant woman. Actions of a subject in conformity go along with peers of own status (Milgram 1974).

On reflection I did not feel cheated in not having my desired birth choice granted. I believe it did not take anything away from my experience, but what it has instilled in me is a conscious awareness that I had accepted this at face value and did not ask any further questions. In the event of my third pregnancy, my decision for a home birth was already in my mind, made before contacting my midwife. Only when I had bleeding early on in this pregnancy and felt my pregnancy was under threat of miscarriage, did I come up against my GP saying to my midwife that he will not refer me to the early pregnancy unit because I was booked for care completely with midwives. I did get an early scan by midwife referral and all was well. My joyous birth took place at home in a relaxed manner with my husband and midwives present – in 26 minutes.

My experiences as a pregnant woman have undoubtedly been profound. I wanted to recreate this feeling of joy and satisfaction in birth to other women in whatever form that satisfaction meant for them. I believed at that time, it was my midwives who had allowed me to have this experience because they 'granted' me my home birth. Only in entering the research process and exploring reflexively in what this thesis has uncovered, have I seen it through a different lens and have come to know:

- The experiences I have had are down to me

- I cannot be, nor should I be separate from my experiences.

- I cannot remain outside the social field (Asch 1952) and bracket my preconceptions (Crabtree and Miller 1992).

It wasn't until the practice encounter mentioned at the beginning of this thesis, in how a woman who voiced clear choices had these dispelled, that I began to question how women are influenced in the decisions they make, which in turn was the catalyst for the inquiry. Questioning this in this context was not from a *self* perspective but from the position of *midwife.* There is some cohesion of the two frames of reference that exist in a situation where we are ourselves, but also as others in co-existing as equals in a system of being, in similar self existences. As experiencing individuals we are all open to the same phenomena and susceptible to the same confines, worries, confusions because we co-exist. Though experience is unique and no experience can be like another (Fleming, Gaidys, and Robb 2003), corresponding experiences occur. Birth for women is still birth, those who have shared that experience undoubtedly share similarities of the characteristics of birth experience as women, and those who have not shared this, ask those who have how it feels. This all becomes relevant forms of human knowledge passed between us; we learn from, take on, or discount this knowledge as we feel is relevant to our personal situation.

I asked myself at the beginning of the research process what formulates my paradigm for inquiry. The questions were drawn from the literature and were reflective of the practice encounter I experienced as a midwife. This acted as catalyst that was also reflective of self experiences. The swathe this puts me in, clearly situates me as *a part of* the process and not *apart from it*. I am not situated *in the here and now experience* as the women who have participated in this inquiry are, but have been situated *in the here and now experience* previously. This reflexive sense means I keep my *self* separate as much as possible within the social field of midwife and woman yet knowing I am not separate of it. In my not being separate of it, I bring something to it that I would not ordinarily do if I believed I can only remain out of it. The knowledge I bring as a result of my inquiry, is reflexive as I look back and see self as changed as a result of it (Lambert, Jomeen, and McSherry 2010, Steier 1991, Mead 1934). This reflexive condition within the social process is according to Mead (1934 p134),

> *essential for the development of mind, and that by the means of reflexiveness, 'the turning back of the experience of the individual upon himself ', the entire social process is brought into the experience of the individual involved in it and enables the individual to take the position of the other.*

In coming to know and understand this process and my position as researcher, I developed my own contextual representation of *self* in the process of research inquiry. This clarity came about as a result of stumbling on Shiva's Circle of Constructivist Inquiry (Crabtree and Miller 1992). Figure 4 overleaf illustrates my own contextual representation that permitted me to see myself as woman and mother, but researcher also and how two social constructions of *self* coalesce in the research process. Moreover, this coming to understand my position guided *self* whilst reflecting during this process. This development permitted me to 'bracket off' as midwife and look through the research lens as subjective other; the subjective other as researcher. Being absent from the clinical practice field aided this furthermore, as I was not looking through a practitioner lens but the lens of a practicing researcher. Developing this contextual representation was instrumental to the theoretical design of the exclusive hermeneutical cycle of analysis presented in this thesis. In simple terms as my research entered the analytic stage of the interview and in working deeply with texts, I was considering how best I could illustrate the iterative nature of what was evolving from the data through my engagement with it. I developed the analytical framework from observing an illustration in Crabtree and Miller (1992 p11). The framework of analysis will be discussed in the next chapter.

Figure 4 identifies my developed contextual representation of Shiva's circle of constructivist inquiry.

Reflections through the process of my PhD journey

Me
Woman & Mother, Midwife, PhD Student

Doing a PhD is like having a baby

Self:
Begins as a novice pregnant being

Experience/anomaly

You submit to your body, you are ready to give birth to your baby. This journey is of self discovery & rite of passage

Explanation & theory

Your body is designed to give birth. It is natural and a normal physiological event. This is your theory, your belief

17 minutes old – our journey continues as a dance of discovery and interpretation

Discovery & data Collection

Read about pregnancy & birth. It is the lived experience. 'It feels all too much' 'I can't do this'. Apprehensive and overwhelming, I don't know where I'm going. Realisation - to take it one step at a time 'bite size chunks' will help me manage this journey

Interpretation & Analysis

Grow & develop becoming more knowledgeable about labour & birth. Reflect & understand my body needs 10 months to train to sustain new life & give birth. You wouldn't run a marathon without training for it first. Listen to the experts, midwives & doctors. You share and draw on experiences with others like you

Self:
Begins as a novice researcher

Experience/anomaly

You submit your study. You give birth to your thesis, to new knowledge. This journey is also one of self discovery & rite of passage

Explanation & theory

I am not here yet. What I will construct remains only part of the larger structure of stories in the world

The academic journey continues as a dance of discovery and interpretation

Discovery & data Collection

Explore literature to find omissions, gaps in the body of knowledge. Don't know where to begin. Confused, overwhelmed. Read theses 'I can't do this it's all too much'. Break it down into 'bite size chunks' focus on a little bit at a time, it will help you manage the journey

Interpretation & Analysis

As constructivist Inquirer I enter an interpretive cycle I am both apart from and apart of the dance – and impossible to remain an outsider of it

Lambert's contextual representation of: Shiva's Circle of Constructivist Inquiry. Crabtree B.F & Miller, W.L (1992) Doing Qualitative Research. London. Sage.

Figure 4 Lambert's contextual representation of Shiva's circle of constructivist inquiry

The study

Presented is a brief background of the local service provision of the healthcare trust where this inquiry was conducted. The healthcare trust was set up following a 2006 re-configuration of the then Strategic Health Authorities. It is one of a number of healthcare trusts that now makes up the regional body of the NHS in the North of England and the management framework for health in the Northern region.

Prior to this, local maternity care provision had provided a service based on the traditional model of maternity care comprising of a shared care system between a woman's General Practitioner (GP) and hospital visits where women would routinely be reviewed by the obstetric team (Jomeen 2006). Midwives provided midwifery care to these women who accessed them, either alongside or as an alternative to their GP. Maternity service provision was traditionally in the remit of consultant obstetric and medical practitioners being at the forefront of care provision.

In the mid to late 1990's, maternity services locally underwent a series of reconfiguration with the merger of two maternity hospitals across the locality onto one site, close to the centre of the city. A stand alone birth centre was built and offered a service to women who wanted natural birth in a more homely environment. Care was provided under the care of midwives and no obstetric, neonatal or anaesthetic services were provided at this stand alone birth centre.

Local provision

Maternity services within the Trust today, are provided to approximately 6000 births. The maternity hospital provides a specialised medical obstetric team and co-ordinates care with other specialist teams such as neonatal care specialists and for women who may require medical specialists for complications and conditions in pregnancy. Midwifery care is provided by community midwives who work in geographical areas across the trust providing care to women who live within these geographical areas. Midwives provide most of the care and a direct referral to maternity and midwifery service now means women no longer need to go through their GP's to be referred to antenatal care. This ensures maternity care booking can take place earlier in a woman's pregnancy. As well as midwives and consultant involvement in care, local women may come into contact with others involved in care including, anaesthetists,

doulas, GP's, health visitor's, healthcare assistants, midwifery assistants and supervisors of midwives, midwifery students and researchers.

The study began to recruit in December 2010. At the time the study commenced in October 2007, women had a choice of care and certain options where they could give birth. These choices were set out for women in a local booklet. The choices available described below remained the case until July 2011. An explanation will follow as to why some changes have been made and why the options at the beginning of the study do not remain an option in the trust today. Until July 2011, women had the choice of giving birth in the obstetric hospital unit where both midwife and consultant care is and remains available today. Here specialist facilities are available for the mother and the neonate if required. Women have choice to book to birth at home and the option furthermore of giving birth in water at home. Alternatively, for women who wish to give birth in a homely environment, a stand-alone midwife-led birth centre has been in operation since 1996. This care provision was built at a different hospital site at a different side of the city to the obstetric unit but can be accessed by any women in the trust who may wish to birth there. Women are aware that in the event of complications arising either during labour or in the early postnatal period, they may be transferred by ambulance with their midwife to the obstetric unit if necessary. Approximately 400 births occurred at the birth centre per year.

In early 2011, the birth centre had been the subject of speculation with some questions about the future of its midwifery-led care provision. Local media reports reported on staff shortages and how this had led to periodic closure of the facilities. Further staff shortages and redeployment to cover staff sickness at the obstetric unit were listed as reasons for closure. Following a critical assessment by health watchdog the Care Quality Commission (CQC), the facility closed in July 2011.

At the time the study was underway, all women who took part still had the option to book for birth to the obstetric unit, the birth centre or at home. The antenatal women who booked to the birth centre had the uncertainty of whether this facility would still be a realistic option for them due to the reports of periodic closures. This meant these women were faced with the real uncertainty of where they would end up birthing their babies or achieving their birth experience at their booked place of choice.

All interviews with study participant women were completed before the birth centre facility closed to women in July 2011. The threat of closure was a lived concern for the women who had booked there as they reached their known expected date of birth. This had a direct impact for some on their decision-making and the experience they had.

Ethics

NHS Ethics and trust governance approval were sought and granted prior to the study commencing (Appendices 1 & 2). The role of ethics committees are to provide independent advice to researchers and protect the dignity, rights, safety and well being of actual or potential research participants (Haigh 2007). There are ethical issues in need of consideration by any researcher undertaking research with participants and Research Ethics Committee approvals are always required for inquiries using patients and service users of the NHS (Haigh 2007). Participants in research have individual rights and researchers must provide evidence to demonstrate that these rights have been addressed at all costs. These include the right to be informed; right to withdraw; not to be harmed and rights to confidentially and anonymity (Williamson 2007). The considerations to ethical issues and participant rights in this inquiry will be identified and evidenced as the methods to the study are disclosed.

As a midwife not in clinical practice, I hold an honorary contract with the NHS trust where the study was undertaken and as a practicing midwife I am bound by my professional rules and standards and uphold my professional integrity (Nursing and Midwifery Council 2013). Specific research issues relate to particular groups of participants (Long 2007) and as a midwife undertaking research with pregnant women, I recognise not only their rights as individuals, but concern for the wellbeing of the fetus. A system was designed in case of distress encountered by women from undertaking interviews and evoking memories of previous experiences (appendix 3). All women were informed of my professional position in relation to themselves and their unborn child.

The study was approved by the Head of Midwifery. Anonymity, confidentiality and security of all information in records and data were of the highest priority and undertaken in line with ethical approval requirements and women were informed of this. A procedure for storage of data was undertaken (appendix 4).

Professional frame

The Head of midwifery; community manager; community midwifery sisters and clinic midwives were written to independently explaining the study. Notification was also sent to the women's GP (appendices 5, 6 & 7). Word limitation and duplication of the same information are reasons for not including all letters. Letters set out the nature of the study seeking midwifery support towards accessing two geographical areas and assisting in dissemination of information leaflets.

Relationship with midwives and the healthcare trust

Having previously working as a midwife within this trust and latterly having an honorary contract enabling healthcare trust access for research purposes the midwives I came into contact with in undertaking this research were simply 'known ' to me and I was 'known' to them. I had not previously worked with them in a same context of practice. Liaison with the community midwifery sister aided negotiations and midwifery support for this inquiry. I felt it was important to have a collaborator, an insider, someone who I could co-ordinate with for professional practical advice, moreover, for maintaining professional relationships that I had made within my clinical practice previously in working relationships. A constructive engagement and cultivating positive relationships with trust staff was of paramount significance to the study and data collection was seen to be dependent on this (Ritchie et al. 2009). This was particularly useful in the initial exploratory stages of inquiry design. It was appropriate in discussing possible geographical areas for recruitment. My intention was to recruit from two areas that were geographically and socio-economically different. It wasn't the purpose to draw focus from particular variables but recruit from two different areas where women would incur similar journey times to both the maternity hospital and the birthing centre, albeit by different route networks, such as, one via inner city road networks and the other through faster 'A' road networks. I considered the community midwifery sister could identify areas where this could be achievable. Moreover, the practicalities of one community team over another, for example in the event of it not being practical in one area due to staff shortages. This could translate into limited leaflet distribution at clinic times by midwives due to added work load and time pressures. Insider assistance was a troubleshooting method for potential difficulties that I felt I could encounter.

From my position as midwife, I share membership to the group of midwives in the same social field. I am therefore an insider in this respect of having insider knowledge and status, and in being equal to those I consult with and those who I write to about it. The importance of researching socially constructed worlds as an insider rather than an outsider has already been established by Steier (1991) as only then can the focus clearly centre on the idea of reflexivity and be understood as 'bending back' upon itself. The status as insider moreover affords advantages that includes ease of access to research settings and builds rapport (Simmons 2007, Reid 1991), necessary for successfully executing the inquiry and alleviating difficulties that might occur (Gaglio, Nelson, and King 2006). The implications to this might mean too strong a relationship could be 'tricky' and could lead to biased, non-credible findings (Ritchie et al. 2009). Especially in acknowledging the findings of Levy (Levy 2004, Levy 1999b) and how midwives protective gate-keep information and choice, it must be acknowledged that midwives could equally gate-keep which women are given study information hence influencing which women might have the opportunity to recruit themselves. It was felt this was overcame by the rapport built up with the midwives and in their collaborative sense of recruiting all potential women to ensure they could play their individual part in the success of the study.

Sample groups

The rationale for recruiting reflects my position above, one as insider and having insider knowledge. Recruiting a purposeful sample of women was initially undertaken by clinic midwives through the distribution of information sheets including replies to those women who fitted the inclusion criteria. Appendices 8 & 9 provide copies of the antenatal and postnatal information sheets and replies women received. The design in recruiting was intended for a low impact on midwives ways of working. Information sheets were provided for women during their appointment times, the midwives briefly outlined the study and how the women could contact me if they were interested in participating. This process maintained patient confidentiality and was in no way coercive by me undertaking this process where women may have felt obliged or put on the spot to committing. Providing participant information sheets at an early stage of the study allowed women to consider whether they wished to take part. Those who replied, when contacted by phone, had another opportunity to ask questions and withdraw at that point. All women had the right to withdraw consent at anytime during the study.

I aimed to meet initially with the teams of clinic midwives who would distribute the participant information sheets at the appointment visits in order to fully brief them with the nature of the inquiry. The letters reinforced the information further. Planning with the insider, the aim was to meet both teams at team meetings. However difficulties faced were reflected in my diary excerpt:

> *Juggling 2 geographical areas and 2 teams who cannot be seen together is taking more time and planning than originally envisaged and it is good I have staggered the recruitment weeks to aid this time lag, despite seeing (intending to) 8 midwives in 7 different venues (satellite clinics) to provide all the information and supply the information sheets for them to give out to the women in trackers. Met with 2 midwives today, but delayed by a number of weeks now in planning to meet teams, further hindered by insider having been off sick and non contactable. Nov 16th 2010.*

Table 5 overleaf provides all participant characteristics gained from within transcripts or diary entries. It wasn't intentional to enquire specific variables such as age, status but left women free to disclose what they wanted to. These are ordered in ordered of interviewing.

Ante/ Post natal	Order	Name	Age	Booked place of birth	Parity	occupation	Relationship mentioned	Medical history	Birth place outcome
						Table 5 Participant characteristics			
A/N	1	Alex	32	Hp	P	Lecturer in children's services	Married		Hp
A/N	2	Tricia		Hp	P	Occupational Therapist	Husband		Hp
A/N	3	Julie	27	BC	M	Receptionist	Boyfriend		Bc
A/N	4	Janet	39	Hm	M	Emergency services	Married		Hm
A/N	5	Mandy	31	Bc	P	Working in accounting	Married	Transferred in labour	Hp
A/N	6	Jose	39	Hp	M	Works in the NHS	Married	GB Strep	Hp
A/N	7	Louisa		Bc	M	Working	Partner	Factor V Leiden-APC Resistance	Hp
A/N	8	Susie		Hp	P	Full time in a hospital	Husband	On long term steroids- Rheumatology	Hp
A/N	9	Fi		Hp	P	Educational rehabilitator community	Married		Hp
A/N	10	Lorraine	26	Bc	P	Primary school Teacher	Married	Postpartum haemorrhage	Bc
A/N	11	June		Bc	M	Full time mum	Married		Bc
A/N	12	Mary		Bc	M	Teacher	Married		Bc
A/N	13	Rosie		Bc	P	Works for the NHS/ giving up work	Husband		Bc
A/N	14	Angela		Bc	M	Receptionist	Boyfriend	Low platelets last pregnancy	
A/N	15	Nicola		Hp	M		Partner	Cholestasis: previous pregnancy	Hp
A/N	16	Anne	39	Hp	P	Works full time	Partner	None	Hp
A/N	17	Anna	27	Bc	M	Beautician	Husband		BBA
A/N	18	Becky	22	Hp	M	Hairdresser/beautician	Partner	Migraines	Hp
A/N	19	Linda		Bc	M	Full time mum	Husband	Low platelets but to able to book to birth centre	Hp (Bc shut)
P/N	1	Sue	37	See table 18* in chapter 7 page**		Works full time	Husband	Risk factors for these participant women are highlighted in table 18* in chapter 7 page**	Hp
P/N	2	Helen	34				Married		Hp
P/N	3	Karen	30			Primary school teacher	Married		Hp
P/N	4	Lisa	35				Husband		Hm
P/N	5	Denise	35				Husband		Hm
P/N	6	Katie				Worked in care previously. Employed	Husband		Hp

The antenatal sample group

Antenatal participants were recruited from women who had antenatal care from two clinic midwifery teams within the two geographical areas, one team from each area. Appendix 10 identifies purposeful recruitment sample. Purposeful sampling was then undertaken within each sample area. Each sample consisted of 10 equally representative primigravida (Primip) and multigravida (Multip) women. Within each geographical area, each sample (n=10) was representative of five women booking for hospital confinement and five women booking for birth centre or home confinement, these were a blend of primigravida or multigravida women. Primigravida women have no previous personal experience of decision making regarding birth options, whilst multigravida women do. This was the justification of this sampling mix. Consequently, a total of 20 antenatal women; 10 primigravida and 10 multigravida women, from two geographical clinic areas were sampled. Inclusion criteria is illustrated and rationale given later within this section.

I considered the number of participants for inclusion carefully. The qualitative literature in this review provided insight into sample sizes. Smith, Flowers and Larkin (2009), indicate there is no right answer to a question of sample sizes in phenomenological research as it partially depends upon the dedication to the level of analysis and the reporting of the richness of each case. The primary concern is the quality not quantity of human phenomena and this can be achieved by focusing on smaller sample sizes. In phenomenological studies using in-depth interviews, the sample size may be small and selective. Size does not reflect the amount of data available, or the depth of the investigation that is possible (Cluett and Bluff 2006). Qualitative studies in this review that explored decision making relating to pregnancy and birth have successfully used small sample sizes of between 5 and 26 participants (Moffat et al. 2007, Blix-Lindström, Christensson, and Johansson 2004, Seibold 2004, VandeVusse 1999) and have generated good quality data. This study aimed to recruit a purposeful sample that could necessitate as far as possible, a cross selection of both primigravida and multigravida women who were booking for the different birthing environments of hospital, birth centre or home regardless of parity. Given the specific criteria of primipara and multipara women booking for the different birth environments this was agreed as feasible following discussions with the insider and her knowledge.

In developing a recruiting timeframe (appendix 11) for both antenatal and postnatal women, I again referred to the practical knowledge of the insider. This followed discussions of how many women attended the clinics in any one week. Difficulties I encountered within this timeframe are illustrated from my diary excerpts at the time:

> *All midwives have leaflets now and are being inserted into the women's trackers for their next clinic appointment. They are aware of what to do. I feel helpless, it is out of my control now as to whether these will be distributed to women. I am relying on the trust and rapport I have developed with them 23rd Nov 2010.*

> *Heavy snow falls, temperature really low I have had no home post for 11 days. Leaflets distributed xxx area reports positive interested ladies in the study. No replies as yet 1st Dec 2010.*

> *The weather has been terrible nationally not had it this bad reportedly for 100yrs. Affected midwives and clinics having to utilise their own resources where possible - walking to visits - time constraints - clinics at children's centres cancelled, centres closed. It's been Christmas and New Year, 6 replies. Recruitment timeframe not achieved due to disruptions out of my control - midwives are positive replies will come and will continue recruitment strategy 5th Jan 2011.*

Process of antenatal sample selection

Appointment notifications are routinely sent from the maternity hospital administration office to the area clinics the day before the clinic operates. This notifies the clinic midwives of women attending the following day for routine antenatal assessment. Trackers, (see glossary), were pulled by the clinic co-ordinating midwife from the women's individual records and patient information sheets were attached by the midwife prior to the start of the clinic. This was undertaken for every woman attending for their 27-28 week to 36 week appointment. A timeframe for inclusion of 27–28 weeks pregnant was determined as some women may attend their routine 28 week appointment earlier, such as those who are a Rhesus negative blood group and in order that Anti D prophylaxis may be offered to her at 28 weeks. I initially attended the sites prior to commencement of clinic appointments to ensure midwives had enough information leaflets and answer any questions, but our rapport meant this was then undertaken by phone and text as the midwives contacted me at will.

Due to being sole researcher overseeing sample recruitment from two community based clinics, it was planned for this to have been undertaken over a two week period. One clinic in week one and the second clinic in week two because each area held various clinics through the week and over a number of days for example, Tuesday, Wednesday and Thursday with approximately 12-16 antenatal women attending the clinic on each day. The difficulties in achieving the timeframe for recruitment have already been highlighted. Antenatal inclusion criteria is outlined below and included:

- Women accessing maternity services within the local NHS Trust who have booked for hospital, birth centre or home confinements.

- English Speaking Women

- Over 16

- Attending from 27-36 weeks

- Regardless of health/pregnancy risk factors

- Have given informed consent

The postnatal sample group

Six postnatal women who had given birth within the healthcare trust and who were still receiving postnatal midwifery care were included. This sample represented women who had had some health/pregnancy related risk factor highlighted prior to the onset of labour and were all advised on where to give birth. Three of the sample group were women whose choice had complied with perceived safety and professional advice regarding birth place and three women whose choice was seen to have been non-compliant to the same perceived safety and professional advice in resisting the advice of where to birth.

The terms compliant and non-compliant were given by definition of Aronson (2008) and Milgram's (1974, 1963) concepts outlined in the conceptual framework chapter. Aronson (2008), in that compliance is a form of obedience (2008), and obedience as defined by the work of Milgram (1974, 1963) on obedience to authority. The authority figure here is understood to be that of the expert, the professional care giver in advising

care. These women either complied with, or non-complied to the advice they were given of where to birth. The non-compliant women it could be argued, stand divided from others who comply with care options within the same culture and system of guidelines and protocols, where medicalised models of care often continue to dominate and where intervention and technology influence practice (National Institute for Clinical Excellence 2008b, Royal College of Anaesthetists, Royal College of Midwives, Royal College of Obstetricians & Gynaecologists, Royal College of Paediatrics & Child Health 2007, National Institute for Clinical Excellence. 2004).

Process of postnatal sample selection

Recruitment of Postnatal women was undertaken by the same clinic midwives assisting with antenatal recruitment from the same geographical areas who were already familiar with the study and recruitment method. By discussing the nature of conformity and non-conformity with them, they were able to easily identify women who fitted the conformer/non-conformer behaviour definitions in their birthplace choice. Midwives gave women patient information sheets at their routine postnatal visits, briefly outlined the study and informing them how they could reply if they wished to be contacted (Appendix 9).

Difficulties were encountered at this point in recruiting three non-conforming women from such a small pool of two clinics. Women seen as non-conforming to advice are a minority group and in hindsight, confining recruitment of a minority sample group to two clinics, was found to be limiting as women fitting these criteria could not be identified at this stage. One woman, for example, was identified from this area that had birthed in the previous three to four months, and a further pregnant woman with an expected date too late for the time scale of the study. The insider community sister notified me that there were potentially a small number of women within the healthcare trust at that time that would meet the inclusion criteria. A request to NRES ethics was sought, to open up trust wide for recruitment for three non-conforming participant women. This was granted (appendix 1 & 2) and women were identified by the community sister to the midwives who were providing postnatal care to them. I was able to meet with the midwives attending these women and after informing them fully about the inquiry, they were happy to provide the information sheets to these women who fitted the criteria. Gaglio, Nelson and King (2006) report that often practice-based research is reliant on

practitioners to do tasks that are normally completed by researchers and in this they have ultimate control over what gets done and what doesn't. This highlights the importance of an insider in collaboration because as a midwife undertaking research, I am an outsider in this position.

Interviewing women

Interviews were conducted within ethical principles of research practice and in a manner that respected the women who participated. The nature of this research does not ignore their voices but essentially allows them to be heard. They remain subjective beings and not objectified in a process where very often women can be studied in a value-neutral way (Bowles and Duelli Klein 1983). At the heart of this inquiry, in permitting their voices to be heard throughout, women remain subjective beings and not objects in a process where very often in quantitative research they can be (Bowles and Duelli Klein 1983).

Women who had returned reply slips were contacted by an introductory phone call. This allowed for rapport building and to plan a scheduled timetable of interviewing. Although women were sampled from as early as 27 weeks, interviews took place following the 36 week appointment. Women at this point were given the opportunity to decide where they would prefer to be interviewed either at home or at the clinic where they attended their appointments and interview times were arranged at their convenience. Location of the interview is important and can result in interviewee's feeling more empowered in a personal familiar environment (Green and Thorogood 2009). However, this might not always be the case, as a lack of privacy in a busy household may prove inappropriate in not yielding a personal space in which the woman feels able to open up or relax. All but one of the antenatal women interviewed opted for interviews to take place in their own homes. One woman opted for her usual clinic location due to having workmen in. All postnatal women opted for interviews at home.

Whilst I felt my own safety was not in doubt I had to devise a researcher safety policy in line with ethical approval (Appendix 12). I was also encouraged wherever possible to interview in a clinic environment. Whilst these recommendations are given in the light of research and clinical governance (Williamson 2007), I did not think it appropriate to imply to women where interviews should take place. I have experience of being a

community midwife and establishments where community practices are undertaken operate procedures such as lone worker policy, the clinic midwives are aware of their own safety and the policies highlighted for use in practice included my safety also and I would have been notified of any potential concerns with interviewing in homes for any women receiving information sheets.

Consent was obtained prior to commencing the interviews and followed, a further explanation of the inquiry using a laminated information sheet to jog women's memories (appendix 13). This enabled them to re-familiarise themselves with the fundamentals of the study and able to decide whether they were still happy to continue. I was aware that postnatal women might not come forward and contact me in the busy time period following their baby's birth, but once the recruitment area was opened up this was not a problem. Rapport is two-way between the interviewer and the interviewee (Oakley 2005) and embraces the interviewer's research goal by the interviewee as they actively search to provide the relevant information. Women were keen to be involved as Tricia explains:

> *"when I was doing my degree I had to do some interviews and didn't get many people come forward and...help out really so that was probably the main reason I thought if I could help somebody else with their studies then that's what I'll do...but also...I thought it might be quite nice to think about certain things as well a little more". [Tricia]*

It was crucial to engage with women, develop a rapport and engage socially with them (Shaffir and Stebbins 1991). Sword (1999) in her study felt her position as outsider hindered in-depth dialogue. I did not feel this was the case. Women accepted me into their homes easily, offered me drinks, even lunch and on a number of occasions when I returned to their houses, asked me to feed their babies. I felt I was perceived as not only a midwife and insider rather than a researcher and stranger, but as a woman and it was a shared goal for improving experiences for women for the future. A trustworthy relationship began to develop between us. Women were assured they would remain anonymous and all tape recordings destroyed once the interviews had been copied into written format. Transcriptions were given pseudonyms by me using names from acquaintances chosen at random and all who did not share same names to the women in the inquiry. This ensured a personalised approach which is central to phenomenology and anonymity is maintained.

Semi-structured interview method

Extracts from women's 'life world' accounts, to permit their voices to come to life and speak for themselves, was achieved by semi-structured in-depth interviews at 36 weeks pregnant. An interview guide (appendix 14) was used to highlight a list of areas to be covered, yet leaving exact wording and order of questions to be determined in the individual interview situations. In addition it aided not losing sight of the original research question to be answered (Willig 2008). An excerpt from my diary illustrates the use of the interview schedule:

> *Sometimes felt there was little point in having an interview schedule as some women mention all what is intended independent of the questions. It then follows a more natural course of chatting in a relaxed manner. February 24th 2011.*

The first two women recruited from within the antenatal group were utilised as a small pilot study to assess the suitability of the questions being asked and to identify whether these were appropriate to aid in yielding rich data. The pilot study was aimed at being a 'trial run' to ensure effective data collection procedures and the use of vignettes previously validated were appropriate discussion aids in interview practice. The outcome of the pilot study provided reassurance that both the interview schedule questions were appropriate in yielding rich data and the vignette proved to be easily used and understood by the women, moreover proving to be a useful aid and providing lengthy commentaries. Interview duration lasted between 41 minutes and 1 hour and 45 minutes. No problems were identified within the pilot study either in the interviewing context or within the recording and transcription process and no revisions in procedures needed to be made. The accounts of these women were included as part of the study (Nieswiadomy 2012).

Semi-structured interviews allow for a detailed picture of women's perceptions, opinions and beliefs on the topic under exploration. This allowed for a degree of flexibility to explore interesting avenues as they become evident as they depict a more absolute picture of themselves (Smith, Harré, and Van Langenhove 1995). One to one, face to face interviews are the most widely used tool for qualitative data gathering (Denzin and Lincoln 2000) and is reputed to be the most important method (Oakley 2005). The interview is a form of social rhetoric by which systematic knowledge is

gained about social interactions with one another and is of course "one of the many ways in which two people talk to each other" (Benney and Hughes 1970 p176). Oakley (2005) argues that the conventions of interviewing reportedly miss out on important issues such as the social and personal qualities of those doing the interview or the quality of the interactions between interviewer and interviewee and the extensions into broader based social relationships. I was completely aware of our interactions together and I reflected on the nature of how the women perceived and engaged with me in our social relationship:

> *she offered me a cup of tea and asked if I was alright with cats...I sat on the floor she sat on the chair is just happened this way it was not in any way reflective of a psychology of dominance or having control in this interaction...I am the guest and I felt this...after the interview finished I found it difficult not to be a midwife and provide her with alternative pain relief methods...the birthing ball in the corner of the room she did not relate this to helping with labour pain but merely as an antenatal means for optimum positioning. 11th January 2011.*

Oakley (2005 p221) examines the mechanics of interviews. She highlights a paradigmatic representation of a "proper" interview that is often characterized by the masculine values of objectivity, detachment, hierarchy and science, rather than the feminist viewpoint of subjectivity. This is where emotions, women's way of knowing and personal experience are accepted as better-quality where the interviewer and interviewee engage as equals and women can ask questions back.

I did not feel I encountered many difficulties in the process of interviewing except for battery failure and losing two minutes of interview data on one occasion (which was subsequently recorded in my diary once I had left). Women gave their stories freely and this gave them the opportunities for personal reflections as Tricia demonstrated. By returning transcripts to women once typed for verifications of our encounters, this gave me something more than just a question and answer interaction:

> *It was nice to see her again and her baby, we chatted and laughed together and she was relaxed and at ease. It struck me this taking the time to show and discuss transcripts is not only important and useful to verify the interview as a true representation of interview, but to gain further understanding post birth and the women continue to tell me their stories after the event, this is priceless for comparing my notes and transcripts...something inherently personal about our encounters*

and meaning making together, this is how I see these encounters.
February 18th 2011

Antenatal interviews focused on general questions about antenatal experiences and choices about birth place. Vignettes were designed and used as discussion aids.

Vignette development for use in antenatal interviews

The idea to use vignettes as part of the interview method developed from literature in the first section, not included in this thesis but was used in relation to practitioner decision making, notably in the work of Levy (1999b) and Regan and Liaschenko (2007). Vignettes are described as stories about individuals and situations (Hughes 1998), simulations of real events (Gould 1996) and are a way of learning to understand the knowledge, perceptions, beliefs and opinions of participants (Gould 2007, Hughes 1998, Gould 1996). There are many applications to the vignette technique including the use of photographs (Hughes 1998) which Regan and Liaschenko (2007) utilized as a way of gathering verbal responses to a primary source as a projective motivational technique, Levy called these 'triggers' (1999b).

This initiated thoughts about how I could actively engage women's perceptions and views about a specific real life situation. These represented two situations of a third person (a pregnant woman), demonstrating conformity and non-conformity behaviour. The vignettes were used as discussion aids shown independently of each other within the interview. The vignettes consisted of two same scenarios with different decisions made by the woman in the scenario. Vignette A (appendix 15) clearly showed the woman conforming to healthcare advice and vignette B (appendix 16) showing a woman clearly non-conforming to healthcare advice. The objective was to engage the antenatal women in discussion to explore their views and perceptions of these third person pregnant women. Each vignette was shown independently of the other in the interview using a set of questions (appendix 17) to prompt discussion.

Developmental stage

Advice was sought via the online midwifery forum of experts MIDWIFERY-RESEARCH@JISCMAIL.AC.UK for design advice. Comments from these experts were utilised in the design process. Appendix 18 illustrates expert comments on

vignette design. In considering the language used within vignette two and that there should only be a subtle difference between vignettes in varying the cue about the central thing studied, 'so' is still used instead of 'but'.

So I'm not – is used as though she *isn't* doing it because everyone else does, as might be understood in using *but*.

But I'm not – identifies there are good reasons for her decision.

The 'so I'm not' was used so this would not lead the reader to just think it's because it's not what *I want* to do but encourages deeper thought about why this might be the case.

Vignette Validation

A process of validation was undertaken following the vignette design prior to study commencement. This entailed the vignettes undergoing a pre-test with a group of independent pregnant women from an independent birth preparation consultancy operating in the North East of England. The consultancy, operate a social enterprise through midwife governance, delivering birth preparation classes. They are commissioned by the local PCT to provide antenatal services working in collaboration with the local healthcare NHS trust. Validation was undertaken in order to establish whether antenatal women regarded each vignette as typical for conformity and non-conformity behaviour. Diary excerpt illustrates how these were viewed:

> *Vignette validation..informed the women these are to be showed in interview, difficult to not give a full description of study which would influence how they perceive these, giving in isolation of no information about the study other than decision-making about where women choose to have their baby, I wanted to see whether they would see the scenarios as conforming. Comments: scenario 1 - just a sheep following, implies conforming. Scenario 2 - doing what she wants own choice, implies non-conforming. October 12th 2010*

Postnatal interviews

These women were all under consultant care and their consultants were notified of the study (appendix 19). Semi-structured interviews were undertaken using the same procedures regarding information and consent as for the antenatal sample. An interview guide (appendix 20) guided the themes to be covered which were risk, choice, practitioners and the birth of her baby. These were considered from the review

as the themes most connected to the decision-making process. Interviews occurred in the same flexible manner outlined in the antenatal sample section and leaving exact wording and order of questions to be determined by the interview situation. The aim was to explore retrospectively what influenced their decision-making, in light of identified increased risk factors. As the decision-making process was complete and the birth had occurred, this would allow for reflection on these decisions in light of the birth outcome.

Limitation/design consideration

Ideally a more diverse sample would have been sought however limited resources meant the feasibility of this would not be achievable. Similarly, women from all language backgrounds ideally would have been included in the study. This was not possible due to financial constraints, with no money to fund interpreters for non English speaking women, who may require these services for interview. Additional costs incurred in production of multi-lingual patient information sheets and consent forms limited the feasibility of this further. The results of this study are not generalisable beyond English speaking women. However they provide a platform to consider some of these issues in other groups.

In hindsight, an impractical time frame led to the sample not being achieved within the recruitment period. This was due in part to issues out of my control such as extreme weather and clinics not running, moreover the time of year the study was able to begin recruitment. Whilst this study had relatively small numbers this was easily managed as transcribing and analysis could continue whilst waiting for replies. It wasn't necessary in an exacting sense to ensure antenatal numbers of five primigravida and five multigravida women were recruited from each clinic area but to ensure a combination of both primips and multips booking for hospital, birth centre and home environments were present to ensure all groups were represented.

Hermeneutical analysis of interview data

This is represented in the following chapter. The iterative process and data that emerged occurred from an initial stage. The following chapter demonstrates the unique and profoundly intense process that informed the inquiry at every level and continued over seven analytical stages. Findings emerging from one stage informed the next.

This is comprehensively detailed and an essential strength of this thesis, in showing how researchers' attention to and confirmation of information discovery in accurately representing women's experiences, can demonstrate rigor (Speziale and Carpenter 2007).

Collecting data on something does not represent new knowledge, *per se*, it is rather the analysis and interpretation of this data which affords new insight and understanding. This thesis goes beyond the presentation of empirical study that simply describes the nature of the world. It searches deeper to explore the reasons and influences, in an attempt to make some sense of our surroundings and sheds new light from original findings so that new perspectives on the world may be generated. This will allow for an original foundation of midwifery knowledge surrounding social influence in birth choice.

Chapter 5: Hermeneutical analysis of interview data

Interpretive Phenomenological Analysis

Interpretive phenomenological analysis (IPA) is a rapidly emergent approach to qualitative research inquiry (Smith, Flowers, and Larkin 2009). Used in the discipline of psychology, it is increasingly being singled out as a fitting approach to exploring human sciences and health (Glasscoe and Smith 2011, Smith 2007, Chapman and Smith 2002, Smith 1996). Moreover, it was the method of choice in studies in parental decision-making (Touroni and Coyle 2002); women's health (Holt and Slade 2003); experiences of miscarriage (Maker and Ogden 2003); male perspectives of pregnancy termination (Robson 2002); drawn on to interpret studies of transmission to motherhood (Glasscoe and Smith 2011, Chapman and Smith 2002, Smith 1999) and more recently used to gain insight into how communications are delivered and perceived by women in normal birth (Kemp and Sandall 2010).

The origins of IPA research stem from hermeneutics and attempts to understand others' understanding of the world and their experience of it. This is where phenomenology, the study of the lived experience and hermeneutics, the theory of interpretation coalesce notably through the work of Heidegger. As Heideggerian phenomenology concerns itself with understanding a phenomenon as it shows itself (Smith, Flowers, and Larkin 2009), as it appears as the lived experience and focuses on "the perspectival directness of our involvement in the world" (Smith, Flowers, and Larkin 2009 p21). How we come to make sense of this appearance is through hermeneutic phenomenology, the interpretation of the phenomenon as it appears to show itself to us. Analytic reasoning is required to facilitate the showing of this as it appears, to help make sense of the appearing (Smith 2007).

IPA approach is both phenomenological and interpretive due to the nature of analysis and is the consequence of the interactions between participants' narratives and the researcher's construction of meaning. It takes an ideographic approach and as particular texts are methodically analysed one by one, distinctive aspects of an individual phenomenon are highlighted, creating insight through the intensive and

meticulous engagement with each transcript that becomes integrated in the latter stages of the research (Willig 2008). It is this depth of researcher engagement that demonstrates rigor in qualitative research so that accurate representation of participant experiences is achieved and credibility, dependability, conformability and transferability identified (Speziale and Carpenter 2007) as measures of rigorous inquiry. I identified early on in the research design process IPA as an appropriate analytical method for this inquiry. This approach attempts to understand how people make sense of their experiences. The process of coming to understand these experiences was a lengthy and continuous one. It had the distinct advantage of easily engaging with and quickly becoming immersed within the narratives at such intensity that it facilitated a genuinely coming to know and understand these experiences at an intense depth of interpretation.

The IPA method used in this thesis draws on the principles presented by Smith, Flowers and Larkin (2009) and was used as an informal framework from which a unique analytical framework developed specific to this inquiry. This sophisticated cycle naturally developed in response to the data, as the data 'came alive' from the earliest stages of engagement. This facilitated the beginning of understanding about how these women made sense of their experiences. A style of coding naturally developed as a way of organising the data from which the analytical framework developed. Smith et al (1995 p9), argue that there is a 'natural' fit between semi-structured interviewing and qualitative analysis due to the detail verbatim interview data provides. Moreover, in how an interviewer can achieve a detailed picture of respondents' beliefs and perceptions in a flexible manner, where interesting avenues can emerge that can reveal a fuller picture on the topic in question. Smith et al (1995) argue that although quantitative analysis can be drawn from this method in the manner of statistical analysis of the frequency of responses, this would be somewhat wasteful of what is created.

IPA concerns itself with the relationship dynamics of the 'part' and 'whole' process at a progression of levels. To understand any given part, Smith et al (2009), state there is a need to look to and understand the whole, and to understand the whole one looks to the parts. This circularity of interpretation Smith et al (2009 p79) argue, is very effective in producing a non-linear, dynamic style of thinking and typifies IPA as an iterative and an inductive style that utilises a method of:

> *"moving from the particular to the shared and from the descriptive to the interpretive"* and values *"a commitment to an understanding of the participants point of view, and a psychological focus on personal meaning-making in particular contexts".*

The nature of IPA presents the participant and the researcher as inter-subjective beings. Inter-subjectivity allows us to make sense of others making possible, a bridging of the divide between ourselves and others because:

> "*we are all at the same time part of a larger whole, a collectivity that allows the possibility of mutual understanding"* (Smith 2007 p5).

The strategy for analysis begins with a line by line analysis; identified themes emerge initially from single contextual cases, and then across several cases leading to as Smith et al (2009 p79) explain is:

> *a dialogue between the researchers, their coded data, and their psychological knowledge about what it might mean for participants to have these concerns in this context, leading in turn to the development of a more interpretive account.*

Smith et al (2009), advise development of a structure or framework that brings together emergent themes which permit organization of the data in a format that facilitates analysis. The framework ensures the data can be traced throughout the process from initial noting to the structure of themes. This strategy ensures that plausibility of interpretation of what is uncovered can be developed through, supervision, collaboration and audit whereby the development of complete narratives through detailed annotations, lead the reader through the process of interpretation. The reflections of the researchers own preconceptions and perceptions are also acknowledged throughout the strategy (Smith, Flowers, and Larkin 2009).

Figure 5 on page 149, illustrates the unique developmental steps undertaken in the hermeneutic cycle of analysis for this inquiry. The colour codes attempt to separate the collective 'parts' from the 'whole'. The pink is to be viewed as data of the 'whole' process and the blue represents data of the 'parts' process within the whole. It is recommended the reader tries to separate the part and whole in their mind so in reading and understanding the hermeneutical concept comes into view. This at first

glance may prove difficult to grasp as the whole study remains whole at all times despite the parts within, and these parts themselves are uniquely representative as individual wholes. The theoretical development of the framework has already been addressed in the design chapter this was concurrent with the developing dialogue with the data that was building at the time.
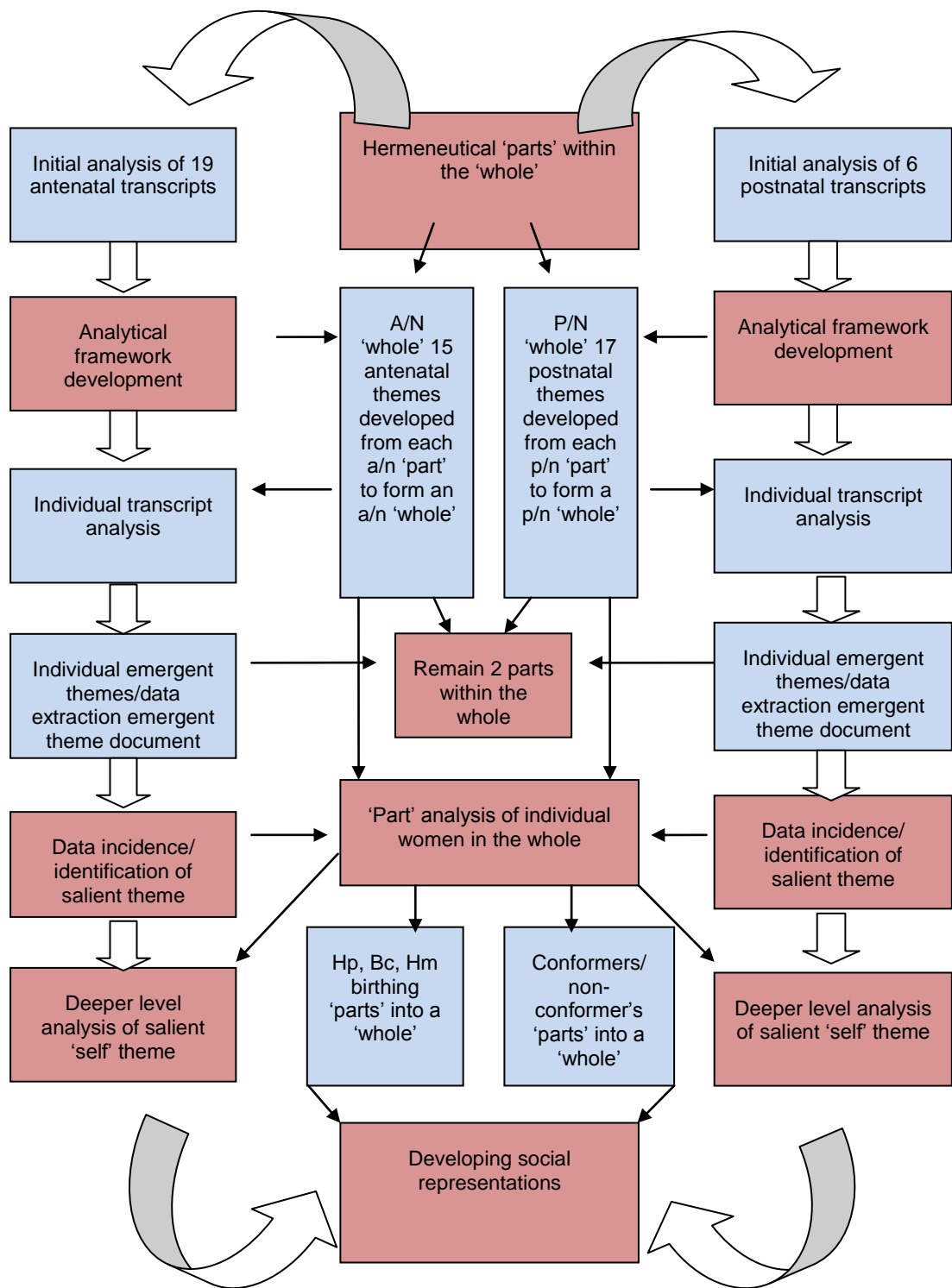
Figure 5 Hermeneutical cycle of analysis.

Both antenatal and postnatal women's transcripts were put through the same rigorous analytical process. This commenced with antenatal transcripts as postnatal women were still being recruited at this time. The methodical steps were maintained for each transcript. However, as each transcript was worked through on an individual basis, this meant the cycle as a whole, was at different stages in a developing process. Interviews were still being conducted whist transcription was underway with earlier transcripts. Those that had been completed and returned to women for verification were instrumental in the process of framework development. The benefit to managing this progression meant that a form of comparative analysis was maintained throughout. Individual transcripts and all narrative texts were being crossed referenced with other text at different levels of analysis so a comprehensive whole picture of analysis could emerge.

The steps that follow illustrate the complete process step by step for the antenatal transcripts. To avoid repetition by illustrating the same steps for the postnatal transcripts, only the differences uncovered within the steps in the postnatal cycle will be revealed.

Analysis of nineteen antenatal transcripts

Step 1: Hermeneutical cycle: the 'whole' and 'part' process.

A process of initial transcript analysis was undertaken. Following interview recording, each transcription was uploaded onto the computer, interviews were typed verbatim and every page and line numbered for reference. I began a handwritten journal for each woman as I typed the interviews. This outlined an initial analysis of individual women. They appeared as individual 'parts' within the antenatal 'whole' of the inquiry. This whole - part process is a characteristic of hermeneutical analysis. This practice permitted me to mentally re-connect with the women and they became the central focus. My initial comments and reflections on the transcripts were made and recorded here in these individual journals. This process permits the researcher to produce "the most open form of annotation" (Willig 2008 p58) that allows for evidencing issues that come up for the researcher on initial encounters with the text. Smith et al (2009) support this notion as this allows the researcher to bracket off own initial observations

and capture first impressions. Table 6, illustrates this initial process providing a segment of annotation from the journal made whist working with Julie's text.

Table 6 Segment of annotation: interview journal of Julie.	
Original transcript	Researchers observations and thoughts
Julie: I'd be quite happy to give birth at home I: and how do you think your partner would have thought about that? Julie: oh he wouldn't mind I: he wouldn't mind? Julie: no not at all I: and do you feel now at this stage in your pregnancy it's too late to think about that or Julie: yeah I: or do you think that the decision that you made erm then has still stood [pause] you've always thought that Julie: erm [inhales] well like I say I've always just had in my mind it's either [birth centre] or [hospital] and nobody's ever [pause] said have you ever considered giving birth at home [pause] so I never have	22.09. By discussing certain thing i.e. is it too late to give birth at home,, I am conscious of my own influence even in this 'just gently probing manner' and in essence then thinking about options I am aware this might potentially influence her and others in reflecting upon the decisions they've made or not made.

Periodic pausing in the recording processes allowed for 'interesting words and phrases' to be noted down and handwritten on to a separate working document. This exercise continued throughout the process for all women and became the foundation for developing the analytical framework, a framework developed with contributions from all women. This facilitated the narrative data figuratively speaking, 'to speak for its self' and sense making of the text began to develop. What emerged from this practice was a uniquely designed framework that maintained a continual thread of 'participant voice', not only instrumental in the developmental processes, but this central and most important practice successively weaved all the way through it to the final stages of the analytical cycle. Examples of interesting words and phrases noted from the collective antenatal narratives are illustrated in table 7 overleaf.

Table 7 Example of interesting words and phrases from antenatal transcripts	
'if I look back now',	'Strong willed'
'they know best'	'They burst my waters'
'you have to accept that sometimes things happen in nature'	'sterile environment'
	'if you've not got a problem'
'have to go to hospital'	'she told me it's only going to get worse'
'horrible lady'	

Step 2: Analytical framework development.

The 'whole' process

Following the process of listing every interesting word or phrase from the 'whole' of the women's antenatal transcripts, these were then sorted and arranged under different naturally emergent themes. All words and phrases that had an association with environment or place were included under the central theme of environment. Similarly, any reference that specified practitioner such as 'staff', 'they', 'professional' was assigned under the theme of professional/practitioner as this term was used mostly. Various words and phrases repeatedly came up and crossed themes. These were allocated to all themes where applicable. For example the phase in the above table, 'she told me it's only going to get worse' signifies the act of information and communication and practitioner so this is placed under the themes of information/communication and professional/practitioner. Following allocation of all words and phrases, a working definition was assigned to each theme. The working definition was sourced from my own working computer programme, 11th edition Concise Oxford Dictionary (COED11 n.d.,n.p.). Table 8 overleaf provides a snap-shot

of the theme of control, definition ascribed and interesting words and phrases applicable to the theme.

Table 8 Theme of Control	
control ■ noun 1 the power to influence people's behaviour or the course of events. ➢the restriction of an activity, tendency, or phenomenon. ■ verb (controls, controlling, controlled) 1 have control or command of. ➢regulate.	
Want to be able to move Not being able to feel anything Needing to know for Just going along Not handing it over to someone else Not being told what to do Wasn't allowed one Told Adamant Catered for the majority	Automatically They told Went along Rushed Let you In the system Err on the side of caution Haven't got somebody there all the time Because it's my first Contractions

The words and phrases are direct representations of meanings of 'things'/perceptions women have and that they note in their worlds. These are physical objects that are recognised as being meaningful to them (Blumer 1969). This proved a labour intensive activity but resulted in a sensible undertaking which facilitated a real feel for the data. Themes contained all of the 'interesting words and phrases' noted from the 19 women interviewed. A total of 15 antenatal themes emerged. This created a unique framework for analysis of the antenatal women's narratives. Figure 6 overleaf represents the emergent themes for the antenatal women.

Figure 6 Antenatal emergent themes

Self	**Belief/believe**	**Environment**	**Professional/ Practitioner**
Knowledge	**Experience**	**Nature/Natural**	**Control**
Risk Perception	**Fear**	**Feel (Feeling words)**	**Others**
Choice/Option/ decision	**Information/ Communication**	**Pain/Pain relief**	

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Step 3: Individual transcript analysis.

The 'part' process

Pseudonyms were randomly allocated to women's transcripts, different from any of their real names. This ensures women's anonymity and maintains a connection between narratives as representations of women who have a voice rather than nameless beings or objective chunks of data.

Original transcripts were read again and themes were systematically assigned to segments of narrative. Each narrative segment had all applicable themes assigned where applicable. A comprehensive noting of descriptive, linguistic and conceptual comments was written alongside each themed segment. Smith et al (2009) assert this first detailed account of analysis provides a critical connection for the researcher to begin to immerse themselves in the 'life world' of the participants and employs analytical depth. This was time consuming but it permitted me to develop a familiarity with the material as I continued to immerse myself at a much deeper level than at the initial stages. It allowed me to gain a more personal understanding of these individual women. This emersion was an attempt to become wholly aware of the individuals' 'life world' and penetrate her frames of reference, observe as far as able to, the world as she sees it (Rogers 1951).

Once each theme in turn was assigned to all narrative accounts, each theme in turn, transcript after transcript was put through a rigorous process of using the computer 'find' button to systematically search for the number of incidences each theme was either referred to, or in the context, inferred, or labelled as being noteworthy by myself. This process subsequently indicates which themes ranked of higher importance to each woman; hence more dominant. Table 9 on page 157 illustrates the incidence of themes as they appear as more dominant to each woman. These are highlighted in colour format to identify five groups, birth centre multips; home birthing multips; birth centre primips; hospital multips and hospital primips. For Mary a multigravida woman, the theme of experience is referred to or inferred 49 times and appears more dominant in her narrative than it does for Tricia, a primigravida who refers to this 12 times. This may imply that Mary uses her prior pregnancy and birth experiences as a way to express more salient matters. Moreover, it could be that Mary might have referred to

the experience of others more than Tricia who might not know about others' experiences and as she has no prior birthing experience herself, experience does not appear in the descriptions she expresses herself by. Conversely, Alex another primigravida woman does have 61 references for the theme of experience. Indeed she refers to this the most out of all participants. This could illustrate how the experiences of others, dominant in her narrative are important, as well as indicating no previous experience on her part as salient. These are the forms of quantitative analysis that can be drawn from this method that Smith et al (1995) refer to.

The point is that in isolation themes do not tell us much more than which, in women's accounts, appear more dominant ways of expression about the *self. C*onsequently however, they do indicate those themes that appear more significant in her consciousness. What this could tell us is whether themes are connected in any way and whether the dominance of these has any relevance to understanding what issues are more meaningful to certain women. At this stage the objective was to observe the themes comparatively against one another.

Emergent themes	Julie	Louisa	June	Mary	Angela	Linda	Anna	Janet	Mandy	Lorraine	Rosie	Jose	Nicola	Becky	Tricia	Susie	Fi	Anne	Alex
Belief/believe	10	21	2	10	2	2	10	5	7	13	1	4	4	0	0	2	1	0	11
Environment	22	29	19	36	18	15	15	25	36	19	38	58	21	18	17	14	33	11	21
Professional/ practitioner	36	99	36	44	27	24	34	33	47	26	28	30	42	39	11	23	28	17	56
Knowledge	7	13	7	11	6	19	10	16	26	17	16	21	14	12	9	11	11	16	36
Experience	54	34	21	49	40	33	24	42	44	32	24	35	23	37	12	24	21	4	61
Natural/nature	10	22	7	11	9	9	21	1	16	32	16	26	11	12	3	10	2	5	5
Control	44	123	34	41	26	24	43	26	32	23	27	80	22	38	12	6	17	6	40
Risk	46	86	36	46	49	45	27	41	50	22	59	115	46	40	31	44	70	26	55
fear	1	4	1	8	1	1	1	2	11	4	5	8	6	2	0	4	2	1	15
Feel	46	34	9	33	18	21	27	33	50	14	27	53	19	34	14	24	18	13	62
Others	22	34	5	18	36	13	16	27	43	30	35	36	4	19	22	13	40	6	59
Choice/ option/ decision	9	16	28	22	31	19	9	18	23	29	34	34	31	10	12	20	18	13	36
Information/ communication	23	43	6	24	15	11	16	10	12	25	25	22	20	15	7	8	15	14	41
Pain/ pain relief	1	10	12	6	6	3	1	6	3	9	6	50	1	5	4	0	12	3	26
Self	170	435	125	196	155	156	161	235	267	165	164	202	165	180	113	110	180	101	306

Table 9 Incidence of emergent themes as dominant to each woman

Step 4: Emergent themes document: data extraction from original narrative transcripts

'Part' process is continued.

The interesting elements of narrative and noted comments from original individual transcripts were identified and extracted using the copy and paste facility into a new themed document. Page and line number codes, for example, 3.18 (page 3, line 18) were assigned to segments of narrative and the new 'emergent themes' document was created for each woman. This created a fourth level of rich analysis for each woman's narrative story. Table 10 overleaf is an example of the antenatal emergent themes document created for Nicola to illustrate this process.

Table 10 Nicola's emergent themes document.	
Original transcript	Dominant themes within the narrative and explanatory comments
Nicola 2.28 No, to be honest, I just went with whatever they was telling me, because, obviously I didn't have a clue about it and they were the professionals, so I just, I just went with it and, you know, they asked if it was okay, obviously I was just, you know, 'get her out if you need to'. As long as she's safe that was the main, so. But they did say that they don't like cholestasis patients to go after thirty-eight weeks, so, that's why they got her out. I think, I was about thirty-six and a half, thirty-seven. I can't remember now, nearly five years. (laughs out loud)	Self. Didn't ask questions re the decision of induction. Knowledge. Choice/option/decision. Self-surrenders compliant because they are professional/practitioner. Self-surrenders. Control in decision making. Self-surrenders.
Nicola 2.38 Yeah, they did say that it's a possibility that it'll come back. Em, that I'd probably, I think they said about ninety per cent sure to get it again. But with this pregnancy, em, I started at thirty, thirty-two, thirty-four weeks.	Information/communication. Professional/practitioner. Risk perception.
Nicola 2.44 I was earlier this time, yeah. But obviously, luckily I know, knew the signs and the itching and everything	Experience. Knowledge.

Step 5: Data incidence from the 15 themes and identification of a sub-ordinate theme.

'Part' back to 'whole'

At this step each of the emergent theme documents were systematically examined at a fifth level of analysis. Figure 7 overleaf illustrates in graphical format themes as 'whole' and the number of times each theme was referred to by each woman. In essence this figure represents the combined data from table 9 (page 157) shown in step three that illustrated individual dominant themes for each woman, hence, represents individual 'parts within the whole' process.
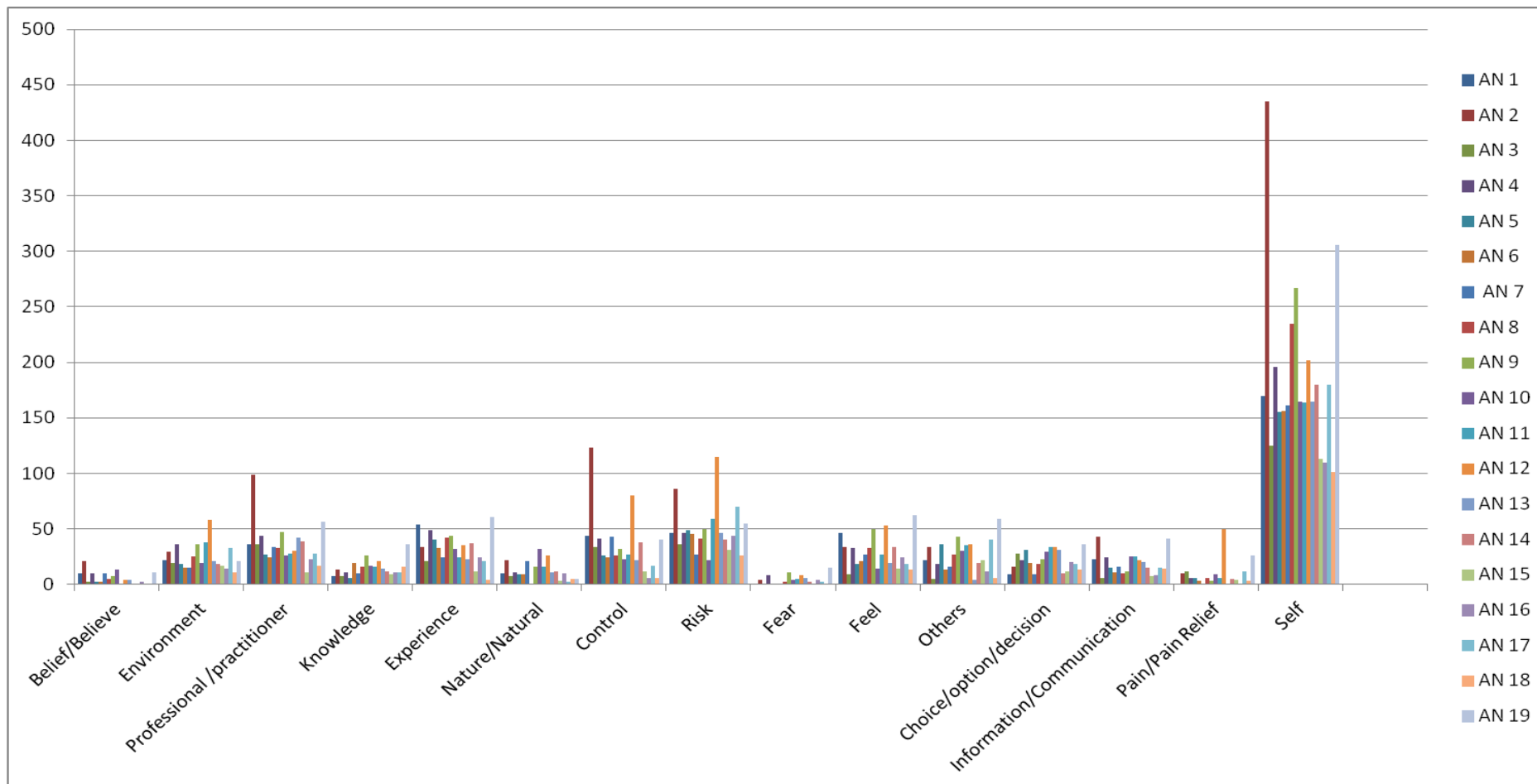
Figure 7 Number of incidences each theme was referred to

Whilst there were a number of more dominant themes, including professional/practitioner, control and risk, the most salient theme to emerge was that of the *self*. The theme of *self* is therefore the super-ordinate theme distinguishable from all other emergent themes (Smith, Flowers, and Larkin 2009). Super-ordinate themes are described as themes that have more instances in the body than other themes, and to be categorized as a super-ordinate theme it must be present in at least a third or a half of all participant interviews (Smith, Flowers, and Larkin 2009) the theme of *self* interweaved and interlinked connecting all emergent themes. The two accounts that follow illustrate this. Firstly in the themes of support, professionals and belief, in how Alex talks about wanting more support in relation to confirming her pregnancy, despite the pregnancy tests done this wasn't enough for her. Secondly, how the themes of control, pain, environment and experience, illustrated in Julie's narrative transcend *self*:

> *"I remember initially feeling I wish I had more support...when I missed my first period and I desperately, desperately wanted confirmation from the medical profession that I was pregnant even though I'd done probably six pregnancy tests". [Alex]*

> *"it wasn't very nice it was all very...medical, I was strapped up to the monitors and it was you know had the drip again and it was just...very medical and very clinical and I ended up having an epidural which I didn't with my 1st labour" .[Julie]*

As the theme of *self* emerged in line with other themes, different aspects of *self* became evident. The incidences of these aspects were created as a result of either her direct use of the word or by my allocation of a particular *self* aspect to the narrative for example:

> *I don't know whether it's just a psychological thing [Mandy] - Self-concept;*

or through my interpretation of the transcript by explanatory comments of her narrative for example:

> *the main thing from an obstetric point of view would be that I would need steroid cover if I had to have a section so that's why I would need to be at the [hospital]. [Susie] - Self-assumption.*

Different aspects of self were all noted within the explanatory comments of the theme document. Table 11 overleaf illustrates this, taken from Louisa's transcript.

Table 11 Different aspects of self: interview transcript of Louisa	
Original transcript	Dominant themes within the narrative and explanatory comments
Louisa: 59.2 yeah so [pause] erm [pause] but no there was never any support groups or anything and when the health visitor took over Txxx had a rash and I was over he was over heated I was dressing him in too many layers and I didn't know erm [pause] and he had a rash and I just was very emotional and she said to me she got out this little pad and she was like now are you crying because he's got a rash or are you crying do you cry a lot of the time [pause] and I thought well if I admit to her I cry all the time she's going to judge me so I was like no no it's cos he's got a rash you know why's he got a rash and went off to doctors and it was a heat rash [laughs out loud] you know cos I'd put too many layers on him	Professional/practitioner. Self-changes. Self-doubt. Self-regret.
Louisa: 59.15 and I thought thank god I didn't have to tell her and now I can hide it and then she came a few weeks after that and she was like [pause] I was like oh I'm sorry I'm sorry that the house is a mess [pause] then she was like oh and she goes oh I'd rather it be a mess you know and if it was tidy I'd be worried that there'd be something wrong with you	Self-doubt. Information/communication. Professional/practitioner. She was worried about being judged. **Being judged-converges with PN women non conformers.**
Louisa: 59.20 so then in the back of my mind I was like right make sure it's a mess every time cos then they're not going to worry that I'm	Self-changes. She could cover the tracks of how she really was feeling.
Louisa: 59.31 and I suppose I did and [pause] but I was doing very bizarre things which at the time I'd lay for hours and I'd breath in the air he was breathing out	Self-awareness. Self-changes.
Louisa: 59.34 and like [pause] I don't know why and I still can't think why	Self-awareness.
Louisa: 60.2 I wanted him	Self-awareness. Self-concept.
Louisa: 60.6 yeah I remember thinking I need him I need I need a bit of him back in me to kind of feel connected and I'd lay there for and I did erm through work [pause] you know a year and a half ago a mental health first aid 3 day course and they touched on postnatal depression and like things like this and [pause] like them bizarre little things that I was doing I didn't even realise that they were kind of weird things to do I just thought presumed they were normal things to do so it was only a couple of years ago that I realised god that was a bit bizarre that I did that	Self-awareness. Self-changes. She needed her baby. Her bizarre behaviour. She describes as weird to herself. She judges herself by doing this.

Louisa: 60.16 I didn't tell anybody just before I met xxxx <u>I went to the doctor and said</u> [pause] <u>anyway I'm struggling a lot</u> not not so much with Txxx at that point	Self-concept. Self-determined. Professional/practitioner. Self-regret. Information/communication.
Louisa: 60.21 [pause] <u>I was like I'm just you know unhappy I'm just everything seems a struggle and I think a lot of it then at that point was just my life</u>	Self-changes. Self-regret. Self-awareness. Self-concept. When she was pregnant initially she was worried about being a single parent.
Louisa: 60.30 erm [pause] and yeah she prescribed me then antibiotics er antibiotics antidepressants like a I didn't want them <u>and I was saying to them</u> [smiles] I don't want antidepressants erm well she was like a really weak one you <u>know I wanted more like counselling someone to talk to</u> [pause] and I was allergic to the to the antidepressants [laughs out loud] I had fits	Self-awareness. Self-changes. She was prescribed medication for how she was. Self-determination.

As each aspect of self emerged, each was attributed with a dictionary working definition, from the same dictionary computer program used to define theme words. What became evident was how the super-ordinate theme of *self*, manifested various aspects Figure 8 shows the super-ordinate theme of self and identified aspects of self. Appendix 21 provides the definitions of antenatal aspects of self used within this thesis.
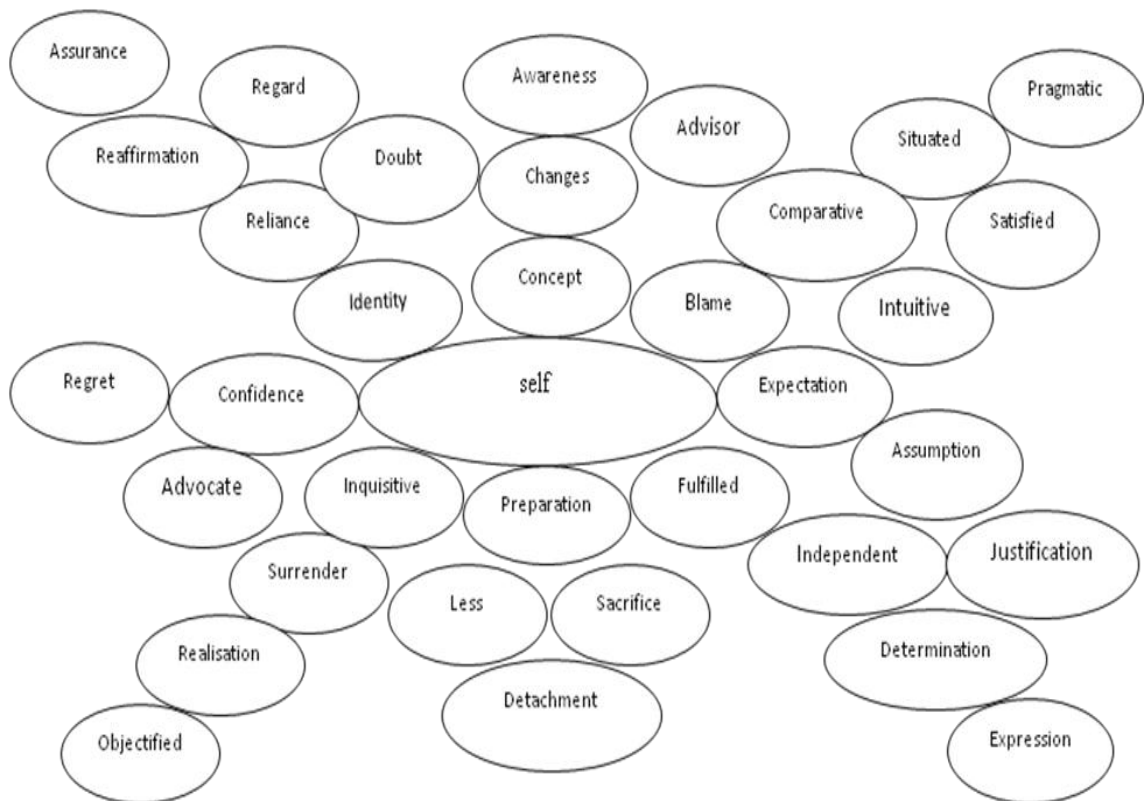
Figure 8 Super-ordinate theme of self illustrating the different aspects of self

As each theme document was systematically re-examined at this stage, if new aspects of self emerged these were noted as 'NEW ASPECT' in the comments box and subsequently added to the table of already identified aspects. The process was completed when all women's themed documents had been comprehensively searched for frequency of the aspects, once again using the computer 'find' button facility, for example, self: determination/determined; assurance/assured or surrender. A total of 35 aspects of self emerged.

I maintained a systematic re-checking of all theme documents when a new aspect emerged in a particular transcript. This technique was carried out in a style akin to comparative analysis (Smith, Harré, and Van Langenhove 1995). A number of comparable selves, developed as a 'whole' in the hermeneutical process, were continually compared against women's individual narrative selves as the 'part' hermeneutical process. This was undertaken to find new emergent aspects of *self* in her narrative that weren't evident at the time of her initial 'part' analysis. Table 12 overleaf demonstrates the 35 aspects of self for the antenatal women (whole) and the number of incidence or references found within their individual theme document (part).

Aspects of self	Julie	Louisa	June	Mary	Angela	Linda	Anna	Janet	Mandy	Lorraine	Rosie	Jo se	Nicola	Becky	Tricia	Susie	Fi	Anne	Alex
Self-less	1	0	0	2	1	1	0	0	4	1	2	0	1	4	1	1	3	1	0
Self-changes	2	30	2	5	8	14	21	13	3	2	5	2	6	10	3	4	1	2	10
Self-identity	24	7	6	15	6	8	10	7	13	6	4	14	9	21	13	20	7	2	14
Self-concept	0	30	16	16	21	15	18	14	48	22	16	18	9	10	18	4	17	12	32
Self-awareness	39	138	14	34	35	22	19	19	19	14	15	34	12	12	11	16	25	14	27
Self-assurance (assured)	8	7	3	1	5	2	8	22	9	14	6	0	1	1	4	0	0	0	3
Self-determination (determined)	7	30	8	5	3	8	11	23	12	23	21	15	11	15	5	3	7	4	11
Self-regret	5	17	13	10	5	4	11	0	9	1	3	5	1	2	1	0	1	1	2
Self-regard	9	13	3	0	4	6	6	15	4	5	1	1	1	4	0	0	1	0	4
Self-surrender	13	20	4	8	9	4	8	8	19	4	12	11	10	21	1	1	8	3	8
Self-reliance	3	2	0	0	0	0	5	8	0	3	0	1	1	0	1	0	2	0	0
Self-confidence	7	10	2	4	6	8	2	7	5	0	4	1	0	2	1	1	0	0	2
Self-doubt	2	16	5	5	6	3	12	1	9	2	2	8	1	3	3	0	0	0	3
Self-sacrifice	2	0	0	0	0	0	0	2	2	0	0	1	0	0	0	0	0	0	0
Self total refs	170	435	125	196	155	156	161	235	267	165	164	202	165	180	113	110	180	101	306
Independent self	0	1	0	0	2	1	4	1	0	5	0	0	0	1	0	1	0	1	1
Self-blame	0	6	0	4	0	1	3	0	0	0	1	1	0	1	0	0	2	0	1
Self-realisation	0	0	4	6	4	17	5	11	3	2	6	6	4	7	3	2	1	2	7
Fulfilling self (fulfilled self)	0	0	0	0	2	0	1	7	0	0	0	0	0	0	0	0	1	0	0

Table 12 35 Aspects of self for the antenatal women: number of incidences

Self-assumption						12		23	32	5	16	25	10	0	23	24	34	16	33
Comparative self						3		10	3	2	13	10	5	9	2	5	4	2	18
Self-preparation						5		11	7	2	15	2	1	15	6	2	3	0	16
Inquisitive self						1		4	1	3	8	2	0	3	2	0	2	6	10
Self-expectation						2		15	2	3	2	1	2	0	0	1	5	1	3
Situated self						1		16	2	3	8	6	1	5	1	1	8	1	4
Self as pragmatist								1	2	1	1	1	0	3	1	3	1	3	4
Intuitive self								3	0	2	0	1	0	3	1	1	0	0	0
Self-justification									5	5	1	12	8	5	5	3	12	4	10
Self-expression									1	0	4	4	5	4	2	1	3	0	4
Self-detachment (detach)									2	1	0	1	0	0	2	2	0	0	0
Self as advocate												1	0	0	0	0	0	0	0
Self as advisor															1	0	0	0	0
Self-satisfied																		1	0	1
Self-reaffirmation																				4
Self-objectified																				1

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Step 6: Deeper level analysis of 'self' theme.

Process of 'whole' back to 'part'

The evidence from the previous step revealed different aspects of *self*, interweaved with other emergent themes essential to all women. It became obvious that there needed to be a pragmatic decision in which a deeper analyse of the complex side of the individual *self* of these women could be explored.

The women's respective emergent theme documents therefore were pragmatically ordered into place of birth groups for both primigravida and multigravida women. The decision was made based upon making separate primigravida women, who had had no previous experience of making birth place choices, and multigravida women who had. As the inquiry aimed to explore women's decisions about where to birth their babies, it was applicable these should be grouped into birthplace choices and Figure 9 illustrates the five antenatal groups a final step of the hermeneutical cycle of analysis would be subjected to.
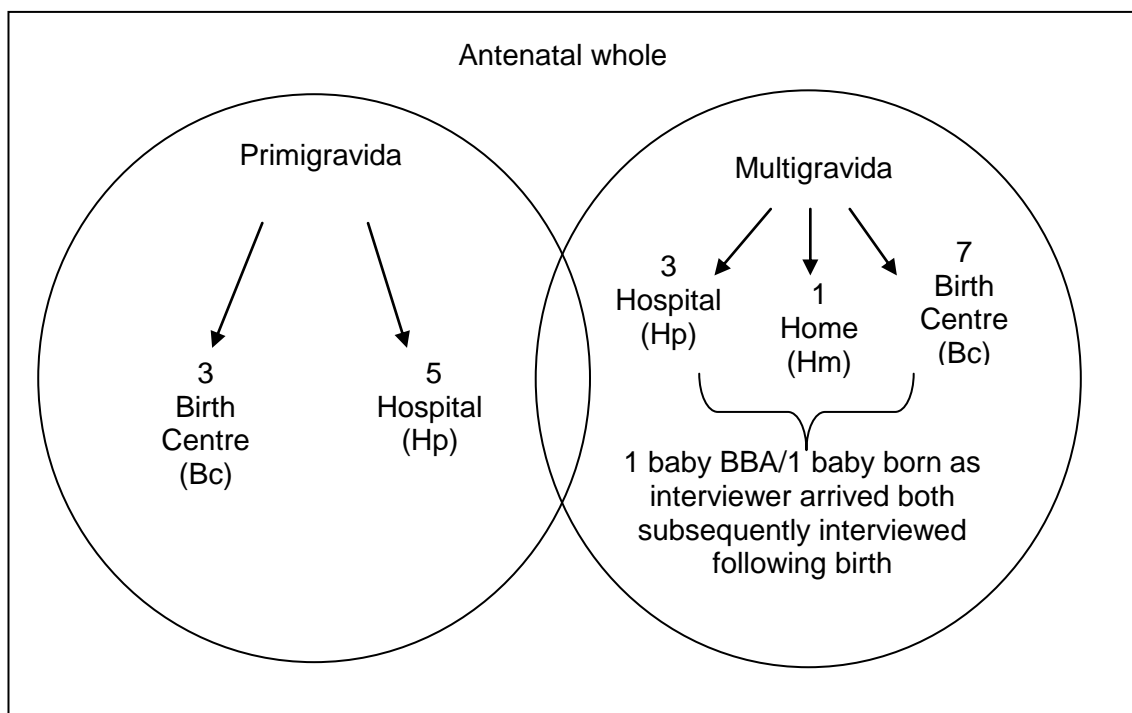
Figure 9 Group analysis by place and primigravida and multigravida women

Analysis involved systematically working through the transcripts within each associated group; primigravida and multigravida women and in their birth place groups. Each theme of *self* and the identified aspects of self were highlighted within the narrative text prior to the final analytical step of collective group analysis. Table 13 overleaf illustrates this process for Julie, a birth centre multigravida.

Table 13 Aspects of self within the narrative text of Julie	
Original transcript	Dominant themes within the narrative and explanatory comments
Julie: 31.30 and I was never sort of told [pause] try your best to stay up right cos gravity helps and I was never told change position I was just laid on the bed and and nobody said anything different to me	Self. Information/communication. Professional/practitioner. She didn't feel informed.
Julie: 32.2 erm I haven't no one's said it to me it's just experiences I've gleamed from other people and watching 'one born every minute' [laughs] where the midwives there do keep people upright and they have said it's it helps so I would like to be more upright and I would like so I think I would definitely be more assertive and I you know things like I feel like now I will say to them please can you leave the room I want to be on my own please can you turn the lights off [pause] please you know and I do feel like I will be saying that now if I have to be at the hospital erm [pause]	Self-awareness. Self-identity. Self-reliance. Self-determined. She learns from these external influences what she wants for herself. Self-reliant to speak out.
Julie: 2.12 erm well I've gone through everything with my husband and he knows the kind of labour I want erm [pause] and I would just like to think [pause 5 seconds] that he would be able to say you know to people 'just leave her alone' cos I just want to be left alone	Self. Self-confidence. in husband to aid her decisions.
Julie: 32.16 when I'm in the throws of labour [smiling] erm who knows who knows I would like to think so but [pause] you know it might come out less polite than though please can you leave me alone [laughs] but cos I would like to think that I would say that before labour becomes really established and I will	Self. Self-determined. Self-reliance. She wants to remain these in the throws of labour. States her position clearly before the situation gets that far.

Step 7: Developing Social representations: Images into montages.

'Part' back to 'whole' process

This step analysed each of the five groups represented by the three birth place choices for both primigravida and multigravida women. This represents the constructs or images of women as they characterize the life worlds of themselves within their social groups. These conceptual life worlds are what became representational of the primigravida and multigravida women who birth in a hospital, a birth centre or home and are a characteristic representation of these social groups in terms of self. Figure 10 overleaf illustrates these social representations as images into montages.

| Antenatal hospital self | Life worlds of this social group and the conceptual life world made up from characteristics of self that are the distinctive attributes of a hospital birthing woman. |

| Antenatal birth centre self | Life worlds of this social group and the conceptual life world made up from characteristics of self that are the distinctive attributes of a birth centre birthing woman. |

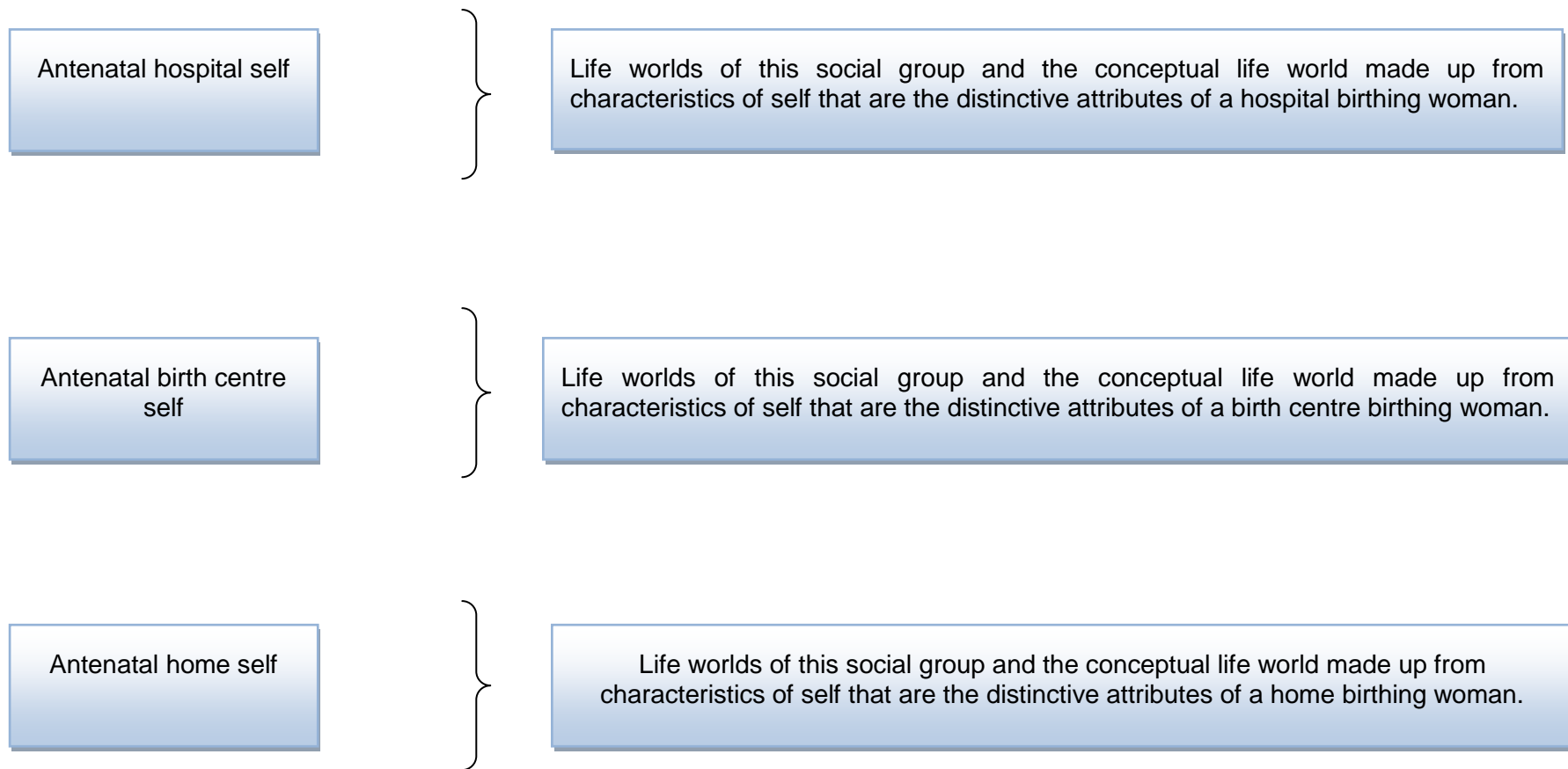| Antenatal home self | Life worlds of this social group and the conceptual life world made up from characteristics of self that are the distinctive attributes of a home birthing woman. |

Figure 10 Social Representations of primigravida and multigravida women: Images into montages.

Analysis of six postnatal transcripts

Step 1: Hermeneutical cycle: the 'whole' 'part' process

The postnatal sample group proved more difficult to recruit as discussed in the sampling section in research design. Women were recruited late in the recruiting process compared to the antenatal sample group. This meant antenatal transcripts were worked with in the analytical process prior to and alongside the postnatal interviews and transcript development. The initial analytical stage of antenatal interviews had been completed. These were all typed and journals had been written as the on-going interview process was undertaken and analytical framework development had already been achieved at this point.

Once the antenatal transcripts were completed up to step six, a pragmatic decision was made to continue the analytical process for the postnatal transcripts and complete the process, instead of reverting back to completing analysis of the antenatal documents. It felt appropriate to continue with the postnatal 'part' of analysis and complete the cycle through to step seven, as I had been working with this data latterly. It also felt right as the actual reverting from parts to whole as a constant, gave a sense of natural fluidity to the process where thoughts and ideas could develop along the way from my considerations of the antenatal narratives. This made it possible to keep a 'third ear' open as it were whilst working with the postnatal narratives, as I could further make sense of both the antennal and postnatal women's' experiences in a shared sense, to see if anything particular leapt out. In this I was maintaining a focus on the hermeneutical whole within the postnatal part.

Step 2: Analytical framework development.

The 'whole' process

17 postnatal themes emerged from the 'interesting words and phrases' noted from the postnatal transcripts. These are represented in figure 11.

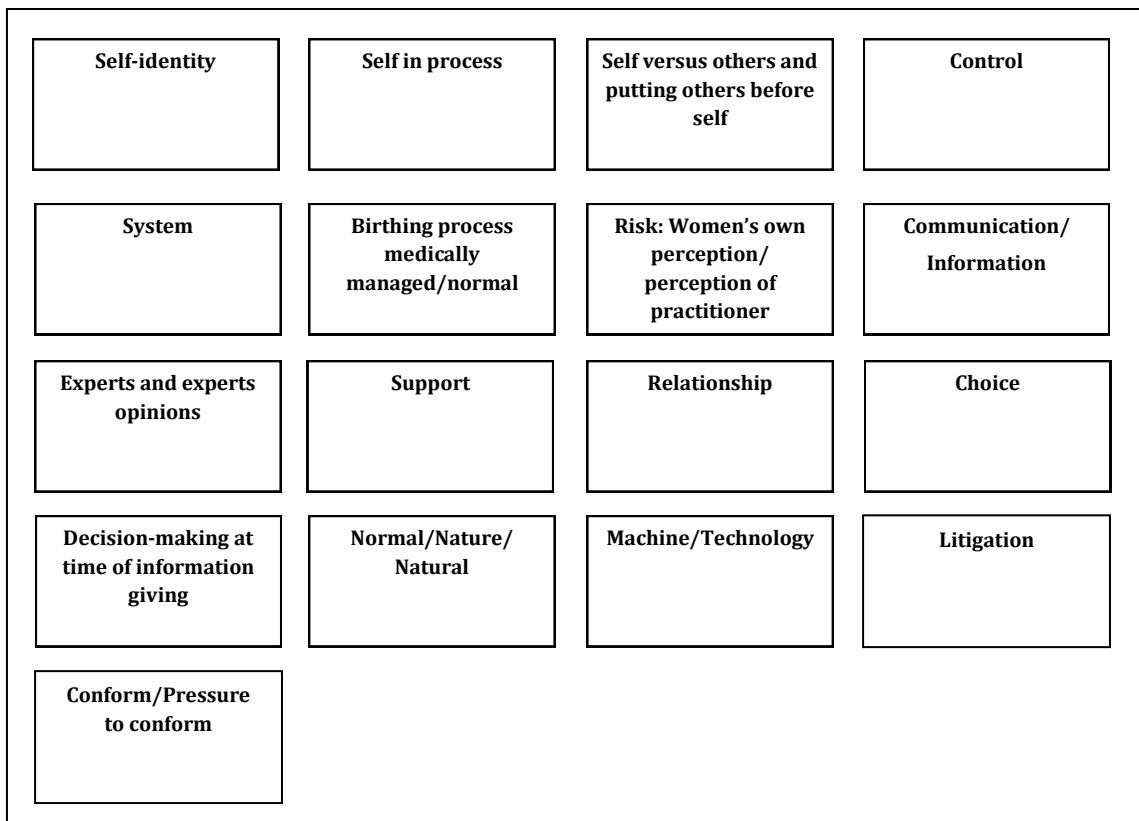|			
Self-identity	**Self in process**	**Self versus others and putting others before self**	**Control**
System	**Birthing process medically managed/normal**	**Risk: Women's own perception/ perception of practitioner**	**Communication/ Information**
Experts and experts opinions	**Support**	**Relationship**	**Choice**
Decision-making at time of information giving	**Normal/Nature/ Natural**	**Machine/Technology**	**Litigation**
Conform/Pressure to conform			

Figure11 Seventeen postnatal emergent themes

Each theme was again allocated a working definition as before using the same computer dictionary. This formulated the individual framework for the postnatal transcript analysis. Themes were derived once again from the words women used within their narratives. Table 14 provides an example of the theme of experts. This group referred to professionals more as experts who were perceived as specialised and medical rather than the antenatal accounts which referred to professionals and practitioners. This could well have been because all women had an identified medical or obstetric condition that required them to be assigned to consultant care and as a result of an identified elevated risk situation women might perceive doctors as specialised and medical than rather define them as professional or practitioner.

Table14 Interesting words and phrases noted from the postnatal theme of experts
Because they are the ones that know what they're doing
I would go along with the advice they're giving, wouldn't challenge – they're the experts, they know what they're talking about
Not that I know because I'm not medically trained
Doctors to be there just in case
They're higher they know what they're doing
When you say to somebody in their position

Step 3: Individual transcript analysis.

The 'part' process

The same method utilised for antenatal transcripts was maintained for these original postnatal transcripts. Postnatal themes were allocated to appropriate elements of

narrative and initial noting of comments in relation to the themes was made on the original transcript. Again anything of interest observed from the transcript was noted.

Step 4: Emergent themes document: data extraction from original narrative transcripts

The 'part' process continued.

Identifying and extracting interesting elements of narrative was undertaken using the copy and paste facility in much the same way as for the antenatal transcripts. A new 'emergent themes' document was created, giving each page and line number codes once again. All notations and comments made on the original transcript were copied across to the new emergent theme document. This practice continued for each of the six women's transcripts permitting engagement with the narratives at a much deeper level. Table 15 overleaf illustrates the emergent theme document for Denise.

Table 15 Emergent themes document for Denise	
Original transcript	Dominant themes within the narrative and explanatory comments
Denise: 1.19 Well, I had this baby at home I did want to have my other children at home but with my first I was told I couldn't.	Self-awareness. Control. She always wanted to have her babies born at home but she was told in her first pregnancy because it was her first she couldn't. (1996).
Denise: 1.49 Yeah, yeah. I didn't argue or anything, I just said that I would like to think about it and I was just told that it wasn't very wise with my first just in case, they didn't know how things would progress and things, so.	Self-determination. Expert's opinion. Control. Risk perception: expert. Reaffirmed that she wanted to consider this option but told it wasn't wise due to not knowing how things would progress. **Aren't all births individual even if a woman has been through labour beforehand so realistically we cannot say how any labour and birth will progress? To be told this is like saying we don't know how any birth will progress. We are aware practitioners have preconceived ideas sometimes (curse of the 3rd baby mentioned in PN 6).**
Denise: 2.6 I don't like hospitals, yeah, I don't like the hospital, I didn't like going when I went and I didn't like seeing all the people stood outside smoking and screaming and ...	Self-awareness. She justifies the negative aspects and negative feelings hospitals do for her and clearly doesn't wish to go there to give birth
Denise: 2.25 I saw a consultant once or twice because I was overdue so I did see somebody, yeah.	System. The policy back in 1996 meant she was seen by a consultant. She didn't say why there was a need for seeing them and perhaps she didn't think too deeply about this
Denise: 2.34 yeah yeah I don't remember, it was a long time ago, I don't remember them saying definitely saying no, but I remember being advised that it wasn't a good idea so when I got pregnant with my second one, straight away I said, I wanted to have it at home. And they was lovely and it was all going ahead but, 'cos I was overdue.	Expert. Control. Pressure to conform. Self-determination. Support. Relationship. It was advice she was given than definitely not. She was more self-determined and led the way to asserting her desire to have her baby at home (2000). She was supported by her midwives. Relationship was good between her and her midwives.

Step 5: Data incidence from the 17 themes and identification of a sub-ordinate theme

The 'part' back to 'whole'

Incidences of themes were again identified each time these were referred to, again using the same computer 'find' technique. Figure 12 overleaf illustrates graphically, the 17 postnatal emergent themes and incidences for each woman. This represents the postnatal 'whole' from combining the individual parts as dominant to them.
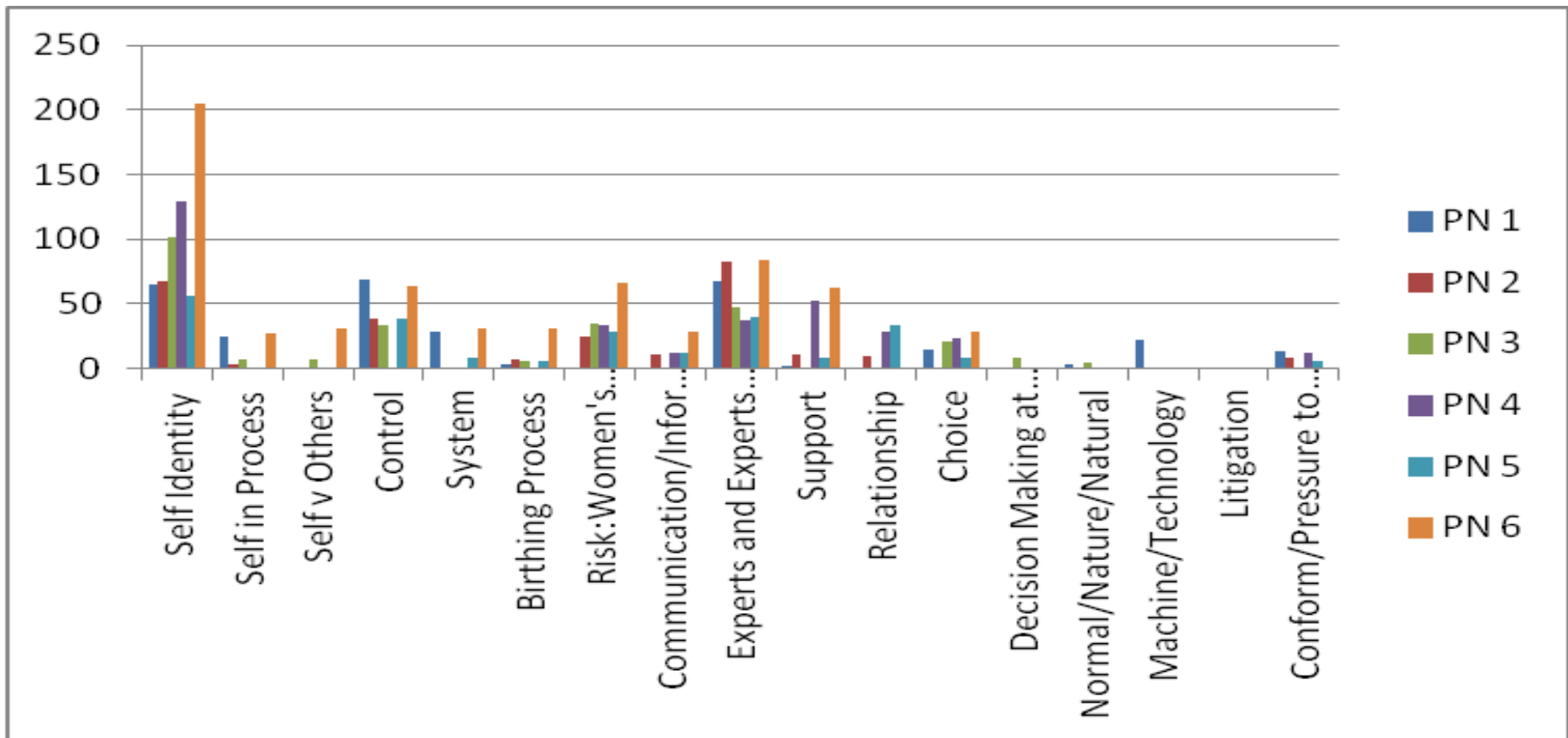
Figure 12 Graphical representations of postnatal emergent themes

Following the same techniques as documented in the antenatal steps, the most salient theme of *self* emerged once again as the super-ordinate theme and within women's narrative the emergence of the different aspects of 'self were identified. Appendix 22 illustrates the 11 identified aspects of self, together with the assigned dictionary definition that emerged from the postnatal data. Incidences of the emerging aspects of *self* were identified using the computer 'find' button in much the same way as for antenatal documents, hence indicating frequency for each participant. The incidences of 'aspects of self' were again created from her direct reference of the themed word, the allocation of theme to the narrative or through my explanatory comments on the narrative, these were once again noted within the explanatory comments column.

Table 16 overleaf demonstrates aspects of self in relation to all themes and occurrence combined from the original and theme document of the six women and their health related aspect. This demonstrates another method of data illustration for the postnatal women similar to illustrating data from figure 7 on page 161 and table12 in step five of the antenatal steps (page168).

Table 16 Aspects of self in relation to all themes in respect of the six postnatal women's health related incidences											
1 Both babies born by em LSCS	Self: awareness 8 identity 3 confidence 3 determination 1 reliance 1 reflection 1 Total references **65**	Control (by others/ she submits) **69**	Experts and expert opinions **68**	System **28**	Self in process (self-surrenders) **25**	Machine/ Technology **22**	Choice **15**	Conform/ Pressure to conform (conforms to experts) **14**	Birthing process (perceived as 'risky') **4**	Normal/ nature/ natural **4**	Support (didn't feel supported) **2**
2 Ovarian cyst 3 normal births	Expert and experts' opinions **83**	Self: awareness 13 assurance 11 identity 9 determination 8 confidence 5 doubt 3 Total references **67**	Control (others control/ self control/ natures control) **39**	Risk: Her perception/ Her perception of practitioner **25**	Communication/ Information **11**	Support (felt supported by her community midwives) **11**	Relationship (positive with her consultant) **10**	Conform/ Pressure to conform **8**	Birthing process **7**	Self in process **4**	Decision-making at time of information giving **1**
3 Previous termination for fetal abnormality	Self: awareness 40 confidence 7 determination 11 assurance 3 reflection 2 doubt 1 reliance 1 Total references **102**	Expert and experts' opinions **47**	Risk: Her perception/ her perception of practitioner **35**	Control **33**	Choice **21**	Decision-making at time of information giving **8**	Self in process **7**	Self v others **7**	Birthing process (perceived as risky) **6**	Normal/ nature/ natural **5**	

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4 Low lying placenta at 20 week scan	Self : determination 27 awareness 24 doubt 13 reliance 11 confidence 10 assurance 7 identity 3 surrender 3 reflection 2 regard 1 Total references **129**	Support **52**	Expert and experts' opinions **38**	Risk: Her perception/ Her perception of practitioner **33**	Relationship **28**	Choice **24**	Communication /Information **12**	Conform/ Pressure to conform **12**				
5 Borderline platelets requesting home birth	Self: awareness 11 determination 11 identity 5 confidence 1 assurance 5 Total references **56**	Experts and expert opinions **40**	Control **39**	Relationship **33**	Risk: Her perception/ Her perception of practitioner **28**	Communication /information **12**	Choice **9**	System **9**	Support **8**	Conform/ Pressure to conform **6**	Birthing process **6**
6 Epilepsy 3 normal births	Self: doubt 29 determination 21 regard 11 identity 10 assurance 9 awareness 7 confidence 6 surrender 5 reliance 4 Total reference**s** **205**	Expert and experts opinions **84**	Risk: women's own perception/ perception of practitioner **66**	Control **64**	Support **63**	Self versus others: **31**	Birthing process **31**	System **31**	Communication/ information **29**	Choice **28**	Self in process **27**

Step 6: Deeper level analysis of self

'Whole' back to 'part' new aspects

Each of the six postnatal 'emergent theme' documents was systematically examined at a deeper level analysis of *self*. These were analysed as two groups of three within the postnatal 'whole'. These groups consisted of the three women who were recruited as conforming to practitioner advice and three women non-conforming to practitioner advice.

Interestingly as I progressed through this level of analysis within postnatal theme documents, I was near completion of antenatal analysis step five concurrently. As new antenatal 'selves' were emerging from this deeper level of analysis the iterative nature of the study meant that it would be incomplete not to go back to the postnatal themed documents, identify and include all the newly identified postnatal emergent selves in all postnatal documents. Consequently a systematic re-checking of all theme documents, when new aspects of self emerged in a particular one, was continued in a comparative analysis style as was carried out for the antenatal theme documents. This demonstrates the constant iterative method used as transcripts were revisited. These further identified 'aspects of self' were handwritten and highlighted on the individual postnatal emergent theme documents. These are identified in red on figure 13 overleaf. Figure 13 illustrates all aspects of self for both the antenatal and postnatal parts of the inquiry and representing these as a whole within the inquiry. This signifies how analysis of the parts were not completed in isolation but connected individual parts; parts within the whole in a naturally emerging cycle as direct consequence of the narrative whole.

Hospital	A N T E N A T A L	P O S T N A T A L	Conformer
Home			Non conformer
Birth centre			

Antenatal Self

Postnatal Self

| Aspects of Antenatal self | Aspects of Postnatal self |

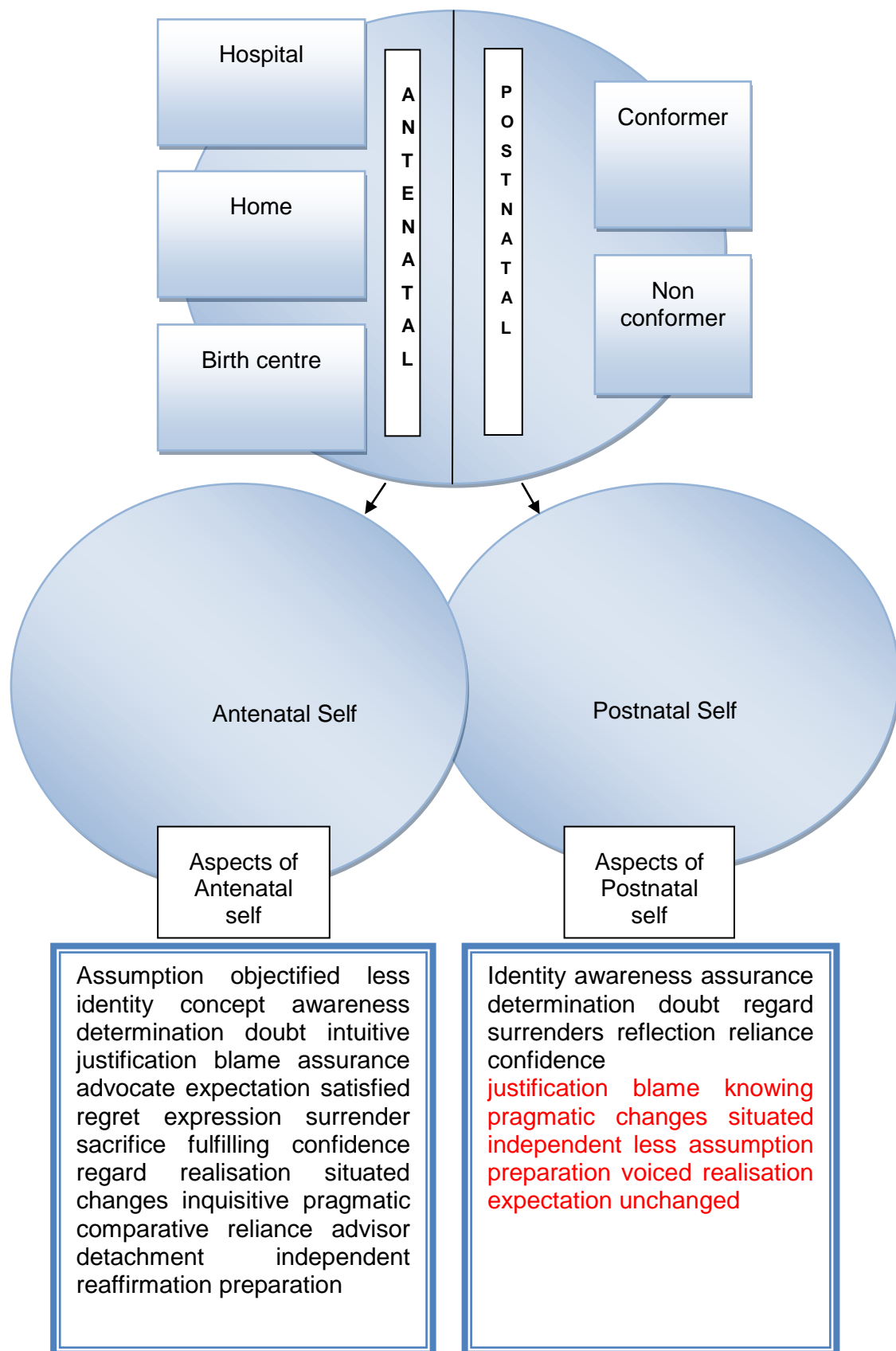| Assumption objectified less identity concept awareness determination doubt intuitive justification blame assurance advocate expectation satisfied regret expression surrender sacrifice fulfilling confidence regard realisation situated changes inquisitive pragmatic comparative reliance advisor detachment independent reaffirmation preparation | Identity awareness assurance determination doubt regard surrenders reflection reliance confidence justification blame knowing pragmatic changes situated independent less assumption preparation voiced realisation expectation unchanged |

Figure 13 Aspects of self for all women

Step 7: Developing Social representations: Images into montages.

The 'part' back to 'whole'

This final step marks once again the development of constructs, images of women as they characterize the life worlds of themselves within their social groups those who conform to practitioner advice and those who do not.

Validity in what was said.

A priority of the data collected was to gain assurance that what was said was a true and accurate account of our interaction. This was achieved by returning transcripts to women for verification and women were given the opportunity to read through the transcript and change anything, or clarify anything that was found not to be contextually correct. Twenty four out of the twenty five women who were interviewed had transcripts returned for verification. All women read through these and affirmed their accounts were accurate. The woman who declined to have the transcript returned was happy not to have the account verified.

For the antenatal women returning transcripts was following the birth of their babies. This was twofold, for validation of what was expressed, providing time to read this to a length and depth they wanted, but this provided the opportunity for them to provide an account of their birth experience. As I left their houses, once our meeting was over, it gave me the opportunity to record in my diary notes. I did not read previous interview notes prior to our second meeting as I did not want to lead any discussions but let them express themselves as they wished to. This allowed me to look with fresh insight, comparing their thoughts and experiences in the fullness of experience.

Chapter 6: Antenatal Findings

Introduction

This chapter presents the antenatal findings from the final step in the hermeneutical cycle of analysis. Presented are the social representations, the images of women that are characteristic of their life worlds within certain social groups. These represent the constructs that make up individual social groups and are characteristic of them. The five antenatal images represent montages, group profiles of the women interviewed, and all profiles are distinguishable from one another. These embody the social representations of primigravida and multigravida women who book to the hospital, the birth centre and home to birth their babies and are characteristic of what became a representation of these social groups in terms of *self.*

This part of the thesis sets out findings both as a 'whole' in illustrating the interplay of external and internal influences that exist in the social context and how this impacts on the different social representations of women and as 'parts', within the 'whole' (this and the following chapter), as the antenatal and postnatal social representations are characterized. Following presentation of the findings from the postnatal representations in chapter 7, conclusions on the vignettes, as characterized antenatally will be drawn upon in relation to the postnatal depiction. Findings are illustrated with the voices of each woman from each social group. Every woman adds value and authenticity to these findings. The narratives provide a compilation of characteristic perceptions, concerns and understandings of the birthing process of these particular groups of women and embody what they characterize and understand within the context of their lived experiences. This offers a rich insight into the life worlds of these childbearing women.

Depicting women as social representations

It is not possible or appropriate to view women as anything but individual. Nor would it be acknowledging them as idiosyncratic beings if analysis solely focused upon them simply as social groups in a microcosm of midwifery culture. Since the analytical progression began as individuals in the 'part' process of the hermeneutical cycle and analysis of each woman's experience was undertaken as a unique practice,

recognizing they remain parts within the whole does value them as idiosyncratic beings. Recognition of this should be evident throughout the continued reading and study of this thesis. A connection between characteristics of individuals within each pregnant group became evident. These comprise of a set of characteristic views, beliefs, misinterpretations and preconceptions held by the women as composite in these social representations. The hermeneutical framework of analysis has made possible an observational frame that enables exploration of their constructed discourses, and opens up new ways of thinking about influencing factors that remain constant in their everyday decision-making about birth choices. In the course of hermeneutical inquiry and exploring the perceptions of these women as parts within the whole, key characteristics became apparent. How these women appear in real terms within a micro socialisation of maternity care culture, illustrates how they are socially constructed within the current climate of maternity care. This raises debate on how choices can be best addressed utilising the experiences of women as a basis for change.

Antenatal and postnatal themes and super-ordinate theme of self

The cycle of analysis exposed 15 antenatal themes and 17 postnatal themes. Themes were identified as either internal or external causes of influence. External themes were characterised as those factors that could cause an effect on behaviour, belief or feelings (Aronson 2008) in relation to decision-making. Internal influences were other influences not perceived as having an external basis that have potential to cause direct change in behaviour as a result of outside forces. An internal theme of *self* was so apparent that it became the super-ordinate theme since it crossed all identified themes.

Interplay of internal and external influences

Aspects of self were identified as internal influences and these overriding notions of self interplay with external influences. Figure 14 provides an exemplar with regard to Katie of her internal influences of *self* such as self-confidence, self-determination and self-regard and the interplay that exists with the experienced external influences of risk, control and professional:
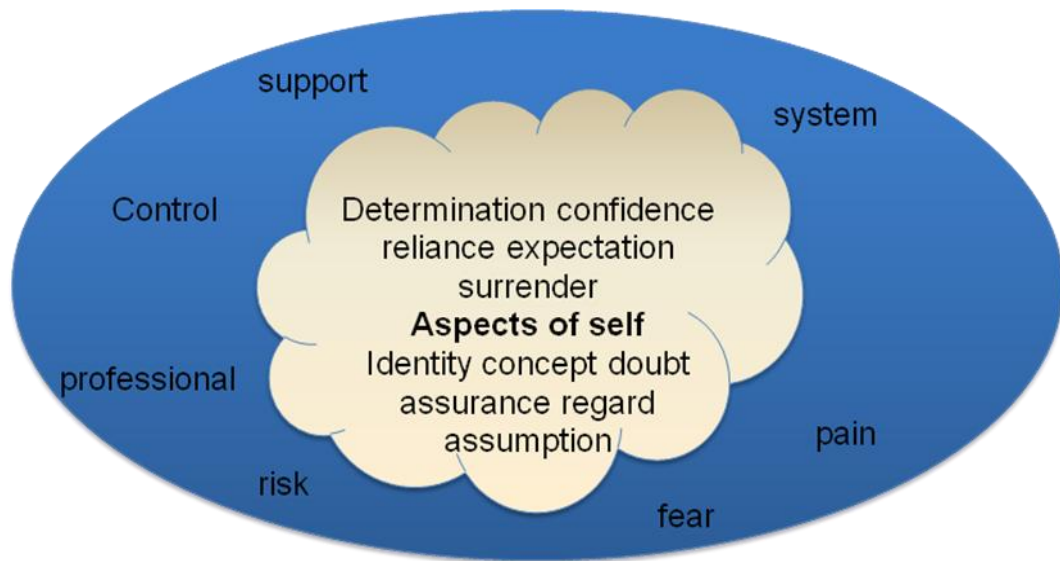
Figure 14 Exemplar of the internal and external influences

Figure 15 illustrates this interplay between the internal and external influences. What this aims to show is how *self* as an internal influence is not fixed, but aspects of self, represented in the cloud, balloon in and out dependent which are in interplay. The arrows demonstrate how all aspects of self as internal influences have the capability to interplay with each of the external influences. The result of this interplay has the potential for both positive and negative effects to occur on the self.
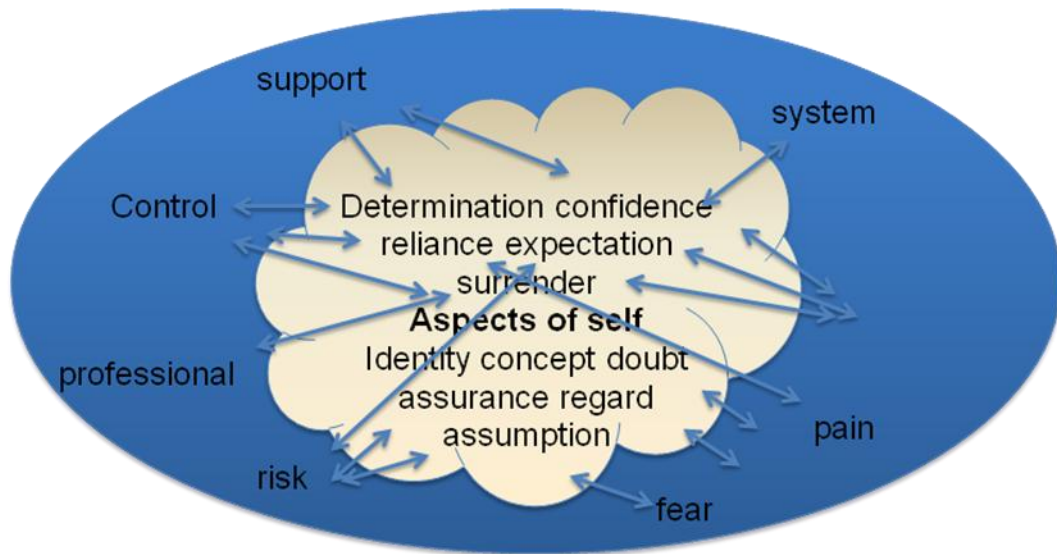
Figure 15 Interplay of the internal and external influences

As a result the implications of this interplay meant that internal influences were either positively or negatively re-enforced. This can be exemplified from Alex, Sue and Karen who illustrate how the external influence of professionals such as midwives and doctors can be very influential, as they are seen as experts:

> *"you do really take what your midwife says as...gold dust, you know the...advice with their experience."* [Alex]

> *"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."* [Sue]

> *"well I don't know you're the expert you're the medical...what do you advise as the safest thing for me to do."* [Karen]

This reflects how women perceive themselves as sub-ordinate in relation to 'professional experts'. Hence experts have potential to influence decision-making. Such implications can impact on self-identity. Self-identity determines what and who she is, the qualities and characteristics she has for example, self-determined, self-doubting or self-assured. Her self-concept is the mental picture she has of herself.

If her self-identity is as a self-assured, questioning woman who knows what she wants, by combining all the different aspects of self these characteristics and qualities can determine her self-concept. The mental picture she has of herself and she thinks of herself as a self-assured and self-determined woman. What her self-identity is therefore, and the qualities and characteristics that determine this, can be established by the mental picture she has of herself. Her mental picture of self may alter as the external aspects interplay with the internal aspects of self and can therefore influence this in given contexts.

Social representations – Antenatal

As women were interviewed in the antenatal period, their social representation (SR) was determined upon where they had made the decision to book for birth. Two antenatal women were interviewed postnatal subsequently establishing a new SR. Table 17 below describes the women that make up the social representations.

Table 17 Antenatal women social representations planned place for birth/actual place of birth			
***** area n = 11	**** area n = 8	Overall planned place of birth bookings n = 19	Actual place of birth
Hp P = 4 Hp M = 1 Bc P= 2 Bc M= 3 Hm M = 1 (interviewed postnatal as baby arrived prior to interviewer)	Hp P = 1 Hp M = 2 Bc P = 1 Bc M = 4	Hp P =5 Hp M = 3 Bc P = 3 Bc M = 7 Hm M = 1	Hp P =6 Hp M =4 Bc P =2 Bc M =5 Hm M = 2

P = Primigravida
M = Multigravida
Hp = Hospital
Bc = Birth centre
Hm = Home

Hospital primips (SR1)

This social representation (SR1) is compiled from the narrative experiences of five primigravida women who booked to the hospital in which to birth their baby. Two of the women had a professional identity within healthcare.

The following provides a brief description of the characteristics of the SR1 group. They perceived themselves at times as silly, ridiculous, cowardly and embarrassed about silly or superstitious behaviour by openly divulging pregnancy too early. They are not necessarily open to suggestions or ideas. They are self-aware of limitations such as not being good with pain, being aware of this does not mean they are not frightened but 'knowing' reduces fear. They self-surrender to professionals and are conscious of being compliant.

This group are worriers having a negative view of birth and a high perception of risk. These feelings underpin the reason they book to the hospital for birth. Tricia, Susie and Alex exemplify the feelings of the group below:

> *"just worrying all the time about whether things are going to be okay and sort of not wanting to tell people until 12 weeks." [Tricia]*

For Susie, her professional identity contributed to these feelings:

> *"I think you get a little bit entrenched in the system when you work in hospital ...I am quite naturally ...a worrier and would want to err on the side of caution and the fact that the birthing centre I...can be the best part of half an hour travel if something happens you haven't got a NICU on the doorstep that would put me off that would have always been my feelings to be at the [hospital]." [Susie]*

Alex viewed anywhere else other than the hospital as risky:

> *"so I...just said [hospital] and if she'd have asked me I would have said because it's my first baby and I am quite nervous, not sure what the pains gunna be like...I don't want to be back and forwards...the girls I know who've given birth at [the birth centre] have said it was wonderful...it's a lovely place really relaxed a lot more chilled out than [hospital] the staff are nice...but for me with it being my first one I didn't want to take any risks".[Alex]*

Fear of risk meant they are worried from the start:

"they've combated a lot of my fears really even though I've still got quite a few fears...I was...conscious about...my age I know I'm only thirty two...I was worried about that...I was worried about reasons why I hadn't conceived before whether I'd have any problems whether I was going to be able to keep hold of the baby...and I was just worried about been active about getting obese just anything really." [Alex]

Sometimes worrying about things that have not been raised as issues in pregnancy:

"but 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, erm, rupturing and the pain". [Alex]

"I think from risk for me as well, is if it's a big baby because I'm not particularly a big person then there could be that risk of...it not fitting through the canal...that's something I think about if I am having a big baby then that might be a bit of a risk trying to push baby out that's too big to want to fit". [Tricia]

Birth is recognized as risky, pregnancy as problematic and a traumatising process:

"as far as childbirth's concerned...the risk to me and my body is probably something that's contributing to how nervous I am, I know friends who have had blood transfusions, who haven't stopped bleeding afterwards or couldn't give birth to the placenta, or the baby cord was wrapped round the neck...all that kinda stuff I've got on my mind, so I do know how risky it is and I do know what a trauma it is on your body...but likewise, you know I know women have been giving birth for years." [Alex]

Birth causes trauma on the body and this just has to be accepted. There can be vivid representations of anxiety and childbirth that result in not having complete control over what you want for yourself:

"If I'm out of control of a situation I'm pretty sure I'm not going to be in a great deal of control in birth, but headaches, I suffer from migraines and things like that and when I lose control of that, then it panics me and it makes things worse and I know that my reactions to the pain or what have you are worsened." [Fi]

This is a nervous first experience with unknown expectations. They want information early on and not only want professional confirmation, but want to see a professional at this time:

> "when it was confirmed I was pregnant...when I had the blood test, the only thing that I remember initially feeling was I wish I had more support was when I missed my first period and I desperately, desperately wanted confirmation from the medical profession that I was pregnant even though I'd done probably six pregnancy tests.. .I've got to wait between another four five six weeks...I went and bought my...pregnancy book to try and answer my questions, spoke to friends but...I would of really liked at that point to just to have it confirmed." [Alex]

They are influenced by others not themselves and in asking permission they lack self-determination:

> "you know you've sort of listened to advice of friends and family...I think that's the thing isn't it you just sort of follow what people do". [Anne]

> "get a group of girls...they all want to give you their advice...and I did take that with a pinch of salt, but, again, I presume it did influence my decision little bit...it's ridiculous, it's not the health professionals, because I'm low risk so I could, I'm assuming, go anywhere...but my option to go to hospital, where I would imagine higher risk patients should be, is based on what other people have said." [Fi]

Decisions of where to birth were made before seeing a midwife and were based on reasons such as pain, fear, others' experiences and own miscarriage:

> "because I've just listened to other people and thought well hospital is good enough for them, then it's good enough for me." [Fi]

These women are self-aware they are not well informed, but with more knowledge and information anxieties reduce. However this doesn't change their choices already made and there is no awareness that there can be change. They believe information is only obtained if one asks for it:

"sometimes you do feel a bit of a plonka asking basic questions but...I do a lot of reading up about it, speak to the antenatal mums and depending on the midwife I'm with...one of the midwives I'm with will volunteer information and ask how I am and...what I'm worried about...the other one I have to ask the questions I don't get much back.. the other girls have had similar experiences...it's not just me... it's just...I've had to find a lot of information out myself, through reading, signing up to the websites which I've just... thought that's how it must be rather than the midwife giving you everything." [Alex]

They consider themselves in control of their own life and speak about faith in their bodies yet do not portray this in their narratives. They believe professionals will give them the information to deal with the experience:

"I've got full faith in the medical profession, I think they are absolutely wonderful and I know I'll be in safe hands and I'll just have to be open minded and trust my body, really and my kind, the way I'm trying to look at it is the way a girl I play hockey with focused on it...she sent me a lovely text the other day just saying 'mother nature knows what she's doing' try and relax as much as you can, let your body do what it knows it's doing, listen to your midwife, breath when she says, you know and just really have faith that your body knows." [Alex]

Self is perceived as open minded, yet this is not demonstrated in the narratives. Not having a birthing plan is perceived as having an open mind. The ideal is in wanting a natural birth, this is their ideology, yet they do not realise they can do things to promote that. Thoughts are mostly about pain relief. This is a fear for them yet they show no evidence of self-assurance or determination to manage this. Not being good with pain and a potential for medical intervention justifies choice of environment. This was an obvious choice since knowledge of *self* and the preconceptions of birth justify reasoning:

"I'm not I'm not too good with pain so I thought I'd be best off where I can get offered as much pain relief as I want." [Anne]

These women are influenced by others because they have no firsthand experience and use the experiences of others to achieve what they want for themselves. They have not heard of any good experiences in pregnancy but consider sharing information and listening to birth experiences as a 'shared experience with others like her' and 'being

the same' is an empowering experience even in listening to others' worries'. Professional self-identity and knowledge gives rise to a negative closed view of things where some may be an open book to suggestion they are not which re-enforces the focus of birth as high risk.

Birth centre primips (SR2)

This social representation (SR2) is compiled from the narrative experiences of three primigravida women who were booking to the birth centre.

The environment and what it signifies is of greater importance for these women. As a group they are more independent and self-reliant. There is an element of self stoicism, a type of determination and self-expectation. The *self* is seen as not having options, because of not wanting to fail and they put restraints on themselves by being self-determined in the experience they want for themselves. The extent to which the level of self-restraint is placed is individual. Lorraine illustrates the restraint she puts herself under by not allowing *'self'* certain options – to give up on breastfeeding:

> *"well for me it's not an option I will breastfeed so whether I struggle or not you know it's not something I would give up."[Lorraine]*

They are inquisitive and self-prepare by finding out and actively search for information, but also see how information can be missed for women and it can to some degree be pot luck:

> *"there's probably still information we haven't got there's so much information that you don't know you're fully informed of everything until someone mentions or asks and then think I didn't know I didn't think of that." [Lorraine]*

Decisions where to birth were made early on in pregnancy before interactions with health professionals or before seeing the midwife because of a fundamental belief in the philosophy of birth in this environment:

> *"I think in the back of my mind I've always had that desire to go to the birth centre...even beforehand we've sort of talked about having a baby...so I think even before we'd conceived it was in the back of my mind." [Mandy]*

This thinking has been strengthened by knowing more and having more information. Consequently decisions are made from a basic level of knowledge and strengthened by understanding. This is illustrated by Lorraine:

"my decision definitely hasn't changed I think more than anything it's strengthened my decision having the information you know more information." [Lorraine]

Conversations are led by them. These women are aware there are a lot of misconceptions by 'others' regarding pain relief at the birth centre. They booked for the birth centre for birthing support, moreover postnatal care is valued because of the support on offer to them, and especially with breastfeeding. The positive experiences of others, was also influential. These women knew what they wanted for their experience so they were self-determined to be in an environment that could facilitate this:

"I think it's a very natural thing...it's an experience you won't have that many times in your life and I want it to be as natural and as pleasant as possible really...I'll be fine with...everything and the fact that I'm not really massively scared about...I just want to enjoy it as much as possible really...I picked it and said...you know this is what I want to do and the more information he had about the choices and from the sessions we've attended and the things he's read the more he really agrees with the choice I've picked." [Lorraine]

The decision was for a natural birth but not at home, potentially underpinned by a lack of information:

"I didn't know much about the home birth I didn't really fancy that too much." [Rosie]

"I don't really know much about home births...wasn't much information about that but maybe it's because I didn't ask." [Lorraine]

They are all adamant they would not want a home birth. They are put off by the practicalities of it, including mess, not doing things adequately to prepare, not knowing how to organise and what it involves on their part as well as from the midwives. Home birth seems a lot of hard work to organise and deal with:

"I know a few people that have said with their second they'd quite like a home birth so maybe they realised it was [laughs] quite a nice experience that it can be done at home I don't know I don't know what it is that puts me off [laughs out loud] maybe it's the mess."[Lorraine]

They assume women are more frightened in having a home birth with a first baby and do not know of the procedures involved for home birthing and whether the midwife brings a resuscitation device with them:

> *"first sign of any sort of complication they'll whisk you off to [hospital] I would imagine it's a bit more strict now with a home birth that anything goes wrong you've got to go straight there rather than trying to risk it but then I can't imagine that the midwife comes with a resuscitation device and a big padded bag and stuff I don't know how that works I would assume that like you know they can always call an ambulance and they've got everything." [Rosie]*

This group may or may not have awareness of others having home births. Yet fundamentally believing having gone through it (birth) re-enforces what is believed and perhaps gives courage of conviction, the confidence to be self-assured to have a home birth the next time:

> *"I do believe that every birth is different but [pause] you know yourself what your body's going to go through because you've done it once even though it's a different birth experience it's still giving birth...I know a few people that have said with their second they'd quite like a home birth so maybe they realised it was quite a nice experience that it can be done at home." [Lorraine]*

Despite understanding each birth is different, the fundamentals are the same; labour pain is still labour pain.

A change in self-identity as a mother is perceived. They view the importance of this being a shared experience and voice strongly to midwives what it is they want. They believe good experiences should be shared. Sharing stories is important, inspirational and gives them aspiration as Lorraine illustrates about home birthing:

> *"yeah because the more people that share their experiences and views on it you know the more acceptable it becomes." [Lorraine]*

Their focus isn't on pain relief and they want the minimum during their birth experience. They opt out of a hospital environment to avoid pharmacological pain relief and want to

enjoy the experience, expecting it to be a pleasant unique natural experience and wanting to be free and free to do what they need to do as Rosie explains:

> *"I really don't want to go to [hospital] because I've heard a lot of bad stories and I don't want to end up on a bed strapped up with a fetal monitor and I want to be free and be able to walk around and lay on beanbags and sort of pretty much do it my own way so I'm hoping that I'll still be able to do that if we have to go to [hospital]." [Rosie]*

They don't want an epidural and are very strong willed. One woman was adamant she will not have an epidural under any circumstance, whilst another is less assured in her abilities to do it without despite wanting to. This exemplifies one key reason why they book to a facility that makes access to pharmacological pain relief impossible:

> *"I'm hoping that I can do it with as little intervention as possible but I know that if I'm at the [birth centre] the only thing I'm really saying no to is an epidural...I've always known beforehand...that unless it was really necessary it's not something I've wanted to do...I know it's got its benefits and it's fantastic in the right place but I've just always hoped that I wouldn't have to go down that road and I think that's why for me the [birth centre] because then if I'm at the [birth centre] I know I just can't and it's just not an option unless I sort of say I'm really really terribly sorry but I need to go to [the hospital] I think there's more chance of me having an epidural I don't know whether it's pressure as such it's just that it's a much more available option isn't it I think it's more within yourself if you know that something's available will you automatically, more willing to take it or...less willing to stick with something else for longer...I think if it was there it would always be in the back of your mind whereas your mindset if you know you can't have one well it's just not an option." [Mandy]*

Care is understood to be woman centred at the birth centre, which is important to these women who believe it supports their desire for natural births with no intervention, Rosie captures this:

> *"I think just knowing that just makes you think well I want to be one of those women as well and knowing that support's there to be available to help you do it and...carry on just to...know that you're not you know it might be somewhere a bit different out of the ordinary going to the [birth centre] but you know most of the women there have a normal birth or loads of them have a water birth and so to them whatever you do there is perfectly normal it's just a bit different." [Rosie]*

They book to the birth centre because of wanting to know more about the facts of coping with pain rather than 'this is the relief you can get':

> *"yeah which is another reason we've booked into the [birth centre] session because we knew they'd tell us a bit more how to cope with the pain rather than this is the relief you can get." [Lorraine]*

They are aware they have choices even if all choices aren't offered, most likely because of being aware of the experience of others, being adamant at having a birth centre birth, and voicing this to their midwives:

> *"I'd gone in there with the express.. idea of that's what I was going to say...it wasn't like I was put on the spot to make a decision...and also I don't think I would have felt...with the midwife that she was pushing me to make a decision at that stage anyway and when I put my point of view across about going to the [birth centre] she'd written it down in my notes." [Mandy]*

They know by booking to the birth centre for birth, they have constant care from a midwife. This is an important aspect of control during birth as Rosie explains:

> *"I think because they're under so much pressure and there's so many women and...[birth centre] it's one to one midwifery care isn't it whereas I don't think you necessarily get that at [the hospital] so I don't want to be just 'oh' I don't think they would look at me as just being 'oh here's another one' but I think I would feel a bit like I'm just another one another women about to give birth in the ward and they've just got to deal with it...I want...my preferences taken into account and I don't know how much I would get that at the [hospital]." [Rosie]*

Awareness of risk doesn't affect their decisions to have a normal birth. They weigh up risk, and are aware the birth process can change and is naturally unpredictable. This group put risk into perspective, adverse is small in reality. They are more conscious of risk and do not necessarily worry about it so they do not do things that they see as complicating birth. Their awareness of risks surrounding birth is evident but is weighed up against birth as a natural thing and something that is done naturally. Risk perception means different things to different people and it is also something nature can dictate – they feel easier with nature being the dictating force more than any other:

"I think we all have different levels of...awareness's of dangers and challenges and things like that so I don't think a risk is a risk to everybody loads of things that can go wrong even if it's a very straight forward pregnancy...the baby...can get distressed and it can poo inside and poison itself or the cord can get stuck round it's neck or it can be back to front or the mother can have a big bleed and the placenta can come away, there's huge risks but again it's the most natural thing in the world...and plenty of people do it round the world with like no pain relief or medical supervision...that can happen to anybody can't it...however healthy you are or however well you've eaten or looked after yourself if something like that happens it could just happen anyway." [Rosie]

They have belief in their body and its ability. They are aware that midwives cannot give their own opinions. They are supported by others (husband/partner) in their choices and these were either made together or as a self-decision with support. They consider the wider population, think the birth centre is different/out of the ordinary, not mainstream and women just focus and book to hospital and are too quick to use epidural:

"a lot of people make up their mind they want an epidural you know before they're even you know 20 weeks pregnant or whatever, they just want anything that means they're not going to feel it whereas my whole perception of childbirth is completely opposite you know, it's gunna hurt obviously because you're trying to squeeze out a little person but...it's the most natural thing in the world but just to be drugged up and not really take part in it doesn't really seem like your involved really it's all been done for you especially with an epidural you're been told when your contractions are coming and things and it all just seems a bit alien to me considering it is so natural that in the 50's and 60's when they used to knock you out everyone came out with like forceps and things like that and then there was a bit of a coming around and that in the 60's and 70's wasn't there more sort of to natural birthing that I'm surprised that that hasn't become more mainstream really." [Rosie]

These women want to be very much a part of their birth experience and experience it for themselves. They recognize their own perceptions as opposite to a lot of their peer group and believe the mindset of women wanting epidurals should be explored, as this particular woman perceives it as missing out on the birthing experience:

"we're all built the same and pain tolerance isn't...but I think if you decide you want an epidural before you've even started your labour

then you should actually be looked at and discussed you know...why do you feel you want an epidural and to be given a choice in that respect not necessarily to take it away from them...cos it's such a big thing.. isn't it you know it's going into your spinal block...numbing you from the waist down when you're trying to have a baby that just to be given that choice willy nilly or put my name on the list sort of thing without...I'm assuming it's all explained to them at the time and what the risks are how it works and things like that but if you just assume that you're gunna go there and have an epidural anyway and then you'll be alright then I think...that level of choices needs to be explained a bit more in depth and looked at a bit differently." [Rosie]

This group are aware of a social culture which supports and promotes epidural use. They suggest there is too much choice in this regard which should not be offered too easily. An 'opting in' approach to epidural could be a way of changing people's outlook and these women suggest that a different system might be needed. They perceive that other women just conform when they've not weighed the options as Rosie suggests:

"if it was all in one site then you just booked in and had an initial assessment when you got there and you'd already spoken to your midwives about you know I might want an epidural or I might not want an epidural and if everything seems to be alright you'd stay there but if there's any sort of complication then they'd just move you round to the standard labour ward." [Rosie]

They know options and discussions should take place with midwives but consider midwives often too busy so women don't always question:

"if you're trying to juggle so many things there's got to be some element of thinking 'well that's easy we'll do that...she hasn't physically got time to go through that sort of discussion process with the lady who's giving birth...whereas normally she would sit down with you in a in a medical appointment maybe and say well this is your options you can go down this route but has she got time to do that." [Mandy]

There is an understanding of the pressures placed upon midwives and upon the service these women are accessing:

"I read something that maybe six thousand babies a year are born at [the hospital]...or something ridiculous like that that's an awful lot of

babies isn't it for...a team of midwives to deliver...and not feel there was pressure on them to divide their time...into very small chunks, they must feel they can't give one to one attention even though they probably want to and that is the ideal for a midwife to...she wants to be with one person and give them their full attention she knows she can't do that and that must be quite frustrating...I think some people just kind of accept that that's the way it is and...that midwives time is...finite isn't it...they only have so much time and if they've got 10 people to deal with...I think most people would hope that we were working towards a situation where you did get more concentrated care from the midwife." [Mandy]

Having the opportunity to talk and think about things assists with a deeper level of thought. Self-introspection and reflexive action where self-expression about certain choices can be addressed on a deeper philosophical level are made:

"they look at pain relief and how it works and that sort of thing but if you're not going to go to those then you're going to miss out on that information aren't you...but I would have thought the midwives would be the best way to do it but with a discussion rather than just giving them a leaflet...it's quite nice to talk about it and think about...making people aware of the choices within the choices." [Rosie]

Such discussions are experiences even if an experience has not been had yet. We don't have experiences of all things in life but one can self-prepare in case we need to think of it when it suddenly becomes lived.

This group believe women can be controlled and the media has a part to play in controlling what women are subjected to. They remember what they want and avoid the influence of negative external factors such as media. Everyone is individual, what happens to one person is different to that of another and no comparison can be drawn; in remembering what they want they detach from the rest:

"I think we maybe can and I think sometimes too much knowledge in the wrong hands is a bad thing isn't it I've tried difficult as it is not to sort of read all these sort of scare stories and I don't watch 'one born every minute' on the television I just won't put myself through it because just think what's the point that that's what's happened to somebody else I can only deal with what happens to me at the time and I don't read birth stories". [Mandy]

These women feel at the centre of care at the birth centre and believe it is a different philosophy of practice here than to the other hospital. Whilst the birth centre is still perceived as a hospital it doesn't feel it and is considered a supportive environment. Closure of the birth centre for them would mean they would have to conform and they would feel coerced and pressured to go to hospital as their only other choice. Interestingly, despite high self-awareness they are not aware of the information and understanding required to make an informed decision about home birthing. Mandy feels for example that her only option would be the hospital and hence she self-surrenders to the external influences of the birth centre closure. Her behaviour is changed as a result of a real pressure to go to hospital and she conforms:

> "I think I probably would go to [hospital] and try to have a natural birth as possible." [Mandy]

They remain self-determined to have the desired experience and have their preferences taken into account something they are concerned won't necessarily be possible at the hospital. This actively underpins their decision to opt out of a medical approach which they believe would result in diminished choice:

> "if any woman has a plan that she wants to go to the [birth centre] and she doesn't want pain relief...just wants a hot bath or whatever and that same women was to go to [hospital] would she be more likely to undergo an epidural or pethidine or just because it's more medicalised there and its more sort of readily available and that's how they do it rather than being given the choice to birth in the way that you want to because it's here and they've readily offered it... especially like...epidurals I know a lot of people that go to [hospital] and just have an epidural not because they've got it for a C section or...any other sort of complication but...as a pain relief really whereas that's not even an option at the [birth centre]." [Rosie]

They perceive that women generally presume a need for doctors 'to save' the situation and that these same women do not really know who does what – there is a clouding of midwives role and skills:

> "just because she's going against the usual of going to the hospital...I think a lot of people are scared of not having a doctor but I think most people may be don't realise that you don't actually see a doctor

unless you need a doctor at [hospital] or [birth centre] it would be a midwife and I think maybe there's not enough information about that and...who's involved in the birth process." [Lorraine]

In the event of birth centre closure, they try to keep an open mind, yet feel undue pressure on themselves. Whilst they see this as removal of choice at that point they would all self-surrender to a hospital birth as the only other option and hence by default to medical authority. In this context they are aware of a need to remain even more self-determined to achieve their desired birth experience.

Hospital and birth centre primips: convergence and divergence

Environment is important to both social representations however the reasons for this importance are divergent. Birth centre women articulate ethos as being the greatest importance, even though they refer to the birth centre as a hospital. Ultimately for them it is about the experience and being central in this process. They have a longer term view of the 'needs of self', and look to ensure support in labour and in the early postnatal period as the transition to motherhood begins. This is a different vision to the hospital representation women who visualise themselves in a process with the process being the primary concern and themselves being the secondary concern. Birth centre primips facilitated selves to maximise the potential to achieve what they want from this experience and for themselves.

All women had made decisions of where to birth before having any contact with a health professional. For the birth centre group these decisions would never change in this pregnancy, except in the event of needing transfer in labour, or if the decision was made for medical reasons during pregnancy. Chosen place of birth for the hospital group would remain constant despite information and knowledge gained since making the initial decision. Health professionals did not have any influence on where to birth for either of these groups.

Risk and pain for women booking to the birth centre are not the central focus as is the case for the hospital group. Rather the experience and journey to motherhood are the focus alongside the end result. The baby and getting this out at whatever cost was recounted by the hospital group as an underlying element of this process. Birth centre women were more concerned with knowing the facts about coping with pain rather than

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the available relief, divergent to their hospital equivalents whose focus was about what pain relief was available. Birth centre women did not consider home birth due to not knowing the necessary arrangements for this, nor what the role of *self* would be in this choice but pain and risk were not considered reasons for this.

Dependent upon how individual's perceived control, the birth centre group felt it was important for the *self* to be in control. Control was viewed by hospital primips as the responsibility of the professionals. There is convergence between both groups in awareness of risk and the same types of risks concerning birth, yet divergent in how they focused this awareness which determined how they dealt with risk. Birth centre women appeared to risk-assess continually throughout the process. This kept them in control of the experience as they saw themselves at the centre of it. Their hospital counterparts handed over the risk processing to the professionals. Birth centre women were aware women can be controlled, yet their hospital counterparts did not appear to have this concept. Further divergence in how to birth and the journey to be experienced is recognised. Birth is perceived as diminished at the hospital by the birth centre group. This is not mentioned by the hospital group hence we can assume this might not be recognised by them.

Birth centre women are not worried, they believed adverse risk is small and this did not affect their decision-making, factors such as what she wanted for herself in this experience took priority. Birth centre women perceived that others held general presumptions that there is a need for doctors to potentially save the situation; reinforced by what hospital women actually suggested in their accounts. The birth centre group articulated how midwives roles and skills are unknown, and is convergent with the view of the hospital group who believed that doctors hold hierarchical supremacy.

Hospital multips (SR3)

This social representation (SR3) is compiled from the narrative experiences of three multigravida women. Each had a previous or current condition such as; cholestasis; previous Group B Streptococcus and slightly raised BP in labour; or suffered with migraines since puberty. They were booked for consultant led care. Not all had seen consultants in this pregnancy for these conditions. They had care by midwives.

These women acknowledged their previous pregnancy selves as, young, scared, naive, weak and not strong enough to voice themselves, but consider themselves differently this time because of experience, knowledge and maturity and feel more assertive. Knowledge has made them, more prepared, more self-assured and confident in what they want this second time because of previous experience:

> *"well this time, at the time I think I was a bit younger I didn't really know what all that meant...this time I have had a talk to my midwife and said I really don't want that to be the case this time if I can help it...unless there is a real medical reason for it which I know hypertension...or pre-eclampsia is but I'd rather things happen naturally I think I felt like things were taken out of my hands a little bit.. and I think if I had been stronger I would have probably said 'can we wait and just see and just monitor it more' but then you never know whether your health and your baby's health's at risk I think that was the weighing it up and when a consultant tells you that's the best option you tend to go with it but I think in hindsight I'd have preferred to go into labour naturally."* [Jose]

This group state 'naturals' and 'positives' in relation to birth but their accounts suggest they do not fundamentally believe in this ethos but rather give it lip service as it is expected. A good result is seen as a good experience in the end whatever the journey to achieve it. A previous negative experience did not influence decision-making to change birth place environment to avoid this again. Jose illustrates this point turning a negative experience into a positive one in surrendering to an epidural at a time she didn't want to, but later justifies this as useful for suturing:

> *"and I suppose there are lots of other advantages such as I had to have stitches...I suppose that took the pain away for all that...but I suppose the disadvantage for me would have been it would have been nice to have been in a different position maybe tried a water birth...I think at that stage it wasn't stressful but it just felt out of my*

control then so that everything else all the other options had been taken away we were going down that route and that was it." [Jose]

Despite the negative experience of receiving an unwanted epidural, Jose turns this around into an advantage. The negative experience became a positive one in her eyes through self-justification as she relates how the epidural counteracted the pain of stitches. She did not consider the epidural could have potentially contributed to her need for suturing, nor if she had laboured upright and mobile not flat on her back with the epidural, or had been allowed a waterbirth, she may not have had to incur such morbidity.

For this group, having experience of something means 'knowing', whilst no experience of it means they cannot know:

"just, basically, that it was an imbalance of the bile acids in my blood and...to be honest I was a bit...scared then, because I didn't know, obviously, I'd never heard of it before, I didn't know anybody who'd ever experienced it before, and then one lady come in and basically just blatantly outright said 'Oh, if we don't get your baby out in so many days your baby could die." [Nicola]

This illustrates how not knowing can be perceived, furthermore how it influences and reinforces what is not known and the experience of 'knowing self' in situations. No self-assurance or self-confidence means when these women are unsure or do not 'know,' they will knowingly surrender to someone else:

"as far as I was aware, they were all obviously people from the hospital. They could have been anybody in there and I wouldn't have known if they'd come off the streets or anything, 'cos I wasn't in that frame of mind to know. But at the same time all I wanted was for them to do what they needed to do. Still tell me what they were doing, but I wasn't really taking any notice. But I know they were saying 'the best option would be', and 'do you want to' and I was just saying 'just do what you want' and that's the way I felt, as long as they did what they wanted or thought was best I felt safe. But as I say, I wouldn't have known anyway, even if somebody had come...and said I think you should so and so, I'd have just said 'yeah'...I wasn't in control but that was only because I couldn't be...but even still if I was in control, I would still just say to them 'I'm in your hands, you know what you're doing, just tell me what to do', type of thing. And I would do everything I could to help it run smoothly. But that's the way I always

have been anyway with risks and anything in life. I've just trusted that person...even if it has come out where you shouldn't have put your trust in the...I've always trusted everybody and it's just a way of life I've gone through." [Becky]

This illustrates, in the face of not knowing how a positive end result is paramount and being comfortable with a situation may depend on what someone else knows; comfort with whatever is expressed as long as the person knows what they are doing.

In making choices these women 'counted in' and 'counted out' certain options. To the birth centre, accepts that an epidural is not an option. At hospital however, there is an acceptance that this facility and the anaesthetist are there to provide this service when it is required as Jose illustrates:

"if I decided to go to the birth centre I think I'd be accepting that I wouldn't be having an epidural that would be part of that decision making...I think if you go into...[the hospital] and you know that there's an epidural available you assume that when you need it, it will be there...one of the reasons I would choose to go to [the hospital] if I do need to have an epidural the choice is there...and I would assume then because I've chosen [the hospital] to go to there would be an anaesthetist available for an epidural." [Jose]

They know what they want and ignore everything else despite having options given. For Becky her midwife engaged in conversation about the choices she may want:

"she asked if there was anywhere in particular first that I wanted to go and I said straight away to the [hospital] and she told me about the other options and that I could still take a leaflet home but I just said I was more than happy there so I'd like to go back." [Becky]

They do not necessarily expect choice, are not bothered about it and in view of this they would not make any other choice even if they were given them all:

"I've never really changed my mind and said 'oh, no, I wanna go there', or 'I wanna do this'. It was just, the first time it was kind of that's how it was because they wanted to get her out and things like that. But em, no, with this, they've never actually said 'would you like to have your baby at the [birth centre]. Do you know, it's never been,

like, put out there...but then again I've never said 'I'd like to have a baby at the [birth centre] so it's a bit of both really." [Nicola]

They voice that choices should be down to *self*, it's personal preference and women should be 'empowered' to make choices. They voice this, but do not follow this philosophy:

"so you can kind of gain some control over what's going on and feel a bit empowered...you can make decisions and feel that you know if you want something to happen then other people help you and support you to make it happen but then...I think that scenario's great but there's also a balance between the risks and you know working in the NHS and having the kind of background I know that sometimes people make decisions and feel empowered and want to be empowered." [Jose]

These women reflect on the environment in which birth occurs, not the experience of birth. The hospital environment is perceived as the professional's domain, and these women refer to 'asking permission' and 'being allowed'. This group perceive it is the best place for them in understanding it to be the safer option due to the available facilities which are believed to reduce intervention. They feel comfortable in this environment because it is perceived as the best in case of whatever happens, professionals know best and they are happy to do as the professionals say, hence self-surrender to them:

"I'd put my trust in the doctors and in the cons[ultant]...I mean, you do obviously, consultants, doctors, midwives who are a hell of a lot more clued up than you are on birthing and, you know, they see it every day, so me personally, I'd just put my trust in them and whatever, unless I had like a really bad need to be at [the birth centre] or to really want a home birth and things like that, if they didn't recommend it for whatever reason, you know, because of some complications that women can, can have, I'd just go with what they say really, because obviously they're the professionals and they know what's best for you and your baby." [Nicola]

Hospital professionals are to be trusted, self-preparation stops at the hospital when others take over. Anywhere other than hospital is perceived as putting yourself at risk:

> *"I'm the type of person that...wouldn't want to think that was going to happen so I'd make sure I wasn't in that scenario at all. I'd make sure I was there and I'd be alright."* [Becky]

Becky was totally against birth anywhere else other than the obstetric unit, she didn't see any point in planning somewhere else when you would have to be transferred in the event of problems. This exemplifies birth as risky:

> *"this is why I see a hospital as...you know you've got everything there, you don't have to do that travelling...That's the way I see it, that's why I'm totally against anywhere else or home births...because I think of what if and what...but what if this happens. Even if I had a perfect birth, I think I'd still like to be there because I know if anything happened I'm there, I'm with the people that can do the jobs...and it's not because I wouldn't trust my partner or anybody either, it's just because I wouldn't like to be in that position where you're thinking... what if it's going to do this and what if that's going to happen, and, you don't think in the next ten minutes is it going to have to get rushed to hospital, you just want to get the baby out."* [Becky]

Transportation via ambulance appears to be a shared consensus:

> *"I think that's probably a reason why when I've spoken to other people who are expecting that's their scenario as well of not going to the [birth centre] being transported in an ambulance because that's putting another level of risk there."* [Jose]

They consider the event of having to be transferred by ambulance from either home or the birth centre environments as off-putting, and feel at that point they are at their most vulnerable and not in control of the birthing experience.

Relationship development was attributed to women and midwives, not women and doctors/consultants. Doctors are the hierarchy and these women looked up to these professionals. They are not comfortable in challenging the professionals and despite describing selves as being different and not as weak in this pregnancy they still present themselves as such in relation to professionals who know they continue to believe know best.

There is an element of self-blame for what happens, which is perceived as a personal responsibility if anything went wrong:

"there's so much pressure that's on your body and, you know...
you've not just got yourself to look after, you've got like, this life inside
that's depending on everything that you do from one day to the next".
[Nicola]

This creates compliance which is furthered by fear or pain. These women are aware they can feel coerced and are 'too trusting too easily', they take the situation at face value and believe all that is told to them. The extent of coercion and self-surrendering occur at different points in the birthing process:

"to be honest, I just went with whatever they was telling me, because,
obviously I didn't have a clue about it and they were the
professionals, so...I just went with it and...they asked if it was okay,
obviously I was just.. 'get her out if you need to' as long as she's safe
that was the main but they did say that they don't like cholestasis
patients to go after thirty-eight weeks...that's why they got her out. I
think I was about thirty-six and a half, thirty-seven." [Nicola]

For Jose this was in relation to epidural anaesthesia and not being able to have a choice if and when she wanted it:

"at the time I was told by the midwife I had to decide...I don't know
how many centimetres I was dilated and I was coping okay I'd tried
gas and air and didn't get on with it.. I was told by the midwife if I
wanted an epidural I had to decide there and then because the
anaesthetist was going into surgery and would be in surgery for about
2 hours and the baby would be born before then...so I had to decide
quite early on." [Jose]

On the one hand they want the 'other' to have control because they are scared of risk and have a primary focus on things going wrong. This is not without acknowledgement they self-surrendered:

"the first time round I let everybody do it for me which was, I shouldn't
have done really but I was more nervous and...yeah, I trusted people
more than myself the first time." [Becky]

Self is perceived as having little or no control, despite this being undesired at times, on the whole they remain unquestioning:

> *"that was where they advised me the best thing to do and I remember saying 'just do whatever', because I didn't feel I wanted to be in control, I just wanted them to get the baby out, 'cos I was in pain and I didn't care what was happening at the time. But obviously now I would, you know, I wish I was more in control. But if you can't be in control then you can't be in control."* [Becky]

Someone else is considered to be in charge of this practice and they are only a product in the process. Becky, due to her physical state, her migraine, wanted the process over with because of the negative effects of the experience which she felt influenced her capacity at this time. Self-regret is evident but it is not perceived that control is possible because of this physical state and she accepts having no control:

> *"No, no, I know that I give it to them but I know at the same time, even if I wanted to be in control, I wouldn't have been able to have been because of the migraine. I knew full well that I'd have to give everything to somebody else and just say sort it, and I think I actually did just say 'just do whatever you want' and I was even saying to my partner 'let them do anything they want because I need to get the baby out'. That's the way I felt in the pregnancy and the labour and everything. I felt as if, they know what they're doing. They know what's the safest option. If I'd have said no I don't want the epidural and she said to me well it's going to be safer and it's going to be this and it's going to be, I'd have still, I'd have just let her do it because I wanted it to run smoothly."* [Becky]

The availability of expertise and facilities just in case things go wrong and to ensure baby is safe, underpins the decision-making about where to birth:

> *"So I think you always have a possible risk, but it's whether or not it comes to it, whether it's going to happen or whether it isn't going to happen. But I like to think, em, that I've been aware of 'if and but' as well. So I'm always prepared if anything did happen, I knew, I do look on, like, the downside of things maybe a bit too much but I know that in my own mind I'm prepared for that as well, whereas I can see it knocking a lot of confidence and things as well...but I think if you set your mind on one thing and the opposite happens it's a big letdown like a lot of things in life...so the way I see, like, pregnancy and labours and things, you've always got to have an open mind in that."* [Becky]

Keeping an open mind means there are no preconceived notions about what they want from this experience. The experience is secondary, primary concern is the safety of the

baby. Consequently, the open mind is exposed as self-surrendering without question to those seen as an advocate.

Birth centre multips (SR4)

This social representation (SR4) is compiled from the narrative experiences of six multigravida women booking for the Birth Centre. Despite these women experiencing their second or third pregnancies they still remained unaware of birth place choices.

Four women showed no evidence of being emancipated in decision-making whilst two did demonstrate these characteristics.

These women knew what they wanted before seeing a health professional. Once again experience is the focus but wanting a full and positive experience this time, within which they are central. Previous negative experiences such as being rushed; lack of information; self-doubt with breast feeding and no support are reasons for wanting a different experience this time:

> *"we always said we'll go to [birth centre] next time cos it's... more laid back and...we felt we were a bit rushed...out of [the hospital] a little bit even though I was there for a day and a half."* [Mary]

> *"the fact I felt happier being in the birth centre without kind of doctors and all the other things on hand, knowing I had somebody there full time...I felt like I was safer than I was...where I was actually...a hospital...I didn't really see somebody very much apart from my husband."* [Linda]

Support is paramount. The expression of 'try to do it normally', conveys elements of self-doubt and illustrates these women were not completely self-assured; seemingly due to not previously having birthed completely independently.

Anxieties were still experienced because of knowing what to expect and remembering previous negative experiences. Experience changes people's ideas and perceptions as Louisa explains about her sister-in-law who thought Louisa was stupid for not booking to the hospital but then changed her own booking to the birth centre:

> *"she's changed her mind and I was like that just goes to show that all the stuff that [she was]...saying before about 'oh but you have to sign... this that and the other...one 5 hour bad experience of been left waiting and everything's changed."* [Louisa]

For Louisa herself it was the experience of the midwife giving her what she asked for with no discussion or alternative solutions:

> *"I think at that time...I was in that mind set I was in all this pain and it had all just happened I was very...confused and I had no idea what to expect as far as the pain was concerned and looking back on it I think if someone had said look this is meant to be happening this is a thing you know your body's working properly if they'd of examined me and said you're however many centimetres do you want to try the other stages first...I would have gone with it." [Louisa]*

Physical care (e.g. urinalysis, BP) is understood as a sign of wellbeing, that everything is okay. No psychological wellbeing is discussed or acknowledged throughout the narratives, however, the concept of mind and body were perceived as being separate entities. This was perceived as a dual role - her physical body does everything to ensure normality is maintained, and her self-identity, that does not have influence over the workings of the physical body, can assist her in the process of her body having ultimate control:

> *"you're never really 100% in control because it's your body isn't it in control...your mind doesn't run it does it, yes yes you can relax and do your breathing exercises and you can...on a ball to help you and stuff like that but your body does what it needs to do it needs to do at the time doesn't it really." [Mary]*

They are not bothered about knowing a midwife throughout as midwives are perceived as skilled medical staff. They aren't always aware of what midwives roles and skills are, Julie, despite booking to the birth centre does not know if midwives are skilled to give first line medical care in the event of a problem:

> *"I would have thought so...I would like to think so...and I just assume that...if there is any real problem that you would immediately be put in an ambulance and transferred to [hospital] anyway." [Julie]*

They are conscious of risk and acknowledge a problem can happen to anyone at anytime, however professionals are trusted and these women have self-confidence in the midwives to perform the necessary tasks in an emergency. They acknowledge risk is normal, but that it is the risk culture in which we live that means we should

acknowledge risk as waiting to happen. Subject to the wider common perceptions of the birth centre not being safe/more risky they put this down to others not understanding midwives skills:

> *"I think very much the view of the [birth centre] they see it as a risk because people automatically see it as there's no medical staff there that they're seeing the birth centre as a risk and I'm er, there are medical staff, there midwives are medical staff." [Louisa]*

How women perceive risk determines where they'll give birth and reflects how they think about birth, the decisions they make, and how they perceive professional roles in different environments:

> *"you need medical staff absolutely...but then not so much as the ones in [the hospital] I view them more medical...more medical intervention ...the whole set up and I think the community and [birth centre] very much more natural...more patient led". [Louisa]*

Control is understood as doing it naturally everything other than natural isn't being in control. Not having control in birthing was the reason for previous negative experience. Angela expresses her thoughts on an epidural:

> *"I know it sounds daft but I didn't like the...procedure that came with it like having to obviously not being mobile...obviously you have the catheter...I just didn't like the...I mean there's a lot of down sides to it like some of my friends have had it and have suffered with...their legs or their back and I didn't want any of that and I just wanted to do it for myself." [Angela]*

Control isn't just having what is desired but how it is individually experienced:

> *"I suppose of how you do it of how you have your baby and where...I think control is like letting your body do it naturally and giving your body the control to do it and not handing it over to someone else like saying...you know I'll book it into hospital...you're kind of giving someone else the right to do it for you." [Louisa]*

Negative relationships with professionals resulted in negative experiences as June conveyed when she went to see her midwife in early labour. She began to think about

changing birthing units to facilitate the epidural option because of what the midwife was saying to her:

> *"because she sort of turned round to me and obviously said it was only going to get worse and you just think 'oh', that's the worst thing you want to hear." [June]*

They put their baby before themselves, with regards to safety. These women self-sacrifice for the sake of their unborn precious baby and are altruistic in this concern. They know what they want, trust their bodies and are self-reliant this time having not had the opportunity to be last time. Julie experienced a lost self-identity in her first birth which left her scarred, she realised that she self-surrendered:

> *"because I've had the experience now twice you know when I first got pregnant I was...22 I was quite young still and I was very scared because I didn't know what cholestasis was and was just told to right that's it we're admitting you and you know I didn't know what it was and I didn't know what was happening and I was very scared so I just went along with what the experts told me to do." [Julie]*

The birthing process is perceived as natural and pregnancies are seen in their own right. These women are conscious there is no control over nature's development and yet they trust in nature. They are conscious of a change in self-identity this time round and feel more self-assured and self-determined, ensuring others' recognise their personal authority. This is due to being older, having more life experience but also as a result of previous experience and knowledge, and now knowing what to look for. This changed self-identity makes for less panic. They build self-assurances, everything factors on the *self* and what makes *self*, must be understood by them and understood as to why and what they feel as Julie expresses:

> *"different priorities whatever you feel is the most important thing to you whatever you think is going to help you the most if you want to have all the pain relief possible and all the drugs possible or if you want it to be as natural...I suppose influence from all...the external influences from your partner from your mum people who you've seen give birth have babies at other places it's everything, everything has a factor on it really." [Julie]*

Deciding on the birth centre was made based on past experiences. If the birth centre closes then no other choice is perceived by them. As they have never been told in their pregnancy experiences about the third home birth option they subsequently have never asked about it.

They experienced previous feelings of being unable to voice *self*, of being trapped and powerless and view doctors as superior in the hierarchy and consequently self-surrendered under their influence:

> *"I was very scared...I didn't know what cholestasis was and was just told right that's it we're admitting you and...I didn't know what...was happening I was very scared so I just went along with what the experts told me to do...I went to [hospital] the consultant had printed me off some information from a medical website and just gave me the paper to read...nobody actually sat down and said to me this is what it is, this is why we need to induce you and I was terrified I didn't know what was going on I didn't know anything about it... I was really really scared but I was just going along with what I was told what the medical experts were telling me to do...because I didn't know any better...because it was my first baby, because they know what they're doing they're the experts you know...I was really scared". [Julie]*

This group of women ask questions now, are self-aware, assured and determined because of these previous experiences:

> *"had a bearing on the labour definitely because...the more...I've experienced I've seen my sister and friends who've had their experiences and the more I've come to realise that...you're frame of mind and attitude of where you are really really affects how your labour goes and I really do believe that it has a massive impact on it so obviously that kind of frame of mind I was in didn't feel ready absolutely terrified strapped to monitor...and then I was on the drip and I couldn't walk around and I couldn't move and...I felt like I was trapped and I couldn't do anything so it was very very negative."* [Julie]

They assume in a hospital setting, that it is generally someone else other than themselves who have the right to decide. Things were previously taken out of their hands. The time pressures on midwives are acknowledged and despite a consciousness that midwives are over worked, under staffed, and an awareness of the

tightrope midwives walk between women and their work, this diminishes the woman's place at the centre of care.

These women are not averse to going to the hospital but recognise a need to maintain self-reliance and determination and assert their preferences and choices. They believe that hospital does not focus on mum and view care between the birth centre and hospital as woman centred versus medically managed. Hospital is perceived as completely medical and the birth centre as having women at the centre of care, which creates recognition that the experiences will be different.

It is evident that knowledge is not always consistent and consequently they are self-led in finding out information. This results in a more determined approach and a recognition that self-realisation is as a result of experience and communication with others. Further, there is an awareness that women trust professionals unquestioningly and professionals as sources of information are in a position of power. Professional language impacts significantly on women, yet these same professionals are not aware of how they say things to women and such comments can be construed or misconstrued resulting in women being compliant as Julie exemplifies:

> *"well where else do you get your sources of information from really cos if you don't have any experience of giving birth, being pregnant you don't have any source of information apart from these people so they sort of don't realise how much of a position of power they're in do they really...I don't think they realise...that they say things and how much it does have an impact on people you know just these kind of throw away comments like 'right I think it's better if you do this or you really should and...it sort of sticks with people I think."* [Julie]

Home birthing multips (SR5)

The social representation (SR5) is compiled from the narrative experiences of two women, recruited as antenatal participants but due to both giving birth ahead of the planned interview date, they were interviewed following the birth of their babies. They represent a woman booked to birth at home and a woman booked to the birth centre whose baby was unexpectedly born at home.

Due to the nature and unpredictability of birth this unique group evolved by chance. A pragmatic decision was made to interview using both antenatal and postnatal interview

schedules in light of this. Whilst they were recruited as antenatal participants, they had gone through the complete decision-making process in this pregnancy; hence it was not appropriate to consider them simply as antenatal participant women in isolation. Time constraints and the depth and quality of existing data demonstrated further recruitment of two antenatal participants was not necessary. For this group, the antenatal scenarios operated as a catalyst to compare 'selves' with other's experiences'. These other's experiences could only be speculative. These speculations did however mirror how they felt about things at times during their own birthing experiences.

Home birthing women have a tendency to be emancipated in decision-making. The power is shared, transmitted between them and the group of experts. They have a support network of others who they view as important. Emancipation it appears, transpires as a result of confidence in others, self-assurance and self-reliance as a result of experience. They do not need to be an 'older self-identity' for this to occur; it is down to the 'lived through' experience that changes self-identity and self-concept. Their self-identity means they have the knowledge and do not need the actual experience to 'know'. For example a waterbirth, they do not need to have had this experience to know how they will feel in labour or what labour pain will be like. This appears to be because of their prior birthing experience even though they have no experience of giving birth in water. In reference to pain, it is an understanding that one has to go through it to know it and once experienced in principle, when parallel pain experiences occur these can add to the overall understanding of knowing the experience.

These women tend to be laid back due to having had different experiences to draw on and self-realisation of how they deal with it. They describe themselves as not being very good with pain relief and they have a positive focus on pain, putting this self-expectation of managing it central in their minds. This positive outlook means they are self-reliant in managing it as Anna demonstrates:

> *"Yeah, then I phoned, 'cos the contractions were getting quite strong...so I rang [the birth centre] and said you know, they're... lasting this long, they are quite strong...but I can manage pain quite well. And she said, 'oh well you sound okay', she said, you know, 'have a bath, two paracetamol', she said, 'but just to let you know, we have got two people in."[Anna]*

Anna knew managing the pain herself was her only option which underpins the need to be self-reliant as there was no available room at the birth centre for her admission:

> *"So she said 'when they're five minutes apart and they're closer together, then'...'ring us back and hopefully we might, one might have finished'. She said 'but if not, you will have to go to the hospital' so that really did put a downer on me and I thought, I don't want to go there so I thought, I'll hang on." [Anna]*

Anna felt unhappy at the prospect she might have to go to the hospital and her choice was being taken away. Self-assurance and determination support her to continue managing and she zones in on the pain to avoid a hospital admission:

> *"When I'm getting strong pain I zone in on the pain and I can't think of anything else. I couldn't think of ringing people, doing anything I just laid in bed and he...laid next to me, massaging my back and things, and I just totally got in, zoned in on the pain." [Anna]*

Her positive self-reliance surpassed the self-realised birth choice, hence avoiding of the reality of a hospital admission. Self-realisation that this was not what she wanted underpinned self-assured pain management to avoid transfer to hospital.

These women don't look to the environment and what it has in place if required but to the skills of their midwives. Doctors are perceived as being different, but their midwives are held in either the same or higher regard than the medical staff:

> *"I'd already given birth at [birth centre] I thought the midwives are just so brilliant I just thought I had so much faith in them I just thought what's the difference [at home]... [the] community midwives you just think...what's the difference you're at the [birth centre] and if anything goes wrong they transfer you by ambulance to [hospital]...and if anything goes wrong [at home] they transfer you by ambulance to [hospital] so what's the difference between being at the [birth centre] or being at home...you see it was a case of you've got somebody who makes a decision you have to trust the healthcare professional you are with and if they're 'no I'm not happy with this and I want to transfer you' you have to just go 'right you're the professional you know what you're talking about I don't I'm not a midwife I'm not a doctor so no I was quite happy that if anything went wrong and if a midwife said no I want you in that was it I was I'd just go". [Janet]*

Experiences with midwives can either be good or bad and may have been a definitive factor that facilitates emancipation in decision-making. Previous experience impacts on this additionally and can provide an empowering influence for her.

Midwives are generally perceived as positive but women are aware practitioners are different. Differences relate either to their ethos or professional knowledge, and the passing on of this knowledge to women. This group are aware what you are told may not always be correct. Some professionals engage differently and pick up on what women are saying. Clearly with these women, there is evidence of a relationship between themselves and their midwife where a joint relationship and respect has developed between them. This supports self-assured decision-making. This is illustrated by Janet as she discusses her decision to have her baby at home:

> *"I had the back up of having known a couple of people who had done it as well even though it wasn't in this area and I think because I knew the midwives so well and I'd known them for so long...I'd had that trust in them whether I'd have felt differently you know if there's a whole new bunch of midwives but then you've got nearly 10 months to get to know them haven't you really." [Janet]*

Janet describes how she willed herself into labour that night so she could have the midwife she wanted to complete her experience:

> *"because we were at home and the atmosphere and the fact that it was [her midwife] that made a big difference that was just lovely for me cos I've known her for such a long time now that to get her, the chances of actually getting her here I think my brain had gone [midwife's] on call tonight." [Janet]*

For Anna this relationship was one where a particular midwife had picked up on what she was saying when Anna was told at a previous appointment she could not book to the birth centre because she had a previous ventouse delivery:

> *"I said that I was getting acupuncture and I was doing this and doing that and she said 'oh, well it sounds like you'd be better off going to the birth centre'. Yeah, and I said 'well I wanted to...she said 'oh, well why not'...I said what the other midwife had said and she said 'I don't think that's right'. She said 'hang on a minute'...she rang through to the birth centre...and told them...then I got a letter...saying they'd*

*looked over my notes from my first pregnancy and have decided that
I'm welcome to register there."* [Anna]

Anna expressed how she felt about this being a chance encounter and how it could
have been different:

*"Well, a bit annoyed really, because if I hadn't had that chance
conversation, and I'd got all prepared that I was going to [hospital]...I
was a bit annoyed but I realised that it was just that one midwife."*
[Anna]

For Anna, her supportive other was her husband as they birthed their baby together.
She describes the experience as being a jointly shared experience and it was important
to her how well they had done this:

*"I think he just got on with it...he was really calm. He said to me the
first thing he thought when the waters went was 'bloody hell...I'm
going to have to clean this up'...he just got on with it...he was just in
awe of what had happened and how we'd all, how he'd delivered his
own son. You know he said he was sat...having a pint in the pub and
he said he could have just cried and cried because he just looked at
everything completely differently...I think they miss out on that when
you're in hospital...he didn't have much part or say in [first child's]
birth, whereas this time he had such, obviously, a massive part of it...
he he's, just a changed man, just in complete awe of it all."* [Anna]

Experience for these women is very much seen as shared and they have faith in
midwives. Experience and the sense of being laid back shows a sense of change in
pregnant self-identity. This change in self-identity develops due to knowing self,
limitations of self and an ability to be self-reliant. They have self-expectation of
effectively managing the process and know their physiological capabilities due to
experience and intuition. There is a reflexive element of looking back at *self* and seeing
self as changed as a result of experience. Anna felt birth changed her forever, the
extent of how profound this is, is realised by her:

*"When I look back at my second one [birth], just amazed, totally in
awe...at what your body can do. At how it just takes over and
obviously it pulls in your mind as well, because I didn't think of
anything, it just was focused on giving birth. So the human body*

amazes me and I look at things definitely, I'm so more, it supports my argument for complimentary therapies...and doing things natural. And it just gives me more evidence that, you know, medical intervention has become too much...has taken over...I just look back on it and I'm really happy about the whole, even though it was totally unplanned, I felt great afterwards and just the whole way. Whereas, when I look at my first, I do feel guilt at how I didn't have as much of a say, and I didn't have the connection and the whole ventouse thing and how it was taken out of my hands and I didn't really have much of a relationship with the midwife. It makes me feel guilty to my first one that he didn't, that I didn't have that birth with him. So it still affects me now, the birth I went through and people say, you know, 'oh, I'll just go to the hospital' and that. They don't realise that you think about that day, you can think about it and it can have an effect on you for years ahead, towards your relationship." [Anna]

This enlightenment meant Anna looked at things differently as a result of her experience. She is fulfilled, has self-realisation, self-awareness yet self-blame and regret at being unable to be heard previously, and how control being out of her hands changed her. Not having the connection and no rapport with a professional was a catalyst for change in her. Yet it took 'this experience' for her to realise this. Logical reflective thought therefore enables self-realisation to occur.

These women do not have fear as a focus. Fear is considered as a predetermined realisation and it is important to train *self* into not thinking about preconceptions but to 'empty the head' and think. To zone in on what one is experiencing at the time. These women do not hold preconceptions. They have a positive outlook and have a firm belief that there are always options even if a situation escalates, as Janet conveys:

"why would anything go wrong...you know if it's gunna go wrong I always think if there is a risk you know by the time you're going into labour anyway I know there are risks that happen once you're in labour but because you've got options when you're in labour of moving and getting...you know even if it was rushing into [hospital] and having a caesarean it's still an option isn't it." [Janet]

They have a positive realistic understanding about birth risk and feel there is no more risk with home birth, anymore than any other environment. There is no right or wrong decision, it's what fits the person but they fundamentally 'look to self' to find the answers, to consider what things mean to you as Janet explains:

> *"I think you need to look at each individual woman and say what kind of person are you...how do you feel about pain...how do you feel about childbirth what is it to you, what information have you got and give them the right information and then let them decide on how they feel about everything because not every woman could give birth at home and not every woman wants to give birth in hospital everyone is so completely different."* [Janet]

They focus on risk differently. Other groups who perceive risk differently consider being in a hospital situation with technology as a way of addressing and reducing risk and understand this as being in the best place for risk to be dealt with by something other than themselves. Environment is not what these emancipated women look to in respect of facilities for risk management, but only for being able to achieve what they want for themselves in this environment. Being transferred from the birth centre or home to hospital in the event of an emergency is not viewed as a problem to them. Others (SR2), who view 'being seen' to be transferred if there is a problem, display their self-identity in this situation, as being 'on show' and this becomes of primary importance for them. This is not replicated within this SR5 group of women who do not see transfer to hospital an issue. It is reasonable to suggest this is due to a changed self-identity and self-concept as a result of previous experience. To a greater extent they see themselves as of secondary importance to the event. The event is of the primary importance not just in being important to transfer if needed, but important to them in a long term primary sense of self-identity as Janet evaluates:

> *"and if anything goes wrong they transfer you by ambulance to hospital so what's the difference between being at the birth centre or being at home."* [Janet]

Environment was not the concern to them but the type of birth desired was and hence their decision-making aimed to ensure that they would put self in an environment that would provide the optimal chances of getting the desired experience. It is perceived as doing it right for themselves and hence their self-concept rather than as something dangerous/risky. The potential of risks did not result in a questioning of the environment, even in light of experiencing previous risk situations at first hand. Janet puts risk awareness into context describing how she perceives it:

> *" it can be risky but when you have to look at the figures and the number of natural births and the number of successful births against the number of sort of complications and what the complications are and that kind of thing and when you've got all that information and the figures to back them up because if somebody said ooh birth is really risky you could die giving birth and then somebody said yeah but there's a 1 in 6 million chance if you die giving birth that may sway your decision...on whether you're gunna give birth or not." [Janet]*

Experience means they do not feel out of their depth or frightened of pain. These women are not frightened because they are more self-assured, self-determined, self informed and independent in terms of self-regard. They are more positive and aware of their self-concept. A self-concept informed by previous birth experiences makes them want a different experience this time. Anna expresses how she felt in her first birth:

> *" I do feel like I was looked, sort of controlled, told what to do, em, and also confidence because I was young, whereas this time round I know what I want, I'm not frightened to say what I want. So you've got a lot more confidence and I think people pick up on that." [Anna]*

In knowing their own bodies and what they want they stick to their instincts, recognising and engaging with that instinct. They acknowledge that we should listen to our bodies and so should others:

> *"I think they just leave it to the medical staff because they feel like they know better. What they should realise is we know our own bodies and...you should always stick to your instincts, and I did doubt what she said and I should have followed that up more. So I think we should always go with our first instincts and listen to what our bodies want. [Anna]*

Upfront discussion was evident with this group and when options looked like changing or did change an obvious weighing up of options occurred after pursuit of the information. They asked questions, questioned assumptions and followed up doubts. In turn they questioned professionals and voiced themselves until they had satisfaction with what they were being told. They present a comparative *self* with regard to others and others with them and are viewed by their peers as being brave in light of pain and risk. Their view however, is they know their bodies, have instinct and although they trust in midwives they also have the self-assurance to trust in themselves and use their

instinctive behaviours for comfort. They are aware that they can aid the birthing process and aid nature by the decisions they make, hence have proactive determination in light of options being taken away.

These women support their decisions with contingency plans. These are different to birth plans because there could be change in the process which requires a contingency of recognition to occur in the event of change, whereas a birth plan is concerning what the process will involve. Janet self-prepares a contingency plan as she does not know how events might unfold:

> *"it's alright having a plan and you also have to have a backup plan because you don't know how your birth's going to go so you know they kind of guide you into...having a birthing plan but if I if people ask me about what did you do I said I had a vague plan but in the back of my head all the time was this might not go to plan have a contingency plan."* [Janet]

They surrender to nature and to what baby requires. Control is seen as in the hands of nature in relation to what their bodies 'told them'. In this, mind and body are perceived differently because 'self-identity' has no choice in the matter. The body was focused and viewed as being in control. Anna situates the act of self-surrendering to nature in context:

> *"being sat in the bath having contractions was horrific... I didn't enjoy it but just the idea of having an epidural takes away your natural body's instinct. You can't have, obviously I haven't had one but from what I've heard you don't feel when you need to push and you don't feel this and that. And your body just takes over, I mean my body just took over, I didn't plan to go on all fours, it's what my body told me, it was just, that was it. I didn't have any choice in the matter."* [Anna]

This implies a sense of separation of mind and body. For the body to manage this event, rather than self-surrendering to nature, it is the self-surrendering of mind to body. In this sense, it is suggestive that nature's physiology does this with both woman and fetus. The woman has no control of this, it is inevitable and this marks a critical moment in an undulating trajectory to 'marker' that this was the point her mind submitted to her body as it submits to the physiology of the birthing process.

They recognise that home birth was not for them in their previous pregnancies as they would not have felt comfortable. Stereotypically these are for women with 'big houses'. The definitive factor for these women in this current pregnancy was a removal of choice. Choice due to the birth centre being full as previously portrayed in Anna's narratives or for Janet in the closure of the birth centre:

> *"we just kind of just booked into [the birth centre]...just because it was...to be honest it was easier going to [the birth centre]...than having a pool there ready than faffing about at home and then they closed it...and so when they closed [it] we thought 'right fine we'll just get a pool and we'll have a water birth at home instead." [Janet]*

Women are seen to opt-in or opt-out of certain choices. If these choices were not made available to them then they choose what they perceive to be a similar option.

Implications of interviewing some women postnatally

Smythe (2011) suggests there is no right time from which to gain perfect perspective and a woman's experience will be recounted differently after her birth. The position that both these women were interviewed postnatally does not weaken the analysis overall and does not allow any assumptions to be made that might skew findings overall. These women it could be argued are a group that strengthens the sample and adds to it. Moreover it may be considered the implications of interviewing these women after the birth might argue they appeared emancipated simply as a result of birth 'turning out well', especially in the case of Anna who unexpectedly birthed at home with no midwife present. These women's expressions within their narratives highlight of how they perceived the birthing experience and how they presented as self-determined and questioning individuals in a situation where their choices were reduced, they searched for other options and did not just accept given alternatives. These women illustrate characteristics of *self* that will be discussed later in this thesis that demonstrates their strength of *self* rather than considering whether this might have simply been because birth worked out well in the end. Moreover Janet had a history of knowing her midwives and she decided to opt for a homebirth following discussions with them, whilst Anna following communications with a birth centre midwife who she did not know, decided to remain at home in labour due to having been told at that time she could not be admitted to the birth centre. What this does highlight is the supporting and empowering

relationships midwives can have with women that enable emancipated in decision-making in choosing what is right for them.

Convergence and divergence: hospital, birth centre and home multips

Hospital multips (SR3,) focus intensively on things going wrong and they have a negative perception even though it is not their intention. Whilst they see themselves as vulnerable beings in this process they still highlight natural and positive aspects. SR3 women do not expect choice and do not seem too concerned about having this. They are divergent with the birth centre multips (SR4) whose focus is the experience to be had, much like the SR5 multips, rather than the means to the end ethos of SR3, in whatever that good result took to happen. There is convergence in an awareness of the risks of birth between all three SR multip groups, but divergence in how these women view these risks to themselves. In light of previous negative experiences, there is divergence between these social representations. SR3 women's previous negative experiences do not result in a change in birthplace situation to avoid this again and where there is an accepting of these negative experiences as the norm. The negative experiences of the SR4 directly cause them to change their birth place context and situation this subsequent time. Fear of risk, and/or of pain appears to be the factors contributing to this unchanged birth place choice of SR3. Whilst for SR4 women, the experience of being controlled; not having control or self-surrendering to control of a dominant other, had psychological impact that meant active decision-making so they would not be put in the same situation again and a clear aim to avoid experiences occurring again.

All multip SR groups are convergent overall in compliance with professional advice. They are divergent however in how this would occur. SR4 and SR5 women comply by an altruistic mode as they would self-sacrifice their own desired experience without question for sake of their unborn baby. Whilst SR3 do not acknowledge the experience to be had and these women would comply unquestioningly at the beginning of the process for the sake of the baby.

For those who are emancipated in decision-making, more positive experiences override previous negative experience. This is due to information, self-understanding,

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self-determination and self-assurance which render these women unafraid of the labour and birth experience.

Chapter 7: Postnatal findings

What follows are the findings from the final step in the hermeneutical cycle of analysis and the postnatal part of the inquiry. This embodies the characteristic images of six postnatal women. Three were women who conformed to professional advice regarding where to give birth and three were women who were non-conforming to professional advice, these are illustrated in table 18 overleaf. These groups represent two further social representations SR6 and SR7 and are characteristic of what became a representation of these social groups in terms of *self*. Following the presentation of these representations, conclusions will be drawn on the vignettes used in the antenatal interviews as discussion aids on the decision-making behaviour of the third person. As stated in the research design chapter, the vignettes are representative of the postnatal women interviewed.

Table 18 Postnatal women with risk factors identified prior to onset of labour				
Accepted health care advice given	Risk factor identified	This pregnancy advice given	Events in this pregnancy/labour	Birth outcome
Sue G2P1	EMLSCS Previous IOL at T+12	IOL T+10	Lengthy induction process system delays	EM LSCS T+13
Helen G3P2	Ovarian cyst diagnosed in first pregnancy – attempt at removal in first pregnancy resulted in perforating the bowel Bowel adhesions as a result of Peritonitis as a child	To birth in hospital in the event of needing LSCS as would require a bowel surgeon to be in attendance due to previous history of perforated bowel	Presented breech at 36 weeks planned external cephalic version Not required fetus turned spontaneously	Spontaneous labour and normal birth at 37 weeks
Karen G2P1	Previous termination at 22 weeks for fetal abnormality	To birth in hospital	Bleeding at 37+2 weeks placental edge detachment. ARM to induce labour	Normal birth at 37+2 days

Example G2/P1= Gravida -Number of pregnancies. P- Number of live births

	Table 18 Postnatal women with risk factors identified prior to onset of labour continued				
Did not accept healthcare advice given	Risk factor identified	This pregnancy advice given	Events in this pregnancy/labour	Reason for choice	Birth outcome
Lisa G3	Low lying placenta at 20 weeks scan	Not to have a home birth	Professional opposition for home birth early in pregnancy 36 week scan showed placenta had moved and was no longer low lying	Previous negative experiences Desirability	Water birth at home T+8 Mother and baby well Mother happy with experience
Denise G3 (+1)	Borderline Platelets Requests a home birth	Need to review home birth plans with low platelets	Borderline platelets at 28 weeks just under borderline threshold at term	Desirability	Homebirth Mother and baby well Mother happy with experience
Katie G3	Epilepsy	To have your baby in hospital	20 week appointment Moved areas did not see a professional until after 30 weeks	Practicality Negative experiences She did not feel she had been given adequate support	Hospital birth Spontaneous rupture of membranes at home Pinkish waters Admitted to A/N ward via day unit Mother and baby well Mother disappointed in much of her experience

Women conforming to professional advice (SR6)

One woman articulated how she would voice *self* as a last resort in an event of having something done she did not feel she wanted and views as not being right for her long term benefit:

> *"frustrating I would say more than anything, I did, I do remember saying to [husband] while we were in the hospital, that the delays with the induction process were spoiling our birth experience. I remember actually saying it to him...it was because we were just sat there feeling frustrated...and that's it really because obviously everything worked out in the end." [Sue]*

This group perceive themselves as anxious and as worriers and these are the characteristics that determine their self-identity. They listen to what they are told, give consideration to it but at the same time they are aware they don't want this. It is this that causes the worry as being 'told' has certain directness about it:

> *"I think it's just 'cos I know of all the problems that's probably there, that it was, well you know I don't really want that doing but...I always listen to what I'm told...I know with [previous baby], she used to turn all the time. I would just bend over to get something and she would turn...every time I was scanned nearly, she was breech but by the time I'd probably got home, I felt her move. But [this baby] I never felt move.. I'd been to the midwife in the afternoon because I wasn't feeling the movements...she sent me in, but she...had him head down so obviously he'd moved by the time I got to hospital and had this scan of him...he had a lot of fluid round him, so they was worrying about that as well. But, like I say [previous baby] had that." [Helen]*

These women view birth as risky and feel safer going to where there is medical intervention. These women want medicalisation and to be cared for by medical experts:

> *"I'd still like to go where I went, just because...they were good and again because of the way we went in with [baby], I just...just think sometimes the unexpected happens and...just for me I would just rather be in the place where there is more technology and more medical intervention on site if I needed it." [Karen]*

Whilst this reduces worry, they also suggest that experts contribute to worry:

> *"plus they were saying, you know, babies don't do as well being breech. That's maybe a factor that'll, like on me I'll think oh if they don't do well, then maybe we should have him turned...because of them saying...'well if baby's breech, born breech, then they're not doing as well', it's...a worry on you then 'cos you think oh, you don't want..to put any worry on, you don't want to put any problems on your baby so you're like well, yeah, turn...turn the baby...I think they make you worry maybe a bit too much."* [Helen]

Experts are in a hierarchical position and this makes them aware experts know what they are doing:

> *"I didn't feel like I...wasn't in control...but I wouldn't have said no I don't want to have it done 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 and...I mean obviously they deliver...hundreds of babies every year, thousands probably, and if they think that there is a problem and it's got to be done that way, then I would always go along with it, I wouldn't challenge it at all."* [Sue]

For this reason SR6 do not question but comply:

> *"You try just to go along and not be intimidated but they're higher, they know what they're doing, so you just let them...it is difficult because when you say to somebody in their position 'I haven't had it removed, have you read my notes' then you think, oh maybe I shouldn't say that."* [Helen]

Whereas the majority of this group have trust in practitioners, there is recognition that some women only have trust in their lead professional:

> *"They explained...that they don't really like to deliver breech babies... because there can be problems...they'd done research on the problems on breech babies and head down babies so they'd explained all that to me...but I think...I had that much information going into me that I wasn't taking all of it in because it was just...I was really worried 'cos all I kept hearing was...sectioning and...that's, having a caesarean.. and with, if it had been [her consultant] maybe because they know me...but because I was seeing different doctors, I*

was more worried that maybe they haven't read all my notes...there was all different ones...I saw about four different ones...and it was worrying because sometimes it's quick just to flip through, but I keep saying, you know, my folders very thick." [Helen]

The practitioner relationship is regarded highly by these women but for Helen it is one that has developed over time through continued interaction. This may constitute an empowering relationship since she does not assume this professional expert as dominant, nor does she view herself as oppressed, but perceives the relationship as equal due to the rapport between them. However, she remains aware of a hierarchy existing between *self* and this professional group, and how she must deal with this in needing to voice herself during these interactions in the absence of her lead obstetrician. She does not feel this same equal relationship. She submits unquestioningly to the advice given by these others who have a certain power over her in the choices she may opt for:

"it was always hospital because of the problems if it ended up being a caesarean I would need a bowel surgeon there, just in case anything went wrong. With [this baby]...because he was breech...when they scanned me...thirty six weeks...which he wasn't, they was worried about that then when they took me in and did a urine test, they said you've got sugar, so they had to do the glucose test and things like that...they scanned me the day before [baby] come but he'd turned, wasn't engaged but he had turned a big relief because it was real stressful...they was taking me in for turning him on the Wednesday... they said let's try and turn him on the Wednesday...they'd give him a week...it can fetch labour on they was going to try it first. I was a bit worried because I wasn't quite sure what it all meant...I went the day before to see the other consultant to see what they was going to do." [Helen]

SR6 women are compliant to those in authority. They wanted medicalised facilities and chose not to question practices or situations even if they weren't entirely comfortable with them. They did not perceive this as a dominant situation where they felt powerless because they were satisfied in having access to medicalised care they desired. There are no perceptions of these others as dominant, despite awareness of them existing within a hierarchy of experts. Knowing that practitioners practise safely, they go along and submit to them in light of risk and safety because professionals are experts who know best. In light of how they perceive these expert professionals, this remains a barrier to questioning what they are told. SR6 women have no awareness of their

liberty to do this. Submission is voluntary because of the trust they have in these professionals, feeling in safe hands:

> *"I knew they were reading it and it didn't really matter to me that...I had to know the why's and wherefore's of everything because they had the information and they were translating it into what they thought was best for me and the baby...so it didn't make any difference I didn't feel that I was being pressurised into anything...Probably somebody else might say 'well why and what's happening' but to me it was more important that everything was done as quickly as possible that it needed to be and just get on with it, yes, I was happy to let them go with it." [Sue]*

And even when left in a risk situation, questioning still does not occur:

> *"They were regular, at one point they were coming every three minutes...and obviously we could see them on the monitoring machine...so we could see them, or at first the midwife pointed them out but then they were very, very busy...and we sort of got a bit left." [Sue]*

They are happy to submit to the control of experts and not question because a medicalised environment with technology to hand is the choice that is understood as usual in maternity care:

> *"they put him straight on a monitor and said he was absolutely fine... and then they came back and said 'look, you're thirty-seven weeks and two days, you know erm with this bleeding you'd have to be in, you'd have to be monitored all the time. If we sent you home you'd be a nervous wreck, I think the safest thing to do is...let's break your waters and you know induce...you." [Karen]*

Despite feeling frustrations with the medicalised environment, finally moving through the system in light of potential problems was viewed by Sue as a positive experience:

> *"this was just a routine monitoring and...we were just waiting to...go up to labour ward and they kept saying, you know, you're third on the list, you're second on the list and then the next morning we'd be, you know, there's other ladies and we was one night where three ladies had come in and gone while we were still waiting...which was very frustrating...I had the trace and the trace showed that...his heart rate*

was slowing quite significantly at points and she came back and had a look. I was on the monitor for about an hour and she said it's not right, I'll have to get the doctor to have a look at it.. the doctor came and said, right we'll take you up to labour ward now because the trace was, em, wasn't right. So we went up to labour ward." [Sue]

A negative experience leaves lasting impressions:

"we might as well have just done that and then we'd have had another couple of days at home and would have been refreshed. We would probably have been able to get something sorted out with [first child] I mean, it was lucky that he was born on the Monday and it was bank holiday. If it hadn't been bank holiday then we would have been stuck...and the likelihood is that [husband] wouldn't have been able to be there 'cos he would have had to have been with [1st child]...it worked out in the end...that initial part was...what was the frustrating part more than anything else." [Sue]

SR6 women do not perceive any other decisions and choices because these are not offered in light of the risk factors they have, hence they always go along with what is suggested and do not challenge. Moreover, because they do not perceive any power imbalance in relation to expert gate-keeping they do not perceive the need to question anything.

For Helen, having disparity between trusting other professionals, she is forced to speak up and begins to feel others lack awareness whilst making judgements on her care. Sceptical of these others, Helen signposts them to her obstetrician with whom she had developed trust. The potential for risk escalation and the role of experts in that and increasing fear is demonstrated:

"sometimes you just feel like they haven't read your notes most of the time, it was 'when they removed your cyst' and I used to say 'I've never had it removed'...but then I did say, 'maybe you need to talk to Mr xxxx...they just flipped through, saw he'd tried to remove it...just took it that he'd removed it...it was the number of times I get 'when they removed your cyst'...the only thing that worried me was that they wasn't reading my notes...and when you're saying to them what you've been told in the past...you feel 'well are you taking it in." [Helen]

These women are self-aware that previous experience heightens risk and security is achieved with medicalisation:

> *"Because I'd had a previous caesarean...obviously they did say I would need to have constant monitoring when the time came and obviously there was a higher risk factor of me having another caesarean." [Sue]*

Normality in birth can be viewed as anything other than a caesarean, hence, medical intervention can be perceived as normal:

> *"obviously if the cord is round the neck and it's causing the baby distress then, that's a risk factor isn't it, even though it's normal. Em, you know, forceps deliveries are probably normal but obviously there's still risk to that." [Sue]*

They recognise birth as a normal every day event and that no one is exempt from risk. Therefore there is vulnerability because things do not always go to plan. There are no guarantees and realisation of nature's role in certain situations is often perceived as unpredictable with no control from either them or anyone else. There is an essence of self-blame as possibly being responsible for problems that arise. Karen had a heightened awareness this time and felt certain vulnerability that there are never complete guarantees. She had realisation that as she did everything to ensure the baby's health, growth and development the first time, she had no control over what happened, it did not work out like that last time so she maintains what will be will be:

> *"It very much put us on, not on edge, in a way I was more laid back this time because...I think the first time I was very much 'no I can't do that', whereas this time I was just well, I did everything right last time. You know, I don't smoke, I didn't drink, you know, I did everything that you should do and that still happened. So this time I kind of thought well, obviously I don't smoke and I'm not going to drink and things, but what will be, will be. It's out of my control now. I did everything right last time and that still happened." [Karen]*

The reality is that there is no 100 percent guarantee of knowing something.

When the experience is something they want, they don't feel coerced into anything, and affirm they would have been able to say no if required. Despite belief in nature and what 'will be will be', there can be an underlying influence for decision-making in the words the experts use and when a situation is negatively influenced this means self-doubt now creeps in, as for Helen:

> *"plus they were saying, you know, babies don't do as well being breech. That's maybe a factor that'll, like on me...then maybe we should have [baby] turned... it's...a worry on you then." [Helen]*

Helen's self-doubt creeps in because of experts' opinions about her baby being breech. This may imply to her that Mother Nature potentially puts the baby at risk. The only way of avoiding potential risk to the baby is for the experts to intervene and ensure baby's' safe delivery.

For SR6 women however, decisions on birth place were made before seeing a practitioner and even before pregnancy existed. Past experiences interestingly both positive and negative were the influencing factors that made it easier to go back to the same environment this time. They would always give birth in hospital despite wanting a different experience this time and did feel cared for in certain aspects such as in intrapartum care. This was not necessarily seen in the antenatal and postnatal context when negative perceptions of care were evident:

> *"obviously because of the delays with the induction...process that obviously put significant damper on things really...but I would still, it wouldn't have made any difference, I would still have gone to [hospital]...to have the baby. It wouldn't have been a consideration at all for me to have had him at birth centre...it just wouldn't have crossed my mind." [Helen]*

Booking to the hospital, provides peace of mind, promotes feelings of safety and promises control over every eventuality through expert intervention for these women. They perceived *self* as having responsibility for this baby in much the same way as for their other children. The consequences of risk and in not being able to intervene and speak up, did weigh upon them. They did not perceive selves as having ability to influence the situation, even in potentially small events, nor realisation they had any voice in this process, hence re-enforces their realisations. Only after the event in their

own environment do they have self-assurance. As they lived their experience, self-sacrifice was experienced as others in the same system were seen to take priority:

> *"because we kept going to the back of the queue because people were in labour, and we totally understand that, then of course there's always the people that were coming in who have started naturally that are in labour that would take priority and that is absolutely understandable but the fact that they then kept starting people off afterwards, after they had with us and not doing anything with us, that was the more frustrating thing." [Sue]*

For this group consensus was apparent believing that women should be able to say what they want and it is an individual choice if advice is not listened to. Not listening to advice was perceived as going against medical opinion. These women unquestioningly believed medical opinion as being best and consequently have no understanding of why others might not believe the same.

Their philosophy was to encourage women to maintain personal control and self-determination. Although this comes from personal understanding and witnessing first hand situations, SR6 do not always question care or discuss concerns, but believed women should have a say in decisions that affect them:

> *"I would get them to speak their mind really. Tell them to you know if they've got any worries to see whoever is dealing with them. Em, and maybe ask to see the consultant. Unfortunately, I know you can't do that 'cos some, being on call and that'…but I would say voice your concerns to them." [Helen]*

Intuition and the experience provide the motivation for this advice. Despite feeling undermined at times, they do not want to be viewed as awkward by these experts when they are only doing their job:

> *"if, like I say, when I feel that they haven't read my notes and looked at everything because sometimes even when they're like checking you and the say 'oh, what's that scar from'? 'Well if you'd read my notes you would know." [Helen]*

In not wanting to be perceived by experts as awkward, they worry about how they may be viewed. In knowing her body, her own history more than anyone else and in fully acknowledging this is her body, Helen admits to knowing more than the experts do. Whilst believing experts also know best, there is in part an understanding by her of knowing her own body by knowledge and experience, yet she does not perceive herself as an expert:

> *"He was quite high but she said your waters will break and I give you twenty minutes and baby will be out, which was spot on and so [with last baby] my waters broke...but I had no pain...but they told me to go in just to be checked out and...all the morning a consultant kept telling me I wasn't having a baby that day. My waters had just broke and they'd keep me in a couple of days to make sure, and then they came to do an internal check and said oh, God there's a head." [Helen]*

Helen knew of the commonalities between her babies and births, she knew her body. For the consultant to constantly tell her she would not go into labour and have her baby that day was negative. This undermined Helen's knowledge of herself and the expert was blinkered in seeing what was apparent to Helen and experienced by her.

SR6 had intuitive belief and understanding in their bodies. There was self-assurance, confidence and knowledge of what was normal for them. This can result from nature's control or from previously knowing the abnormal even when the normal can be known in retrospect. Karen shares her feelings about her second healthy pregnancy in comparison to her first one when having to make the decision to terminate due to fetal abnormalities:

> *"I felt nerv[ous] I felt different, I don't know if my husband did 'cos he didn't feel anything was wrong the first time. So he was quite probably still very nervous...and I don't know what normal was meant to be like before it was my first pregnancy...but yeah, it just felt better." [Karen]*

And consequently, they come to *know* what normal is in retrospect.

Women non-conforming to professional advice (SR7)

This group are self-determined, self-assured and self-reliant. All had previous negative experiences, some had unsupportive midwives:

> *"I just mentioned that we were planning on a home birth and she said, 'oh we don't discuss that at this stage it's much later on that we'll discuss that'...I knew I was going to have problems then and I was really upset and actually, every appointment I had with her I ended up crying either during or afterwards." [Lisa]*

The midwife controlled the discussion of Lisa's desire for a home birth. In this the midwife did not perceive Lisa as an individual or explore her reasons for wanting a homebirth. Consequently a dire relationship with her midwife began to emerge. This made Lisa feel very bad and her persona may have come across as emotional in discussing this. Whilst this may have been the midwife's impression of Lisa she did not attempt to address the request and listen to her. The midwife did not show any awareness that she was the one making Lisa feel this way.

Lisa experienced instances of not feeling guided or supported and she describes how she felt in an earlier birth experience where she had no voice and was not heard by the midwives who were looking after her:

> *"it wasn't a very nice experience at all. I didn't feel guided or coached or supported, or anything...I mean I'd actually said I didn't want Pethidine I wanted the other drug that's got a longer name that you can ask for, that they don't normally offer, or so I was told at the time...I can't remember what it is now. I've seen it in research that I've been doing when I was pregnant for this one but...yeah, I ended up with Pethidine and I just remember feeling like I'd just been given it to shut me up sort of thing. It just wasn't very pleasant."[Lisa]*

This was also experienced by Katie whilst discussing with her midwifery team her decision for a homebirth this time:

> *"I felt like they were trying to make me a little bit more anxious than I needed to be necessarily...one of the other midwives...she was the one that looked a little bit more not happy about it you know, 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 as well [husband] was then a little bit, hearing all of these facts and...was getting a little bit, sort of are you sure we should be doing this." [Katie]

These women had felt isolated in past experiences for example Lisa describes her experience as despair and the worst experience. As she expressed her feelings during the final stages of her second pregnancy she compared these to a near death experience:

"I do remember thinking towards the end of the pregnancy that I would rather go under a bus than give birth, I was that frightened, really frightened." [Lisa]

Denise's negative experiences related not to her interaction with midwives but in having to be admitted to hospital for a post-term induction and artificial rupture of membranes:

"I was really disappointed. I hated it, hated going into hospital, but I would have like them to have induced me and let me come home or something like that." [Denise]

Katie's negative experiences emerged from admission to hospital in her second pregnancy. She felt the midwives did not support her like they did in her first birth. Having the support of a midwife there all the time meant she felt in control:

"it's your first experience of it, they're sort of a bit more patient with you, and a bit more understanding and wanting to talk you through things...I think...with [second birth] it was like, well you've just had a baby anyway so you should be able to remember everything and of course...with it being your second one you know what to expect and... people just weren't the same way inclined you know they weren't sort of...there with you holding your hand as say the first midwife was." [Katie]

The lack of support was a definitive reason for booking her birth at home:

"if I am at home where I can just, you know, plod around for the first stages and what-not. Get to the second stages and obviously move upstairs with [husband] where he can support me and I'll have the midwife there with me all the time to, obviously, give me the guidance that I need." [Katie]

In contrast, despite previous negative experiences, all of these women experienced the genuine support and value of supportive midwives. Midwives in these subsequent pregnancies were more responsive, they felt they had better relationships with them and felt at the centre of care:

"it was just really a fluke that I got my midwife...she just happened to come on the day that I went into labour. It was her weekend on, so it was only a fluke, but I think even if it had been a midwife that I didn't know, as I say, the same midwife delivered my cousin's baby and she was thrilled to bits with her midwives and she'd never met either of them before so I think it's just, it could be any midwife...I think they enjoy doing home deliveries as well because they haven't got the pressure of time and the hospitals and all the rest of it so I think they're more at ease as well...the midwives asked me how I wanted to be sat, they asked me how I wanted, what I wanted, if I wanted drinks.. they was asking me what I wanted rather than saying stay on there, or we've got to have you monitored so you've got to keep still I could go get in the bath if I wanted it was just a bit of freedom and it was just easier being at home." [Denise]

Katie's positive experience began with the support of the first midwife she came into contact with in this third and final pregnancy:

"[she] was wonderful right from the start...she was always very optimistic and very much, you know, she didn't see it being a problem really. She said, you know, at the end of the day you seem to be absolutely fine in your health. You know, 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. And she said, obviously we'll be constantly observing you and if we feel that there is like, you know, 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 like, you know, okay I' 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. But, you know, she was always that way inclined to tell you the way it was, give you the advice and then obviously let you make the decisions." [Katie]

For Lisa, her positive experience was at home giving birth with midwives who supported her and her family:

> "my son cut the cord with them and they were brilliant they showed him how to do it helped him and everything they were really good... stress wise I would like to have changed not having those run-ins with the initial midwife would have been wonderful...if my idea of home birth had been the support etc and the continuity of care and everything; that would have been wonderful...it would have been even better had my regular midwife...been able to deliver the baby that would have been ideal...but as far as the delivery went, I couldn't I couldn't fault any of it, it was just absolutely perfect." [Lisa]

Their views of birth in these past experiences were painful, terrifying and left some, scarred by the process. They are aware of risk in daily life, are quite anxious about it and describe themselves as worriers yet are self-assured. They have confidence in their bodies and feel that they cannot put themselves in a position where someone else will determine their fate:

> "I can't just hand over to medical people and accept that they know best because I don't actually think that that's the case all the time and they certainly don't know the best for me because I know me and I know my body and I know my family and how we'd react to things." [Lisa]

When they did not have to struggle for choices with midwives or services, they almost waited for something else to spoil it, that wouldn't allow the desired experience. They experience self-doubt about nature and confidence in their body's ability as well as imagery of potential problems which would cause the experience of home birth to be taken away:

> "when I hadn't dilated and then I carried on having those contractions...and the Tuesday he was born on the Wednesday morning, the Tuesday before my new midwife came out and did a stretch and sweep and I'd gone to...two maybe three and then one o'clock that morning I'd gone to four when the midwives came to deliver him so I did dilate, it just took a long while from nothing...and I started panicking thinking I'm not going to dilate or the stretch and sweeps aren't going to work and then they only let you go over for so long for a home birth." [Lisa]

This created self-doubt that labour would progress, but because her body had done it before there really was no need to doubt. There is an awareness of how nature can be seen as potentially constraining choices as the deadline for homebirth approaches. This thinking is reinforced through clinical guidelines that constrain women's bodies and natural experience. Despite being self-assured, self-determined and confident in their bodies' ability they can also develop self-doubt through their interactions with some midwives as Katie and Denise highlight:

"Well in the sense I understood what they meant because I looked and I thought they're saying you can go home but there's something not quite right...and they don't know what that is so, in a sense, if I go home and then call [midwife] and say look...I'm in labour, but by the way there's something not quite right anyway. Then [midwife] is going to get a little panicky with thinking oh my God what's going on and you think is the stress going to start circulating and make things into a worse situation. You know, I just started thinking, well if something's not right should I really risk going all the way home for something to happen when I could have been here and it happen and obviously at least, you know, being in the right place." [Katie]

"I didn't argue or anything, I just said that I would like to think about it and I was just told that it wasn't very wise with my first just in case, they didn't know how things would progress and things." [Denise]

Despite being self-proclaimed worriers generally, these women are more laid back. Even with no previous experience of a situation, this does not automatically make them become worried. They are self-reliant and can see themselves as brave in mentioning home birth choice to an unsupportive midwife:

"one of the other things that was happening wasn't just the fact that the placenta was low and she'd said no home birth, we'd then talked a little bit about it and I'd mentioned, I got brave one day, I'd mentioned I wanted the baby in my bedroom and she said 'absolutely not, we don't have our ladies on the bed on their backs giving birth' well I'd no intention of being on my bed." [Lisa]

Self-reliance develops from a belief that their body can have control of the birthing process:

"if you're more relaxed then your body has to be more relaxed doesn't it, so that must make it a bit easier." [Denise]

"I was much more in control that time and I felt they were much more receptive to me my midwife was really good." [Lisa]

For Lisa being in control meant:

"Knowing what I wanted and knowing how to ask for it or how someone else can ask for it for me if I can't and getting it if that's what I can have, if that's what I want and it's possible." [Lisa]

Second births were more positive. Midwives were more receptive and whilst on the whole they felt at the centre of care there were occasions where they did not feel supported as much; because it was a second time:

"and of course, you know, with it being your second one you know what to expect...people just weren't the same way inclined...they weren't sort of...there with you holding your hand...I think in them situations, no matter what, it's always nice to know that people are there supporting you and that's what you need, especially when you know, you're getting to your second stages where you're feeling like my God I'm losing control here." [Katie]

Their problem solving is realistic and they ensure they remained informed. They all problem solved and risk assessed their own scenarios. In constantly risk assessing their own situations, they wanted support and discussion. They problem solved their situations through what they felt was the best option for them, this fostered self-assurance and an ability to feel in control of *self* and the situation:

"I'd done my research on the internet and I knew that we're half an hour from hospital. If you were in hospital and something happened it might take them half an hour to prep a surgery anyway so, you know, we'd go in as a priority, so it just didn't worry me, it didn't worry me at all." [Lisa]

And at her twenty week scan the sonographer told Lisa that the placenta was:

"partially covering the cervix, she said but she did say that it could be that my bladder wasn't full enough or, I mean, she felt sure that when I came back at thirty something weeks for a review, it would have moved...I decided to continue as planned, book the home birth and then if it did turn out if it didn't move, then we would have to reassess the situation then." [Lisa]

And for Katie:

"we both felt that home birth would probably be more suitable for the practicality of it...because I don't drive either so getting me up to a hospital, I don't even know how I would have done that if [husband] had of been working." [Katie]

Own surroundings gave more confidence:

"because I think when you have a home birth they talk about the risks and things, so you go into it aware you're more aware of what might happen or what might not happen, and they discuss it with you, you don't discuss things going wrong when you go in hospital, you just go...you don't go and talk to them about things, you don't talk as in-depth...and you don't get the same midwives so you don't get the same information I don't think, I think if you have them at home you know more". [Denise]

There was a sense of they would do it themselves and they were self-determined to do it right this time as a result of previous negative experiences. Lisa felt she had a point to prove to practitioners as she'd felt ostracised and unsupported the first time:

"but I ended up breast feeding her until she was four and a half and I think that was a bit, stuff you I can do this, sort of thing...because nobody, I watched them all going round showing everyone else how to breast feed and nobody came to see me to show me or anything like that." [Lisa]

Denise had just always wanted to birth her babies at home but for one reason or another she did not have this opportunity:

"I had this baby at home I did want to have my other children at home but with my first I was told I couldn't." [Denise]

This time, there is self-assurance, self-reliance and control of both self and situation and a better relationship exists with their midwives. These women talk about this with regard to their family unit:

> "second midwife arrived just as I got in the water pool...the friend that was videoing it arrived just as I got in...Mum was there, kids were there kids went off to bed to get a few hours kip, because we thought it would be a lot longer than it was...and I spent the whole second stage in the pool in the water, completely silent breathed through every contraction without a murmur just such a different experience to my last two and then I was actually pushing him for seventeen minutes the records said and it was just brilliant that was the only time I ever made any sort of noise was pushing him out and I didn't swear once, I said to my mum, please take note I haven't sworn once it was just, the midwives just left to me to it I had my own space in the pool, no-one interfered I only had one internal to see how far gone I was when she came." [Lisa]

> "you're in your own environment I didn't have my partner in the room with me all the time, so that was less stress because I wasn't worried about him being worried about me being worried about everybody else and so there was just me doing what I wanted to do...it was really nice and as soon as he was born, within five minutes, my mum and my eldest daughter was round before he was even dressed so they didn't have to see all the intense bits, but they were still involved with him as soon as he was born." [Denise]

The SR7 women speak as 'we'; this implies shared emotional implications regarding outcomes of such actions and events. They perceive themselves as head of their family group. Birthing in their own environment, the choices they make are made with all family group members in mind. They have self-reassurance and self-reliance in knowing everyone is alright at the time of birth, midwives, family, themselves and this was important to them and how they wanted it to be. For Lisa this meant she could relax and not worry about her family:

> "they just sat chatting amongst themselves and chatting to the kids and everyone who was there." [Lisa]

They are self-reliant in not being in a position that anyone else determines outcome. In situations where they felt under pressure to conform, the midwife was seen as negative and controlling:

"If I'd have been with the same midwife I'd have felt like I had no option but to go to hospital I'd have been devastated." [Lisa]

SR7 women are very aware of societal birthing practices. Some did not know anything about home birthing in previous pregnancies so never considered them:

"I don't think it had any birth centres and a home birth, I just never, ever considered it." [Lisa]

"that's why I didn't go to my doctor's when I was pregnant because I know that a lot of doctors don't agree with it, so I didn't go and inform them I didn't tell them." [Denise]

"with it being the first you're always worried, what if something happens...you're always thinking will I be able to cope with the pain 'cos you've never been through it, so you don't know how your body's going to react...then, of course, the other thing is I do have epilepsy so we had to see a consultant and his advice always was until the day she was born, was make sure you get to the hospital as soon as because of course, their worries are always that the stress of labours can bring on epilepsy...I think we always had choices it was never a case of they'd taken choices away from us but I think back then we just didn't even consider anything else. Because, like I say, you know, when it's your first, you generally are a bit worried aren't you so you want to be where everyone is there, in case of an emergency." [Katie]

They searched out information on home birthing with pre-related problems and kept an open mind. This justifies their decision and supports their argument. They wanted their family to be part of this experience and felt sole responsibility for this experience for these others as well as for themselves. They question their self-reliance in viewing things as a family unit and see it is on their shoulders and their own needs and desires are not just considered in thoughts of knowing there could be a major risk:

"we was already debating, thinking about...if something happens what are we going to do and...of course, the other thing as well which we forget is that we've got the kids in the house as well and I'm looking and 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." [Katie]

They don't want to let themselves or everyone else down and are aware they cannot just make judgements for themselves; *self* is also a mother figure within a family group. In the above, the sense of letting herself down by doing what she saw herself as needing to do for Katie was more than having a baby at home, it was much deeper than that. For Lisa it was a huge relief that a new midwife now supported her in achieving her desired outcome, not to achieve this, would have been a real problem to her:

> *"I felt that I was letting myself and the baby and the kids and [husband] down if I'd have ended up in hospital that would have been really bad for me." [Lisa]*

Life pressures of the family unit are considered by these women and desires and decisions are put into a realistic perspective:

> *"I started really looking forward to the home birth and just thinking, do you know what the only thing that was going to go wrong then was that [sick child] wasn't going to be at home for the birth which I knew would be detrimental to her emotionally because the other kids were here and she wasn't, she was stuck in hospital...they all paled into insignificance it's like what contractions you know the kid's on death's door it doesn't really matter in the grand scheme of things." [Lisa]*

These SR7 women continue their quest and consider their options:

> *"So at that point from being moved from downstairs where I was happy to be staying in hospital, then going up there and being put with the other ladies, all of a sudden I started, you know, going back to the home birthing sort of situation, thinking no, I just want to be home." [Katie]*

Some felt the need to pluck up the courage to convey their wishes to the health professional. They worried they would have no support at all if they chose to go against practitioner advice, worried about giving birth without midwives, and did not want to be viewed in a bad light. This concerned Lisa; she did not want to look bad in their eyes, as though she was doing wrong:

> *"what frightened me about that was...upsetting people if I'd been refused a home birth and I went into labour at home and I really wanted a midwife out I was more worried about how that midwife would treat me for doing things in their eyes, the wrong way if that makes sense...I actually spent a lot of time researching how to give birth on your own as in what you have to do if you end up on your own giving birth."* [Lisa]

Katie went to the antenatal day unit the morning she awoke with pinky waters, despite her wanting to be at home she was faced with a dilemma:

> *"So they said what could have happened, if obviously my waters had of been clear, is they'd have just sent me home and said, you know, wait for things to happen, pretty much but because of that they were a bit concerned. They hooked me up, he was absolutely fine...so they checked all that and said he was fine, 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, you know, 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. Well in the sense I understood what they meant because I looked and I thought they're saying you can go home but there's something not quite right and they don't know what that is."* [Katie]

How this group are perceived by their birth attendants is a huge issue for them. Positively being supported by practitioners enables them to remain in control. Support and relationship appear to be decisive factors. This support and relationship can develop either over a long time, in this pregnancy, from previous pregnancies or simply within fifteen mins of meeting during birth. The length of time seems to be immaterial but her knowing she is at the centre of care makes the difference.

The majority of SR7 women felt they self-surrendered in their first pregnancy due to having no choice. The pressure to conform this time was exerted by midwife opinion, this made them determined. Lisa had to dig her heels in. She had no support and the midwife exerted authority over her in a forceful and direct manner which left her feeling she had no voice. Any submission would only be with a fight:

> *"I think I might have tried to fight it I would have done more research and tried to fight it probably. But there was only so much more*

fighting I could do because it was really affecting me not having this dream." [Lisa]

Even in this pregnancy Lisa felt backed into a corner at times, leading her to seek independent midwifery care and she felt self-despair at the prospect that she might have had to go back to the hospital:

"but we decided the sensible thing to do would be to look at other options so we actually erm spoke to a private midwife when we kept coming up against this lady [pause] we decided that we'd go private." [Lisa]

Generally they felt in control with the midwife accepting their birthing desires and were very much aware of being able to change their decision if they no longer felt comfortable with this:

"and it's your decision if you change your mind a day before your due date you can still go to hospital, so I think you've still got control and if you change your mind it's not going to be an issue with anybody so it's just your choice." [Denise]

There was trust and mutual respect between these women and their midwives this time at a certain point in their pregnancy experience. They were aware of developing risk in situations and they would not put any one in a dangerous position:

"they know what they're doing, they're experienced, they wouldn't give me advice if they didn't know so I think it's only fair to listen to what they say and that's what I said to them at the time, I said, if at any point you think [pause] that it's too dangerous or there's something going to go, then I would listen to their advice". [Denise]

The relationship they had with their midwives was not one of control but shared understanding of a common goal. The impact that midwives can have on these women, who might look at first glance as going against practitioner advice is of paramount concern as Lisa describes:

"one of my biggest concerns was what if I didn't get on with them what if those two ladies between my legs, delivering my baby, that

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don't like me or...don't like the situation or don't like that fact that I've got very particular things that I want doing or not doing...it must be horrendous doing something like that with someone that you don't seem to get on with or bond with, that isn't supporting you as my first pregnancy was." [Lisa]

They had self-reliance in these latest pregnancies to ask the right questions and decide what they wanted to do, once they were armed with the facts. Having self-reliance gave them complete relaxation with no worries. They felt amazing during these last birth experiences, knew their bodies and were self-fulfilled in the birthing process:

"I would recommend it to anybody everybody thought I was mad for wanting to have a baby at home, but I would recommend it to absolutely anybody. I think it was a lovely experience". [Denise]

"It was just amazing... I was just amazed at how well everyone coped with it including myself and really...thankful that I couldn't have written a better birth if I'd have tried it was just beyond everything I'd dreamt of, it was just so wonderful and it was a really enjoyable experience I really enjoyed it and if I could pop a pill and do it again every night I'd do it, it didn't hurt unbelievably I was completely with it the whole time I remember reflecting during a contraction do you want to do this again, is this too much, could you cope with this again at your age? Yeah, sure I could...it was just lovely." [Lisa]

Except for Katie:

"it's a case of you know, the minute 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...because of course they're the ones, you know, with the experience you always believe, don't you? They're the ones...that are there to give you the actual proper advice, and...if they say something to you, you're taking it that, wow, they must mean this then so I best follow their advice then, when it's a situation of an emergency, but, obviously my situation of emergency didn't seem to be that much of an emergency now, does it, looking back." [Katie]

Vignettes

A précis of the vignettes is given followed by conclusions drawn from the interpretations by the antenatal women. Vignette one, represented the situation of a third person demonstrating conformity behaviour. Vignette two follows in the same format and represented the situation of the third person demonstrating non-conformity behaviour. The antenatal women were shown these independently as a discussion aid. The conclusions that follow are the perceptions and views of all the antenatal social representations on the third party's decision. Comments were comprehensively analysed however a summary is presented to avoid lengthy repetition. Individual SR summaries can be made available to examiners if required.

Vignette1

> This is my second baby. I had a caesarean section last time as I did not progress past 9cm dilation.
>
> I want and believe I can have a normal birth this time. It seems usual that women book to the hospital.
>
> So I will.

Vignette 2

> This is my second baby. I had a caesarean section last time as I did not progress past 9cm dilation.
>
> I want and believe I can have a normal birth this time. It seems usual that women book to the hospital.
>
> So I'm not.

Vignette conclusions

Vignette 1

Both hospital representations and birth centre multips (SR1, SR3, and SR4) had a tendency to see the situation first and foremost and a woman in it. The situation was perceived as risky with a negative prognosis. Hospital SR1 and SR3 women perceive birth as risky and control is achieved through medicalisation and experts. These women perceived her as influenced by social norms family and friends but not by the experts who are there to deal with the situation and achieve a safe birth as the primary focus. The SR4 multips in receipt of their own knowledge and experience, perceived her as more inquisitive as they do themselves this time round. These groups perceived the risk as a reason for her to be heavily advised and undeniably believe women should only have choice up to a point. In the face of complications they believed women should go with expert advice as they would themselves. Moreover, this woman should be made to conform to that advice. SR4, birth centre multips were reluctant to pass judgement on the situation, however, only in the expert granting her this choice would they agree to her having choice. These women were unquestioningly likely to agree with expert advice themselves. As the situation was seen by these women as risky with a bad prognosis, they believed the woman needed to do what is expected to ensure a safe result. SR4 women, having previous birthing experience and in the light of risk, think similarly that she should be made to. This is contradictory to their view all women should have choice.

The SR2 group, the birth centre women and SR5, the home birthing women had tendency to perceive the woman in the situation and NOT the situation with the woman in it. These women put her central to the experience as they see themselves in the process; self and experience being the most important and not self in a process with a healthy result at whatever this takes to be achieved. These two groups socially construct the scenario further, reflecting upon it, wanting to make sense of her experience and give explanations of it. They see her voice is silent and choice is not evident but see her as open minded and determined in what she wants from the experience in much the same way as they are.

Vignette 2

SR1, SR3 and SR4, (both hospital groups and birth centre multips) again shared similar tendencies. They saw the situation primarily and the woman secondary. She was behaving outside of the perceived norm and was seen purposefully doing something different. In making sense of her decisions, they perceived her as not logical and hoped the professionals would get to the bottom of it. The woman is viewed as awkward and is wasting the midwives time, she is lowering her chances of having a healthy baby and she should be advised of such in view of the experience she has had previously. In considering the woman, SR3 applied their personal understanding of a second prospective birth. They consider that this woman, like them, knew her options through comparison with her previous pregnancy, it was viewed as different so previous issues are not perceived as relevant in this case. Though she is in control, the advice is only advice and she cannot be told, they see that she won't get personal choice. Only one woman in the SR3 group primarily saw her as not wanting to be seen as difficult and that she had real reasons for her choice.

SR5, home birthing women see the woman in the situation as opposed to the situation presented. They felt her decisions were based like theirs on past experiences. They see her as voicing herself, confident and assured. They were reflective of her position in this situation; they constructed meaning; provided information and made plans for her to have a changed experience. In part, SR2, the birth centre primips shared similar tendencies in seeing her as central. The SR2 group were split, some perceived the 'risk' as the situation and that she should be coerced into realising and that it was a case of making her realise. Choice is choice, but only up to a point, and seemingly only in the exclusion of risk.

Summary

The preceding two chapters have presented empirically grounded interpretations generated from the data. What follows in the following chapter are the interpretive conclusions generated through discussion.

Chapter 8: Discussion

Introduction

The following chapter presents an integrated discussion of the qualitative findings and aims to answer the questions that gave direction to this inquiry:

- Are women socially influenced about their birth choice options?

- Does social Influence link to emancipation for women in decision-making about birth options?

- Does emancipation in birth choice reduce the pressure to conform?

This chapter discusses the social representations independent of each other and illuminates the relation these have to a continuum of emancipated decision-making. The social representations are observed at different points along the continuum, illustrating how these groups may be represented in their decision-making about birth options. What follows explains how the *self* interacts with external influences and provides answers to the second question posed. Attributes of emancipation are explored in relation to the social representations before discussing and answering the final question.

By applying findings to the underlying fundamental concepts of social influence and emancipation that underpin this thesis, understanding can be drawn and the research questions answered. This results in the presentation of a new humanistic model of emancipated decision-making in childbirth. In recognizing these concepts, detected in the literature, it is clear the unique hermeneutical framework was undoubtedly fundamental in illuminating these findings. Women are profoundly influenced in their birth options. Moreover, the decision to revisit the conceptual framework chapter once narratives were being analysed, before the women were introduced in the traditional thesis format, has brought further depth and understanding. Smythe (2011) speaking from a research context advocates the need to do analysis slowly and that it is important to revisit this process in order that further meaning can be uncovered. Using the *lens* of these women allowed for critical analysis that gave real understanding in an

illuminating and unique way that brings these deeply theoretical perspectives into real life context in an identifiable and meaningful way.

What this discussion elucidates, is how this highly complex, critical and delicate process of decision-making is profound for women in maternity care. This concurs with others who write authoritatively within this arena (Thomson, Dykes, and Downe 2011, Edwards 2010b, Kirkham 2010b, Edwards and Murphy-Lawless 2006, Anderson 2004, Kirkham 2004, Smythe 2003, Smythe 1998). Furthermore the discussion illuminates how *self* is critical to this process. What is discussed is how influence causes both positive and negative experiences for women. How this affects them is fundamental to whether they can achieve emancipation in their decision-making, reduce conformity, and whether informed choices can be truly achieved.

Initial thoughts regarding making sense of these findings were considered in looking to understand *self* and identity. This thesis is not exploring the concept of identity from a psychological lens. It is not concerned with the construction of a health identity (Christodoulou 2010); nor individualization of identity (Budgeon 2003) or the social identity of women as a social group (Skevington and Baker 1989) hence identity from these perspectives was discounted. It merely acknowledges identity exists, the aim is not to deconstruct it from a psychological position but sociologically acknowledges the existence of *self* and what this means in a culture of maternity care relational to the concepts identified within the literature on decision-making. Furthermore, this was the reason for rejecting the work of Rogers and his Self Concept Theory (Rogers and Stevens 1973, Rogers 1967, Rogers 1951) despite this being an early prospect of consideration for understanding findings. Roger's theory explores how individuals understand and interpret their own existence and how *self* might manage this. It was not the intention to interpret this within this study but *self* in relation to decision-making and influences that encompass this. Wittman-Prices' five attributes for emancipation, was considered equally applicable to Asch's concept of conformity as appropriate theoretical perspectives in which to explain findings and where conclusions can be drawn.

The identified social representations

SR1 Hospital primips

This socially represented group show no characteristics of being emancipated. This is foremost due to internal influences of *self*, whilst for others in this group it is the external influence of others. There are self-expectations about pain and these women present no self-determination or feel any self-assurance in managing it, but are self-aware that individual self-identity can mean we can have preconceived ideas about it. Fear of risk and pain were the reasons these women booked to the hospital despite having no previous experience of labour pain and no perception of their ability to cope with it.

As they negotiate risks that surround birth fears manifest and women can easily end up following the medicalised route for pain relief, one they may later regret. Breaking down barriers to understanding pain through knowing and understanding that it can never be known fully and can never be perceived in reality should be embraced and understood in a positive way rather than in a negative and fearful way. It is important that practitioners maintain a reflexive critique in practice for understanding and making sense of women's experiences (Edwards and Murphy-Lawless 2006) but reflexive critique is equally as important for women to do this for themselves for their own understanding. Consequently women refocusing initial thoughts positively on pain at an early point may make way for more informed decision-making. The point at which they have first contact with a midwife could be the time for supporting this refocusing. Hospital primips showed they wanted confirmation of pregnancy, had initial questions and wanted contact with a midwife at this early point in their experience, and had already made certain decisions. The first contact could be a determining factor in addressing concerns, breaking down barriers and facilitating knowledge transfer; especially in knowing the importance of midwife-women interactions (Kirkham 2010b, Edwards 2005). These choices are based on information from others that is not necessarily correct. In coming to recognize there is no certainty, and having no certainty is a normal state with nothing to fear from this, this could address women's preconceived ideas that ask as the first question, what it is they want from this pregnancy and birth experience.

When these women are asked about something in the context of limited information they make assumptions based on knowledge or experience of a situation someone else has experienced or what they want for themselves. In absence of personal experience they say they 'don't know' and are not able to make judgements. Yet they make decisions about either what they want, or see as potential to cause them harm, despite having no experience of it. Of concern is that these judgements are often based on wrong or misleading information.

Within their self-concept, there is an internal struggle with not knowing and a degree of self-fulfilling prophecy exists. They think mostly of pain relief because they believe they will be in a lot of pain as labour is a long and painful process. They are aware of their self-concept in knowing they are fearful of pain and have reduced ability to cope with it.

The use of milestones and other people dictating and planning the next step in pregnancy does not help women to see their pregnancy as a journey of discovery and transition from womanhood to motherhood but rather as a medical process that might not continue or develop to full term. Previous negative experiences of miscarriage by some of these women could possibly be the reason for the belief that medical intervention is effective in dealing with adverse outcomes (Edwards and Murphy-Lawless 2006).

There is tension between these women's ideologies of having a natural birth and narratives that do not articulate this as their aim. There was no perception of how they could influence and promote a natural birth but this relates back to them not possessing the necessary information to know how this can be achieved. Their ideology of wanting a natural birth, contrasts with the fear of pain which may mean they do not self-believe the expressed ideology of giving birth naturally. Whilst they state they are open minded to needing pharmacological pain relief their fear of pain re-enforces the need for pain relief which supersedes their desire to give birth naturally. Natural birth is perceived by these women as not having pharmacological pain relief, yet they book to the hospital because they view pain relief as essential and as such do not believe they can give birth without it.

These women book to the hospital because they have a high perception of risk (Edwards and Murphy-Lawless 2006). They do not fully engage with an ideology of natural birth because they have no self-confidence in the process, but believe they do.

Being nervous of the unknown and expecting to be in a lot of pain overrides their narrated ideology. As individuals therefore we socially construct ideas about what we believe natural is. What may be considered natural to one is not necessarily natural to another. It is possible that these women want natural for themselves but in the context that they perceive it, perhaps they also want what is perceived as being right within traditional birth culture and social norms (Edwards and Murphy-Lawless 2006). Consequently there is difficulty in promoting a proposed desired birth experience when we cannot be definite what it is perceived to be by this group of women. It questions whether natural is perceived by them as something that is promoted as natural, or something that is believed to be natural in the event of no pain relief? It could be this lack of clarity of what they understand natural birth is professed to be that is keeping them from their ideology and understanding the experience of the birthing process.

SR2 Birth centre primips

Whether these women have the assurance in *self* to explore the option of home birth is debatable. They do not have the information, hence understanding through which they can make an informed decision is lacking. They relate *self* more in the knowledge of what they want and voice this. There is divergence between these women but clearly it is as though an imaginary scale of self-determination exists, *self* moves along it, some are clearly more self-determined from the start, and others' rely on 'an empowering other' to support self-determination. This needs to be constant so regression to a state where self-determination is diminished does not occur. In this case there is need for the influencer to be constant for self-determination to be maintained. As Aronson (2008) proposes this is fundamental. This clearly is a crucial group which can be nurtured and positively empowered along a continuum of self-determination, if not the situation and the woman may be negatively steered into compliance and autonomy denied (Williamson 2010). These women all have a belief in birth being a natural and normal process and a positive belief that 'feeling' the 'pain' is all part of it. Yet it is not this belief that makes them emancipated birthing women. Empowerment from professionals is necessary to maintain self-reliability and effectiveness.

Birth plans have been described as a strategy for women to attempt to put forward their views (Edwards 2005). To some extent this group have a birth plan, this relates more to awareness that things can change and they want the option to still make decisions

when this happens. They are aware as situations change choice is reduced and someone else is seen to have control over decisions. Control therefore is perceived to be given or taken at any point. They still remain self-determined and emancipated decision-makers as power in the choice context is perceived as equal (Williamson 2010) between the dominant group and the woman despite change in the process. Hence continue to maintain what Williamson (2010 p204) describes as "equality of voice". Perhaps completing a prescript birth plan gives *self* a focus and reflection as to what is wanted for the experience. Further it is recognised by these women that the purpose of birth plans necessitates discussion between midwives and women so understanding by women about their purpose can be fully appreciated. If what women write is meant as prescriptive, then awareness of the implications of this prescript should be made known. Especially with regard to thoughts and decisions often made months previous and potentially prior to any discussion, as women decide what they want for themselves prior to contact with health professionals. Perhaps the focus should be understood as a flexible framework but not a prescriptive one.

The general concept is that birth can be achieved, should be experienced and not given in to. This group represents women who move along an imaginary sliding scale of self-determined decision-making where they opt-out of certain choices.

SR3 Hospital multips

These women did not show any characteristics of being emancipated or wanting to be so. They present a more negative outlook even if they do not intend to come across that way. When women conformed to professionals even in light of a negative experience, they self-justified the decisions they made and remained accepting of these afterwards. Women internalise their experiences (Edwards 2005, Cosslett 1994). These women reconceptualised a bad experience as a good experience in the long-run, and this perhaps exemplifies why some women, despite previous negative experiences do not alter their choices for something different next time, such as a change in birth place environment or lead carer to avoid this again.

Thinking and questioning occurs more in subsequent experiences yet they still put *self* in others' hands again. They remain less confident, not self-determined or self-reliant, but self-doubting and believe they can put themselves into risky situations. Birth is perceived as individual and undoubtedly risky, they want everything to hand as in the

hospital and this makes them feel safe. Self-reliance is observed in the use of facilities accessed and self-confidence is assured through service provision chosen. This results in experience of positive feelings of being cared for whilst experiencing a negative experience while in labour the first time.

These women do have a medicalised view of the process of birth and consider pregnancy as something that causes stress on the body. Their self-concept is one of being on show and birth is not a personal experience for them, but seen as a process that's just got to get done. Risk perception is the reason they booked to the hospital and this would always be the case. This means they do not consider exploration of other possibilities.

They view the women in the scenarios and provide their interpretations of them in line with how they perceive themselves and how they would want to be perceived by others. They compare their selves to the woman in scenario one. Although they say they believe it is down to personal choice and women should be empowered in choice, they are knowingly contradictory, because of perceived medical problems they believe there is a need to be in hospital. In their focus on risk they reinforce in themselves the obstetric model of risk that generates unsubstantiated fear (Edwards and Murphy-Lawless 2006, Edwards 2005) with no concept about what could be safe (Smythe 2010, Smythe 2003, Smythe 1998). What is in fact declared by SR3 is how some women can be free to make choices, whilst others must comply with authority and it is this authority that will dictate who has that choice since medical professionals know best. They themselves are accepting of this. They cannot understand the perspective of the woman in scenario two since they have no experience of this physically, they cannot empathise because they do not know how it feels so judgement for them is reliant on what others say.

They believe birth has to be taken as it comes and cannot be prepared for because they have no experience of it. This implies previous experience gives knowledge in which opinions can be based. Moreover, in having no knowledge or previous experience they construct a 'preparation plan' in its place based on listening to others' experiences which facilitates knowing of what they want for themselves. Another's experience cannot be recreated, but there is no conscious awareness of this in their decision-making. Consequently the implications of this are that women make choices

for themselves based on perceived ideas and understanding. Of course women might unrealistically make choices they cannot fulfil that may have negative outcomes if the choices are too prescriptive. Constructing a preparation plan as opposed to a birth plan, consciously or in the form of a written birthing plan should encourage reflective thought about something of which they have no lived experience. Only when they have lived through an experience do they possess the primary experience, a knowledge on which they can truly reflect on as clearly they use 'own' previous experiences to make decisions.

Experiences are handed down to others within this 'pregnant group', in the sharing of women's stories. Each having their personal pregnancy, labour and birth experience they openly share. Women's stories influence this significantly and illustrate the power of women's own knowledge amongst their group and the capacity this has to share perspectives positively with each other. Edwards (2005) informs that women often share and acquire knowledge best through conversations, life events and their involvement with community activities. Perhaps therefore women should take the lead from a bottom-up approach in sharing this knowledge amongst their social group and be formally supported to do so by those who provide care.

For these women, there are elements of the possibility of being built up only to fall, which means they avoid building themselves up but let others take control.

SR4 Birth centre multips

Self is important as being at the centre of this experience, the experience is fundamental to these women. Anxiety and elements of self-doubt still remain but this is because they know what to expect from previous experience, rather than not knowing what to expect.

There is a strong sense of a relationship, perceived as a dual role between two 'beings', her and who is supporting her. Where they saw doctors previously as an influential hierarchical figure to which they self-surrendered, they perceive midwives as skilled medical staff who know how to advise and support women with complications, from a position of equality and not one of control.

This group have different perspectives of risk awareness. They know risk can be introduced to a situation by the type of environment a woman is in and this can have a

cascade effect further along the process. These findings concur with Edwards (2005) in her study about home birthing women. SR4 women recognize risk can happen at any time, yet the knowledge of risk events and the potential for happening to anyone at anytime does not deter them from booking to a birth centre environment. In knowing that the last thing they would want was transferring to hospital in the event of complications, this implies a perceived difference in risk between 'known' complications rather than possible risks.

They are aware of social norms and the common perception that the birth centre is widely perceived as more risky. They examine the perception that one place can be more risky than another but believe in what the place signifies for example, no doctors and technology. They believe that risk is about the situation and not to the place of birth, and in this are convergent with home birth multips and birth centre primips.

These women have a mental picture of *self* and consider 'mind and body' as separate. The mind cannot influence the physical workings of the body but in their perception of the physical body, they intimate a psychological wellbeing that can influence *self* in birthing situations. Moreover, they have self-realisation of a need to be more self-assured in different environments for example in the hospital. It is possible that reflection on past experiences is influential in this consciousness as it was not apparent with primigravida women.

Control in birth was perceived as the body doing it naturally and everything other than natural birthing is not having control. Having no control in birth and pharmacological pain relief was the reason for previous negative experience. These experiences gave rise to the experiencing of a lost self-identity which they did not want to repeat again. Nature was understood to have control and deeper critical thinking begins to emerge within this group. *Self* becomes reflective in relation to the social world within which they exist which promotes understanding that everything has an impact. Aspects of altruism become evident, not in the sense of handing over control, but as in the need to do anything at any cost to get the baby out safely, self-surrendering to the needs of her baby. This is convergent with hospital multips, but divergent to the point at which this would occur and under what circumstance they would do this. It is the experience that is of concern to these women not the environment and this is why on the whole they are not adverse in going to the hospital if necessary.

Previous knowledge, experience and self-identity give a sense of assurance yet this can also increase worry. They know professionals hold a position of power so they must be self-led in searching out information, not being informed is not just accepted but facilitates self-determination to gain the knowledge required.

Psychological impact on *self* is seen as important to them and they consciously weigh up their self-concept. Knowing choice is not always apparent they do not want to be judged by others and they are convergent with non conformers in this regard. Behaviour can still be compliant if they perceive the result will benefit them in the end and if they are not being made to do anything they do not want to. At this point the risk to them psychologically if they do not comply, is more detrimental than if they do comply.

SR5 Home birthing multips

One birth experience enables these women to view themselves within a journey of pregnancy and birth. They are able to know about things not experienced and understand what they have no experience of. Their experiences enable them to perceive a self-identity that means they have an innate knowledge and they do not need experience to know.

Their analysis on self-surrendering to nature is different to self-surrendering to professionals. While there is convergence that women want support in labour and birth with those who book to the birth centre, these women do so because they are aware by putting themselves in this environment they are more likely to ensure they will get this necessary support. This concurs with similar findings in Edwards (2005) homebirth study.

SR5 converge with all representations in an awareness that each woman's, pregnancy, labour and birth is completely unique and every woman should have choice, as an individual right. Other SR's believe women's choice should be allowed 'only up to a point' and that is often predetermined. SR5 women believe that 'up to a point' is actually determined by nature. Their analytical thought is divergent with both the hospital primips (SR1) who perceive 'up to a point' as determined by the expert and SR3, multips who argue despite choice, medical problems have a need to be in hospital under a medical eye.

SR5 women reported that practitioners do not mention the third option of home birth because it will be viewed as pushing a home birth onto women and leading their decision-making. They have regard for midwives and feel it is unfair to accuse them of leading women in decision-making. For midwives this is a fine line, information if it is not asked for could be perceived as leading, yet if women don't ask then they will not be advised. This is why this group believe that only statutory information in line with the national guidance is given to women and other information is only given if women press midwives for it.

This group of women are risk aware but recognise that risk does not mean they have no choice. They weigh risks up from a complete perspective and defend their stated arguments. Risks are weighed up in a context of managing them without medical help and this implies self-reliance and analytical thought, for example, the cord wrapping around babies' neck, they know it does not have to be lethal. They believe that what is not known or not informed about, forces women's mind to construct meaning about what risk is. They consider the self-assumptions of some women are often made up from misconceptions and not reality. These women consider situations are never real depictions of how things really are even birth preparation classes and how things are presented is not how things might be. For this group however, these women are able to counterbalance their awareness of risks in the choices they make. They have awareness of how birth is different in 'actuality' hence rely on intuitive self and experience. Their awareness is that birth is unpredictable and there's no way of knowing how it'll go.

Comparative selves are recognized by them as problematic in making judgements about others, without questioning, women are accepting and compliant in thinking. Logical thought enables women's comprehension amid potential risk, to be determined dependant on the circumstances. Potential risk does not make them question their chosen birth environment. For these women it is their observations of upbringing; doctors; what they have been told; what they have investigated and their previous experiences that underpin self-confidence in giving birth. They recognize birth as natural, having gained enlightenment through the previous experience and are in awe of what the human body is capable of.

They consider the mind and body as separate, but one aids the other in the process. Without one or the other the process will not work effectively. They consider things differently as a result and there is an element of feeling lucky in comparison to others. It is questionable that luck is involved, is it rather her concept of *self* that opens up the mind frees the body and in so doing enables her to maintain this equilibrium.

When self-realisation, self-awareness, self-blame and self-regret was unable to be heard and loss of control encountered, this was a catalyst for change. They are self-fulfilled and self-confident. These women have self-belief and as a consequence their self-concept and self-identity has changed with experience and they see themselves as stronger women. They follow instinct, communicate and explore risk factors, understanding this as acquiring essential knowledge for the fuller picture. Self-realisation is due to an earlier experience and their self-concept changed positively as a result of this. There is a realisation by these women that it is hard to change someone's mind because of their beliefs but communication and exploration of what is known and understood by the individual is needed for a fuller picture. These women are aware risk can be brought to a situation by context and place, and in how one is within in this context. This is convergent with others and why women opt-out of certain environments.

Having previous experience of risk situations does not faze these women, they had confidence in their midwives who empowered and supported them with communication to decide what was right for themselves and their midwives had confidence in them to make informed decisions about what was best for them. This was due to these women feeling able to voice themselves to their midwives as needed and their midwives responded in supporting the judgements these women had made. There is a difference between them and their friends in judging risk; others see home birthing as risky but these women's positive outlook means they are able to question, why would anything go wrong and accept that there are always options even if the situation escalates. They perceive a flexibility of the home situation, similar to other's who birth at home (Edwards 2005), are self-prepared to take on the responsibility themselves, and do not want to give this responsibility up to someone else. They are emancipated and empowered and had equality of voice (Williamson 2010). They possess a positive, realistic understanding about risk and home birthing and they do not perceive it as problematic or creating additional risk. These are intuitive feelings. There is no right or

wrong decision it is which option fits the person. They do not perceive the context of environment per se as the most important factor, rather the nature of the midwife-woman relationship is more important; being comfortable with decisions made and how they are able to deal with pain are of greater importance. Some may want the pain taken away, this depends on the individual person and how they view it. Knowledge gives them the understanding to make decisions that are right for them as others can about themselves.

They have a deeper insight than all the other represented groups and reflect on knowledge imparted positively by midwives. They know it is a norm that information is imparted to and from each other as women listen to 'horror stories' from within their social group. They recognize doctors and midwives as having different professional roles, they view midwives as giving options best for women, whilst consultants are more likely to coerce women for their own goals. They believe further, midwives have women at heart more and act to promote women's voices, whereas consultants, in their experience think of birth as a medically managed process. They believe women's voices and midwife support can change care when doctors are keen to intervene and not give women a voice. This is reflective of competing ideologies between women, midwives and doctors (Williamson 2010, Edwards and Murphy-Lawless 2006, Edwards 2005).

These women reflect in a wider context, that there is need for women to answer specific questions, hence a need for professionals to ask specific questions. Moreover women need to consider themselves and what things mean to them. *Self* in this context is distinguishable from the rest and underpinned by confidence which enables a voice - being head-strong is the key. These women believe that it is good to pass on experience and they consider they are in a good position to convey information to other women as non-professionals who cannot be accused of coercion. They articulate the importance of group influence, in getting all the information and offering this advice to others. These women have an element of self-assessment in decision-making.

SR6 Conforming to professional advice

Findings illustrated this group showed no characteristics of being emancipated decision-makers. They perceived birth in a similar light to SR1 and SR3, as risky and would comply with professional advice for whatever it took to get the baby out. They

perceived themselves in a process, whatever is needed to make it safe and they surround themselves with what is necessary for a safe result. They perceive themselves as having no ability to influence, and no realisation they have a voice in this process.

SR7 Non-conforming to professional advice

Of the three non-conforming women, two showed definite characteristics of being emancipated in their decision-making about birth options. One woman did not and this was inherently due to the relationship with a professional influencing her self-determination and self-assurance. Decision-making about birth choices began for these women as a result of their previous experiences and they either voiced or tried to voice these desires as being right for them and their family group. Dependent on their own circumstances and practitioner reaction to such requests at their first interaction, this was found to be a definitive indicator as to how much or how little they would need to continue to exercise in self-justification to professionals throughout their journey.

There is a correlation between the underlying fight for what these women want, the relationship between them and their midwives and emancipation in decision-making. The influence midwives can have over women has a capability to either make or break emancipated decision-making regardless whether or not the midwife attempts to empower in given encounters.

For the women who are emancipated in their decision-making, what is observable is the requirement to be heard and supported by their midwives in choices made. Katie, who did not show attributes of emancipation, clearly did possess elements of working towards this. These elements appear to originate from oppressions encountered in her previous interactions with midwives in past pregnancies. Confidence in and reliance on these midwives was not perceived as the same as in this experience but to have achieved the outcome of emancipation in decision-making there was a need for continual support. This relationship, confirms a shared common goal. The ability to maintain a continual regular dialogue between women and midwives seems an essential component to maintain self-determination and continuation along a trajectory to emancipated decision-making.

Relationships that existed between women and their midwives, developed through previous shared birth experience, were nurtured through equal respect and connectedness and this strengthened existing bonds. This was evident, moreover, for home birth multips and their midwives. Furthermore, the potential influence of the midwife-woman bond was evident even for those just meeting at birth. Arguably then the empowering other, the midwife, does not need to be present at all times. These women internalize actions that are intrinsic to them because of their underlying values and beliefs. As Aronson (2008) highlights, this is the result of believing that someone who provides this influence to be of good judgement and trustworthy, women come to internalize this in their own belief system and therefore can be resistant to influential change. Change resistance in this context is in the response to compliance not in resisting treatments and hence putting their baby at risk. Emancipation enables women to become self-determined because of their previous experiences of oppressive behaviours where they have had to fight for what they want.

What influenced these women and altered their behaviour into becoming emancipated decision-makers was the lack of 'right' support as they saw it not how others determine support to be. In previous pregnancy encounters, this impacted directly on aspects of self-determination, self-assurance and self-reliance. As a result aspects of self-doubt and now decreased self-regard, self-assurance and self-determination were exhibited, as they submitted to the influence of professionals. The woman 'working towards' emancipated decision-making perceived a loss of control and self-determination in her ability to voice what was desired.

There is reference to midwife skills as providing a sense of being 'looked after'. These women would listen to advice but not necessarily take it. This illustrates how they felt in an equal position to their midwife within the situation that encompasses equality of moral agency through equality of voice (Williamson 2010). This was evident in Katie, the non-emancipated woman at the beginning of her journey in her continual struggle to fight for what she wanted. She was supported initially but lost self-determination when a different midwife and oppressive other was encountered. She did not have at this point an empowering other to support her self-determination; hence she was unable to fulfil her trajectory to emancipated decision-making.

Internal and external interplay on a trajectory of pregnancy

Self as a pregnant identity experiences critical moments in pregnancy that represent an undulating trajectory of decision-making. Figure 16 overleaf, illustrates such a trajectory and critical moments are seen throughout the pregnancy and decision-making journey.
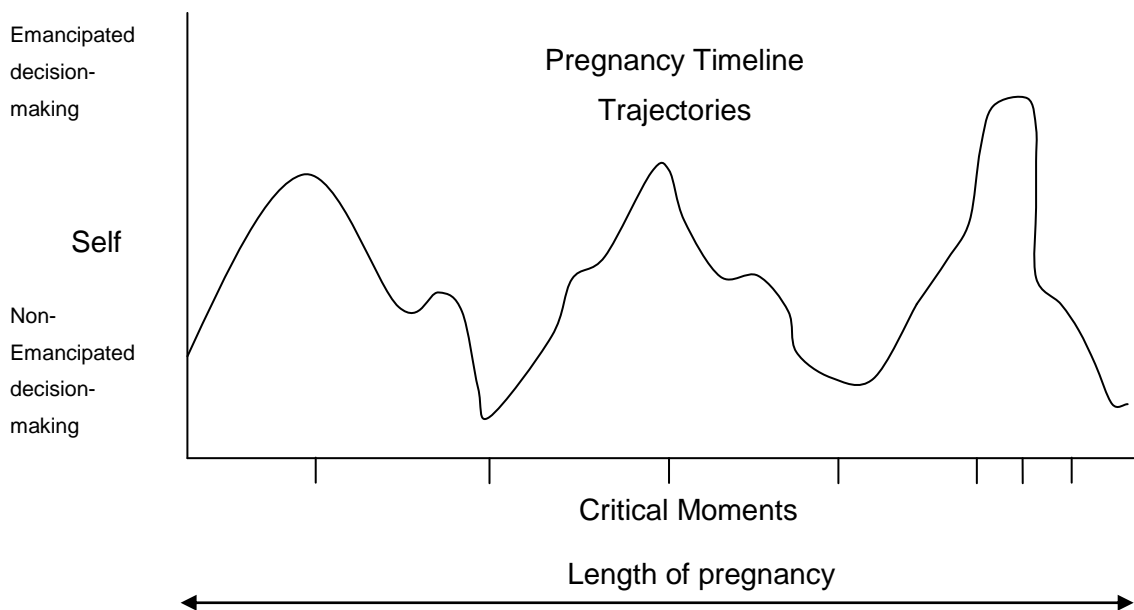
Figure 16 Pregnancy timeline trajectories

Undulations represent the changeable *self* at critical moments that alter self-identity. Decision-making is a continuous process and internal and external influences interplay situating *self* in a constant state of flux. The interplay between the internal and external influences was illustrated in figure 15 on page 191. Critical moments are critical points in pregnancy where women may have to make choices for themselves. For example decision-making about antenatal screening as they experiences self-doubt and reduced self-reliance in whether to have a Downs Syndrome test, where decisions may be influenced by external influences such as practitioners who interact with them. Katie experienced similar critical moments in going to the Antenatal Day Unit (ADU) with 'pinky waters'.

Undulations illustrate points in decision-making in pregnancy and the ability to remain self-determined and self-assured at these critical moments is fundamental to emancipated decision-making. Trajectories are individual, for different women at different points and different times and why no labelling of these critical moments is shown.

Continuum of emancipated decision-making

Women's decision-making in pregnancy can be viewed as a continuum poles apart. Decision-making behaviour ranges from those who are compliant to those who are non-compliant at opposing ends. The continuum illustrated in Figure 17 overleaf demonstrates the social representations as they appear from this inquiry at different points on a decision-making continuum. Some SR's are shown to be at the furthest pole, being emancipated decision-makers whilst others are situated at the non-emancipated pole. The opposing poles distinguish their perceptions, characteristics and comprehension that are representative of *self*. The continuum can also illustrate women individually and give explanation for their individual characteristics as decision-makers along this continuum.

The social representations illustrate how groups sit at points on this scale dependent on group characteristics of *self*. Individuals, as mentioned have their own points at which they enter an individual scale and it is feasible that in context of the individual, women move along this continuum back and forth to or from emancipated decision-making.

Compliant
woman

Non - compliant woman

Self identity
made up of
aspects of self

Self identity
made up of
aspects of self

SR1/SR3/
SR6

SR2/SR4

SR5/SR7
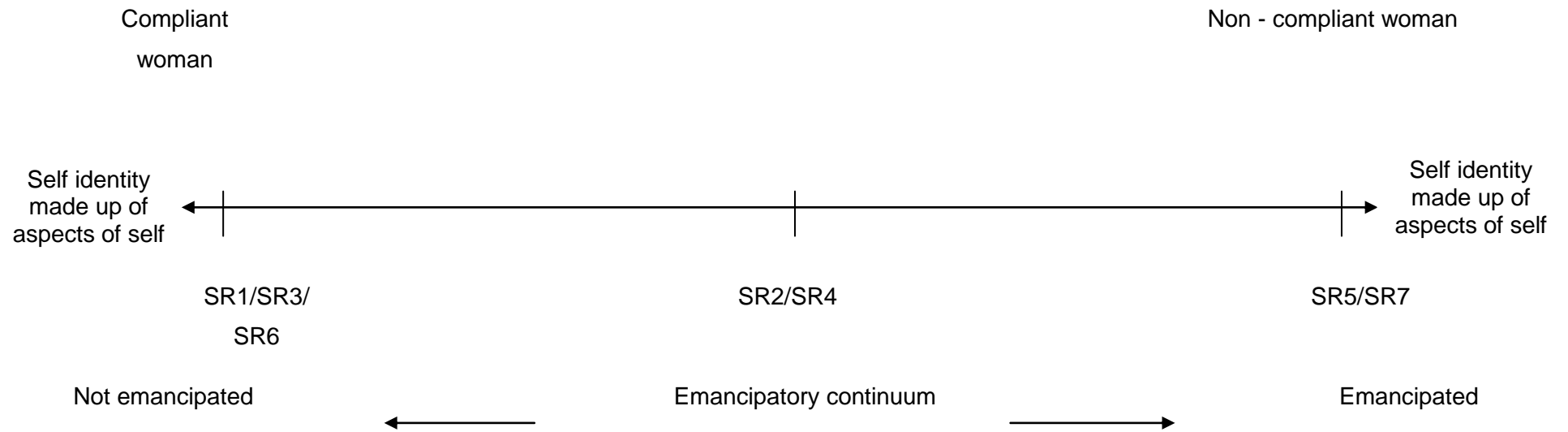
Not emancipated

Emancipatory continuum

Emancipated

Figure 17 Continuum of emancipated decision-making

Social perspectives and constructed realities

Hospital women consider the third party in the vignettes should take the advice and birth as advised as it is for her own good. This is apparent in the synergy of their views and similar decisional actions they would take and is reflected in the views they have about the birthing process as problematic and risky. Birth centre women reflect more upon the situation in a back and forth manner, more aware this is only advice and she does not need to take it, however they would most likely concur with advice because of the elements of risk and uncertainty. The home birthing multips extend the story further, in making plans and suggestions which would support a changed experience this time.

The personal behaviours of the women who define the different social representations, determines their position on the emancipatory continuum, somewhere between the extreme poles; relating to whether their behaviour is likely to be conforming and not self-assured or self-determined, or whether they maintain self-determination and self-assurance in changing situations. Parity does not appear to determine position in relation to, for example, self-determination as might have been expected to be the case, but is more likely to be resultant from the position from which they commenced on the emancipatory continuum, hence self-identity and the perceptions held reflects this.

The vignettes illustrate theoretical complexities that are fundamental to understanding women's decision-making further. They presented quite by chance, as a useful tool in which to contribute understanding of women's perceptions in maternity culture. They illustrated supremely, how in their own perceptions, women construct realities as expressions of how they identify with the birth process and their decision-making about birth. Emery (1978 p39) enlightens this paradigm and the issues of reality:

> *"our individual personal reality-the way we think life is and the part we play in it-is self–created, we put together our own personal reality... we literally create a reality that reflects our view of the world and who we are in relation to it."*

Emery explains further, how this is made up of our perceptions of the way things are and what has happened to us. The relevance this theory has to this inquiry indicates

that the way things are, is due to the cultural and social norms within which women exist, and the micro-culture of maternity care they come to join (Thomson 2011, Kirkham 2010a, Williamson 2010, Edwards and Murphy-Lawless 2006, Edwards 2005, Kirkham 2004, Kirkham 1999). Emery's perspective is evident within the narratives of women, how they voice experiences and express justification of their reasoning. SR3, birth centre multips, perceive themselves as comparative to the woman in the first vignette. Their reality is they would also go with health professional advice, despite previous negative experiences with professionals. The reality of risk out-weighs the potentially desired experience because it is an already 'known risk'. Experience of an already lived reality creates a perceived *self* that needs to remain self-determined in potentially changing situations to achieve the desired experience. As Emery (1978 p39) highlights:

> *"if we have a reality that says that life is about suffering and struggle we will create a life experience that proves our reality is accurate, if we have a personal reality that says our well being is dependent on others we will arrange for life to support our reality of dependency".*

The reality for hospital primips was that they believed professionals would give them the information to deal with the experience. Hence, they are out there in the world, creating a reality through experiences that accurately reflect their notion of the way life is (Emery 1978). Creating these experiences backs up their notions, thus the women accept the professionals will be in control of this experience for them.

This provides a plausible interpretation of why some multips may return to the hospital following less than positive experiences due to their perceptions of risk and uncertainty. Whilst others situate *self* in an environment to ensure experiences are not relived. This assumption is reinforced by those who view birth as a process that one must endure for the product at the end of this process, this product is the safe delivery of the baby at any cost; divergent with those who perceive the experience and the birthing journey as paramount, albeit equally wanting a safe result.

Emery (1978 p39) argues we hold basic assumptions about life from an early age and we add to and adorn our script during childhood until we are about seven years of age. Moreover arguing these are decidedly inaccurate perceptions of ourselves and the world, because they are constructed from our perceptions at such a young age; in this

he says, *"we put together an environment that is a perfect reflection of our view of the world."* As a consequence of this we treat the world and behave in it, in such a way as we see it, by the choices and decisions we make and this is the story of our lives "*we literally create a reality that reflects our view of the world and who we are in relation to it.*" (Emery 1978 p39).

Emery (1978) further argues self-created realities invariably create problems. If we create realities for ourselves based on our perceptions in receipt of no experience, knowledge, and from general misconceptions, what we do create is indeed a highly inaccurate perceived reality, and it is this that reflects our view of the world and how we are in relation to it. This is clearly evident in how some women had constructed realities based upon the experiences of others in absence of their own, and from misconceptions they held regarding certain practices and social norms.

It materializes when there is a 'risk label' attached and it is considered more than likely this will happen again, as this was the consensus of SR3, the multips birthing at the birth centre in response to scenario one. Labels are examples of constructed realities that help us to easily sort reality (Lincoln and Guba 1985), hence determine what we recognize as risk or not. The reality for some in managing risk was to reduce it by compliant behaviour with experts, medicalised care and technology (Edwards and Murphy-Lawless 2006, Symon 2006). Whilst other's, SR5 women in particular, perceived the reality of risk as relatively rare and that risk can be constructed differently in different situations by our interactions. What this reliably suggests is how multiple realities exist; women's narrative voice (Edwards and Murphy-Lawless 2006, Edwards 2005) opens up these alternative constructions for interpretation and enlightenment.

All women are out in the world creating their reality, accurately reflective of their view of the way life is (Smythe 2011, Thomson, Dykes, and Downe 2011, Edwards 2010b, Edwards and Murphy-Lawless 2006, Edwards 2005), and as Emery explains (1978) subconsciously creating experience that back up their notions. Hospital primips had no examples of good experience to draw from and many friends had 'complications', hence, backing up their notions that birth is risky, even if the complications reported by others weren't necessarily so, but made to be through their constructed realities. These then become a reality for the hospital primips. This is comparative to professionals who experience complicated midwifery care more routinely and hence may also

subconsciously think of these experiences that reflect and back up their notions that midwifery care is mostly complicated and full of risk. The impact this has for midwifery and maternity service delivery is a constructed reality of risk and uncertainty that continues to preside as dominant to all other notions of reality, such as natural childbirth (Symon 2006). These become ingrained as cultural norms and practices and women come to join this maternity reality when they become pregnant. This then becomes reinforced as both groups interact (Williamson 2010).

Some women in SR3 (birth centre primips), did not perceive the woman in vignette two as doing something 'best' for *self*. Choice is perceived as different for them because the woman is perceived as likely to have a problem again. Their judgement of this woman as compromising the health of her baby reflects a constructed reality which contradicts their apparent belief in choice for all women. This reveals they are still making choices within a perceived reality of risk, and choice should only be available up to a point.

The individual realities engaged within to make sense of a context of truth and reality overlap; these differ in meanings that we attach to the same phenomenon. In sense-making, individuals engage in these in a way that keeps their world whole and seamless (Lincoln and Guba 1985), or safe in the context of decision-making about birth. This is how we make sense of a situation. The determining factor is whose construction ought to legitimately prevail (Lincoln and Guba 1985). The postnatal 'labelled' non-conformers in their own constructed realities appear different in presupposing they are women who are non-conforming to healthcare advice. In reality these women are no different than every other woman in having their own constructed reality and are as unique as the next, they too would transfer in the event of untoward events occurring and would problem solve at every stage as they perceived their reality changing.

Making-sense of reality depends upon how we view reality (Lincoln and Guba 1985). Objective reality asserts a tangible reality and experience of that reality can result in knowing it fully. This might be one way to explain how women's perception of professionals as experts possess an object reality gained through experience for example, risk and safety. Therefore the woman believes that the experts know 'it' fully, which engenders trust in their judgement and behaviours.

Perceived reality Lincoln and Guba (1985) indicate is about knowing there is reality but the actor understands we cannot know it fully and that it can only be appreciated from particular vantage points. These vantage points are our perceptions, a partial incomplete view of something that is nevertheless real, and capable of different interpretation when seen from these different viewpoints. The supposed non-conforming women wanted to have their viewpoint acknowledged they wanted to voice themselves and felt unrecognised in a situation of elevated risk. The health professionals encountered have different viewpoints to women and these women particularly. This exemplifies how individual perceptions of those involved within the decision must be acknowledged; consensus should not be predetermined with either actor engaging in ways that could override other courses of action (Aronson 2008). The consequence of overriding behaviour is that one side acts as a mind-guard (Aronson 2008) or a gatekeeper (Levy 1999b).

The differences between objective and perceived viewpoints are that some women may believe objectively, that the reality they face may be known only through the body of expert knowledge, research and technology and this knowing can guarantee the safe delivery of their baby. If this is equally acknowledged by the perception of a professional who interacts with her, the reality might mean the choices women make are largely unconsidered and unquestioning.

Lincoln and Guba (1985) argue that others, who they term 'perpetual realists', believe that no one person, or group of many persons can know all of reality at any point in time and that reality for any individual, group or discipline still remains a partial picture of the whole. This was observed within the narrative of some women, those who booked to the birth centre, including the primips, the home birthing women and the non-conforming women. The difference between the perspectives of realities here lies with what these groups believe is knowable about reality. That is in knowing the responsibility for safety lies with experts and the use of technology to aid this or by those who believe that it is the journey and influences along the way that determines what reality will be.

Lincoln and Guba (1985) describe constructed reality as reality seen by some constructed in the minds of individuals and they question whether this reality really exists. No amount of inquiry can create convergence because the numbers of

constructions that result in multiple realities are infinitum. Constructed reality was evident in the interactions Katie encountered with her midwife as the midwife explained what the reality of her epilepsy meant:

> *"And then obviously she was putting into place, you know, the fact that obviously you've got epilepsy so you've got to put yourself into the higher risk of category with doing a home birth. And obviously, you know, make sure that you're prepared for things to go wrong because there's more chance of it going wrong with you than say another woman down the road that hasn't got epilepsy which is true."* [Katie]

Katie constructed the reality of rupture of her uterus and being rushed covered in blood in front of her children. No one had mentioned rupture to her and when she attended the antenatal day unit with pinkish liquor, constructions of uterine rupture began to manifest. She constructed the above reality of rupture as a consequence of being told she would need transferring to the antenatal ward to see what was causing the bleeding. This exemplifies how the language practitioner's use can lead to women constructing realities that influence decision-making. The realities constructed result from the external influences of others. Internal aspects of *self*; arguably may be dependent upon a personal ontological perspective of how one perceives reality in a certain context, and an ability to remain independent within this perceived reality. However, practitioner interactions at critical moments caused fluctuations in Katie's capability to remain emancipated in decision-making.

In understanding women's perceptions of the vignette scenarios, it is evident they form mental pictures of themselves within certain situations, in so doing unconsciously combining aspects of *self* to make decisions based on the interplay of external and internal influences. Both internal/external influences compete for supremacy, for example, their self-concept and the characteristics they have such as self-determined, self-assured or self-doubting become the overriding factors that determine their self-identity and what the *self* is, either compliant or emancipated. Understanding theoretically what the social representations suggest in the context of decision-making about birth choices, can be further expanded through consideration of the attributes of emancipation.

5 Attributes to Emancipation

Wittman-Price (Wittmann-Price 2004) defined the meaning of emancipation as an equalization of internal and external demands through which an individual chooses what is best for them, even if this is not the most accepted alternative sanctioned by others or by society's norms. Referring back to page 97 the reader will find the outline of these attributes according to Wittman-Price. These include reflection, personal knowledge, empowerment, awareness of social norms and flexible environment.

Considering these attributes in relation to the emancipatory continuum, the social representations positioned as non-emancipated do not show these attributes within *self*. Women do not ask questions and are not self-aware, not because they have not gone through the experience before (SR1) but because they do not consider any alternatives that might be open to them. They do not reflect upon the impending situation they are encountering. Because SR1, SR3 and SR6 do not ask questions they do not reflect or consider any other options like their potential ability to cope with pain and not requiring pharmacological pain relief and low self-esteem about *self's* ability to cope increases conformity (Asch 1955). Encouraging women to reflect on their experiences in the 'here and now' and reflective exchanges to take place with those providing care, this could increase women's awareness of other options and facilitate increased autonomy (Edwards 2010b, Cameron and Ellwood 2006) in future decision-making. Women's approach to knowledge about childbirth affects how they come to understand *self* (Bergum 1989), these women know they are compliant, are accepting of what they are told and do not support freedom of choice for others.

These groups (SR1, SR3 and SR6) are not empowered by the professionals that they encounter as information is not imparted to promote autonomy and independence. For those who have previous experience they do not consciously consider alternatives but are accepting of the experts on the same grounds. In accepting risk and a medical approach themselves, these women do not consider that society places more value on one competing paradigm of birth over another, nor do they themselves consider these alternatives competing as others do (SR7) which may be as a result of being happy with the medical approach they want. Consequently they have no self-awareness due to having never experienced or explored this as others have.

At some point further along the continuum but not fully emancipated decision-makers are SR2 and SR4. They demonstrate some attributes of emancipated decision-making. *Self* and experience are the driving force, not risk and fear as with the non-emancipated representations above. These groups have developed a desire to ask questions and are naturally more inquisitive. They reflect upon the situations they encounter and step outside of it, through self-awareness of other alternatives they opt-out of choices. Reflection and stepping out of the frame signifies a deeper awareness about things and they readily question. Personal knowledge increases because of questioning practices and a consideration of how their actions affect situations. They are more self-aware because they have increased information, this strengthens their understanding and they lead conversations. In booking to the birth centre these women have considered alternatives in the process of their decision-making. Personal knowledge is still lacking and impedes decisions relating to homebirth choices. Their perception is that each birth is different but the fundamentals are the same. Their perceived change in self-identity as a mother means they have the ability to develop a critical consciousness. Independence is a pre-requisite to empowerment and they are empowered by midwives and through their questioning of practices. As the knowledge is imparted further, this promotes the independence and autonomy already possessed. These groups weigh up risk and are aware of social norms, of how culture sanctions these societal child birth norms and how doctors are perceived as saviours of situations, but this is not for them. They use perception to step out and reflect on actions and have self and experience at the centre of their decisions.

At the furthest point on the continuum are SR5, the home birthing women and SR7 the perceived non-conforming women. These were women who were emancipated decision-makers. They had all of the attributes for emancipation. Self and experience were the driving forces behind their decision-making. True reflection enabled them to take action. They could step out of one *self* and be reflexive and reflective to understand it logically. They had a deep critical awareness, questioning practices as normal behaviour and consistently considered alternatives. Personal knowledge was due to self-awareness they were conscious of their feelings experienced in the 'here and now' and possessed a deep critical consciousness. Personal knowledge is not just about previous experience. It is possible that this could present in others who do not have experience, but who do have personal knowledge for example, home birthing primips, who do not need to have had the experience to know it. SR5 and SR7 women

were empowered. Despite having supportive partners, it was ultimately their midwives who empowered them by positively promoting their autonomy and independence so these women could reach their personal goals. These women are emancipated and as the relationship between both parties remained equivalent, power was equally shared between them, guaranteeing freedom of choice as naturally occurring, indicative of emancipation. These midwives positively promoted independence and autonomy where alternatives were discussed. Contingency plans were developed in case of untoward events occurring within the home environment, rather than alternatives being dictated in relation to what she can or cannot have. Hence, the environment that developed between them and their midwives was and remained flexible and responsive to change by both parties. This explains why the perceived non-conformers would immediately act unquestioningly to advice when their midwives raised concerns. Sanctions were not attached to any decisions made by these midwives. Wittman-Price (2004) explains this enhances self-esteem and understanding, which was clearly evident in these groups. These women did possess increased abilities for self-determination, self-assurance and self-esteem. They were aware of social norms and cultural practices for those whose care is perceived as not straight forward. These women were aware of how they are perceived by others, and for the perceived non-conformers (SR7), how this had grown from experiencing oppressive encounters. This was a determining factor in self-determination, and fundamental to reducing pressures to conform.

Research questions answered

Question one posed at the beginning of this thesis has clearly been answered through the process of interpretation showing women are socially influenced in their choice options. The extent to which this operates is fundamental to informed choice. Question two in how this influence links to emancipation and question three in whether emancipation reduces pressure to conform clearly demonstrates this is the case.

Women appear to be positioned on a trajectory and have empowering supportive others alongside them. The further along this trajectory they appear, the more self-determined they are and possess less of a need for their constant empowering other. This is due to experiencing or coming to independently experience an internalization of own values. The less self-determined women are, the less they are emancipated in

their decision-making and the more they require an empowering other for them to move forward through their trajectory. Self-determination in women who have not experienced oppression may still require an empowering other as emancipation is perceived by them as a balance of power. All women will come into contact and experience this balance at some point whether they are conscious of this or not. It is the consequence this balance of power has for women, for those who may or may not perceive this as control that is of unease within a choice agenda and informed decision-making, as this could undoubtedly impact directly on birth experiences. It is obvious self-determination is fundamental for emancipated decision-making, for perceiving good experiences and reflecting positively on these. Women who have experienced oppression discover or recover their self-determination following often quite foreboding experiences that they have come to identify with through reflection and self-realisation. The results of this are decision-making practices that are justifiable for women but are misunderstood by practitioners and others within the social field.

Whether oppressed women can reach the point of emancipated decision-making and not demonstrate compliant behaviour is dependent upon *self* and their empowering other; their ability to internalize and move from a state of compliance to internalization as they continue along a trajectory, and resist regression to a state of compliance. There is a point in pregnancy or birth when submission is to the reality of their lived experience and situation faced in the 'here and now', that is, risk at that point in time. Emancipated women at this point and only at this point, submit to the situation and transfer to the hospital. This is because of internalized understanding and the equal relationship of trust and judgement that exists with the midwife (Williamson 2010, Edwards 2005). This is not understood as submitting to the midwife as a powerful other. The reality is women do not perceive their midwives on the whole as controlling figures, even before the 'here and now experience', despite some having a concrete reality of control by others. These women perceived themselves at the centre of care finally – they've voiced, it's been heard and is respected as her choice.

A limiting factor

It is naturally a limitation that no home birthing primips came forward to represent a complete SR group. The fact that this social representation is non-existent from the recruiting phase is illustrative of a limited pool of primips booking to birth at home. This

demonstrates as clearly evidenced elsewhere, that these women are in a minority (Birth choice UK 2012), profoundly so that no primigravida woman were booked for home birthing within the sampled geographical areas. Furthermore, there were at the time of recruitment, no primips booked for home birthing from the trust locality. The reasons for this cannot be made clear but may corroborate findings from the literature and Barber et al (2006) who reported primigravida women are least likely to be offered a home birth.

Model of pregnancy identity

To be emancipated women must possess the five attributes proposed by Wittman-Price (2004). Possessing all five of these, women illustrate the ability to move along a continuum to emancipated decision-making. The interpretations show social representations of pregnancy identities. It is clear that:

- Women might possess these attributes as a result of experiencing oppression. This causes self-identity to change as a result of these past experiences becoming self-determined and self-assured from this point on.

- Some women are self-determined to begin with and supported by another. These women may be those that are not challenged in their decision-making since there is no reason to be. This may be because decisions are in line with service provision and social norms. Additionally, these women have not experienced any form of oppression or as they perceive it – language, behaviour, group pressures.

- Some women are self-determined and empowered, these women have to a greater extent (perhaps completely or working towards) more attributes for emancipation. Situations can make or break women and they may regress backwards to compliant behaviour.

- Some women are not self-determined or self-assured, they are compliant without question. They may be either happy or not happy with this situation and either considers consciously or subconsciously, *self* as oppressed. Their conscious behaviour determines what they will do - maintain compliance or if

they consider *self* oppressed, steers behavioural change and become self-determined and assured from this point.

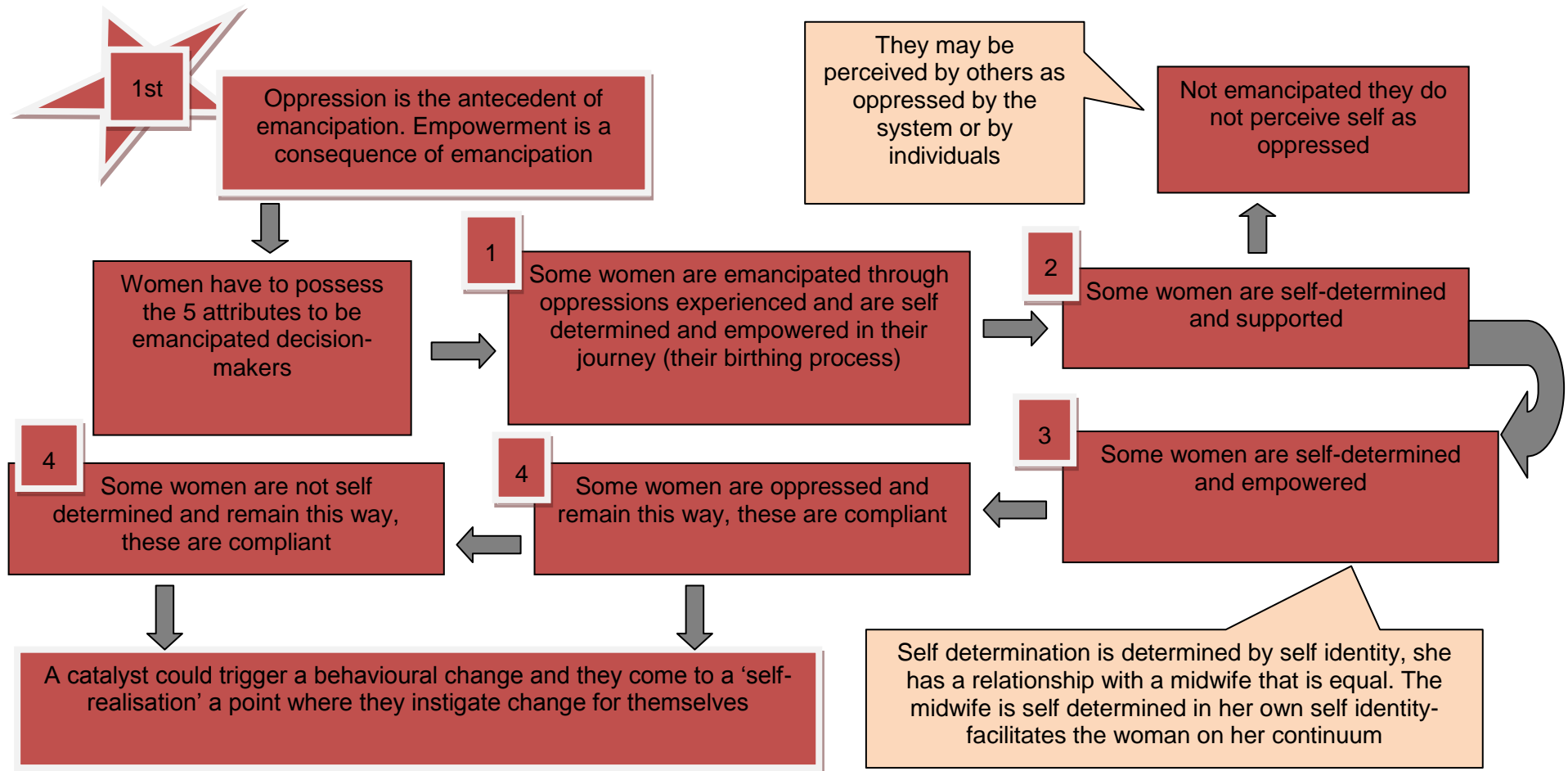Figure 18 overleaf illustrates these points.

Figure 18 Model of pregnancy identity

It is proposed that to be emancipated women have to be empowered. Some women are self-determined and supported, some self-determined and empowered and some self-determined become emancipated as a result of oppression in this process. The concepts of emancipation and empowerment in the conceptual frameworks chapter explained these concepts in full. Empowerment is a consequence of emancipation (Wittmann-Price 2004) therefore empowerment does not exist without it. It is possible to have empowerment with emancipation if there is an empowering individual that facilitates women's independent thought and action, that in turn encourages autonomy, rather than simply support by approval. Midwives can facilitate empowerment to an emancipated woman, but by this same understanding, only if the midwife demonstrates attributes of emancipation. Hence the midwife must also be self-determined and possesses the characteristics of *self* to demonstrate intrinsically these attributes in her practice. Midwives, like all professionals in this sense, can only be an empowering individual to someone who also ascribes to these attributes. The two are synchronised in this shared decision-making process and this is why fundamentally these coalesce as a dual concept for both women's and professionals' autonomy.

It is not a requirement for women to reach the furthest pole on the emancipation continuum, but with these practiced by both, in a shared understanding, power is equalised and truly informed decision-making naturally occurs. However, experience of oppressions in past experiences might present women outwardly as non-conforming. This inquiry has illustrated these non-compliant women, as they were perceived, are not as they appear and the often perceived reality of them is based upon misunderstanding. Previously, at a point in the analytical process, non-conforming women appeared perhaps as non-conforming conformers. What reality shows now is that they are emancipated decision-makers, similar to the home birthing women. It is not the fact that they experienced oppressions that has created them as emancipated, but more than likely these oppressions have been the catalyst that exerted behavioural change in self-identity. The catalyst was self-realisation, which underpins growth and adoption of attributes of emancipation (Wittmann-Price 2004). It is in how we come to understand their journeys to emancipation that illustrates whether this is a result of experiences of oppression.

Humanistic model of emancipated decision-making

The determining factor is there has to be a concept for a humanistic model that facilitates emancipated decision-making in maternity care that aids every woman through empowerment to reach emancipated decision-making, hence free choice.

External influences of fear and risk; pain; internal aspects of self; misconceptions and misunderstandings are reasons why women may remain compliant and not emancipated in their decision-making in childbirth. It is important to address these reasons and facilitate a culture toward emancipated decision-making where women can feel self-assured about the choices they make and maintain self-determination. It is imperative that the profession of midwifery addresses this and make it central to the decision-making process for both women and midwives.

There are clinical decision-making models used in nursing, however these explore processes applied in practice for practitioner decision-making (Banning 2008, Rashotte and Carnevale 2004, Thompson 1999, Offredy 1998, Baker 1997). A humanistic model for emancipated decision-making has, as the focus, women as central to this process. A humanistic model of emancipated decision-making does not reflect a clinical decision-making model that midwives and practitioners engage in, but would enable a self-led continuum to informed decision-making by women; free from coercion and free to explore preferences and alternatives.

As the midwife-woman relationship holds together the tapestry of maternity care (Hunter et al. 2008), and midwives are synonymous with the women they care for, a model of decision-making that holds these principles as equal parts within a whole is respectful of the positions held by both. This makes the dual aspect model not only relevant to women but also pertinent to autonomous decision-makers. The process of addressing each element as dual characteristics of joint decision-making ensures knowledge transfer and critical thought by both parties as parts within the whole. Strengthening the relationship between both, as women are afforded an opportunity to act in an emancipated manner and in practicing midwifery autonomy; the midwife is free to facilitate this. Acting in this way, only when all other elements have been considered, can an emancipated decision-making process be embodied that is representative of free choice. Without consideration of the other elements the process

is less well thought out, does not contain all the characteristics for emancipated decision-making and may result in coercion.

The decision-making process for practitioners naturally begins with women as they come to join the existing midwifery culture. For women they have been formulating perceptions, ideas and decision-making practices well before this point and they come to midwifery culture with existing knowledge. Decision-making is a systematic approach based on Information Processing Theory and belongs to the larger field of cognitive psychology. Decision-making is an important part of cognition (Pitz and Sachs 1984) and the theoretical assumptions of information processing are that there are a set of processes that produce the behaviour of the thinking man/woman in which theory asserts to explain rather than just describe (Newell and Simon 1972). As such these cognitive mechanisms remain individual. As a result of one's own perceptions and opinions the reality we perceive in how we view our world is open to misinterpretation regarding the issues about which we are making decisions. The innately personal decision-making processes women undertake about where to birth for example, what screening to have, what pain relief might be required for example, are decisions about normalised situations and are different to clinical decision-making models practitioners use in every day practice. Women do not make decisions about clinical issues like professionals do they make decisions about alternatives from a social perspective, in a sense, a continuum of what is about problem-free decision-making circumstance in a cultural system that focuses predominantly upon risk (Symon 2006). Moreover where meanings of risk are ambiguous and become a mechanism for disempowerment for both women and midwives (Edwards and Murphy-Lawless 2006). There is need for a model of decision-making that embraces and acknowledges women's decisions about birth as a normal life experience and to have alternatives in maternity care. Women's preferences ought to be part of this process and fundamentally key to this. It should for that reason maintain a bottom-up approach where women are central to the decisions being made, instead of a service top-down approach where they remain recipients of service provision.

Wittman-Price (2004) suggests five attributes for emancipation to occur. This inquiry has indicated how *self* profoundly affects the decision-making process for women about birth options and in view of that it is suggested that a model that aims to promote emancipated decision-making in child birth must include not only these five attributes;

as they have clearly shown to be critical to social influence and women's decision-making in pregnancy, but a sixth essential characteristic extends this and generates new theory in midwifery. A sixth essential element of self-perception completes the complexities engaged in for an emancipated decision-making model in maternity. Self-perception relates to issues such as:

- What do I feel about the birthing process?

- What is my understanding about it and where does this knowledge come from?

- What do I worry about?

- And what am I frightened about?

Exploring ones self-perceptions encourages reflection, the ability to stand outside the situation and critically examine the frame. This encourages self-awareness, the personal knowledge that enables women to begin to develop awareness of how their knowledge can affect the situations they encounter. This increases knowledge of social contexts as they develop this through knowledge exchange through equal partnerships. As both parties engage in this together, new understanding emerges as midwives empower women who become or work towards emancipated decision-making about their birth preferences. This facilitates a non-judgemental environment where free choice is supported and encourages self-determination, self-assurance and increased self-esteem.

Figure 19 overleaf, illustrates the six elements of the humanistic model of emancipated decision-making in childbirth. Central are the social representations shown within the culture of midwifery constructed from the characteristics of women's individual selves. The six elements influence pregnancy identity and their perception of reality about the birthing process. Addressing these elements in practice produces women's independent thought and action through autonomy, the outcome of empowerment. These behaviours are reflected back to the elements in practice and barriers begin to be broken down and social norms begin to change. There has to be an equal sharing of responsibility and authority between women and their midwives, or other care provider, but facilitated by women's midwives as the supportive other for this to take place.

Self perception

Reflection

Personal knowledge

Self

Awareness of social norms

Social representations of pregnancy made up from individuals' selves

Empowerment
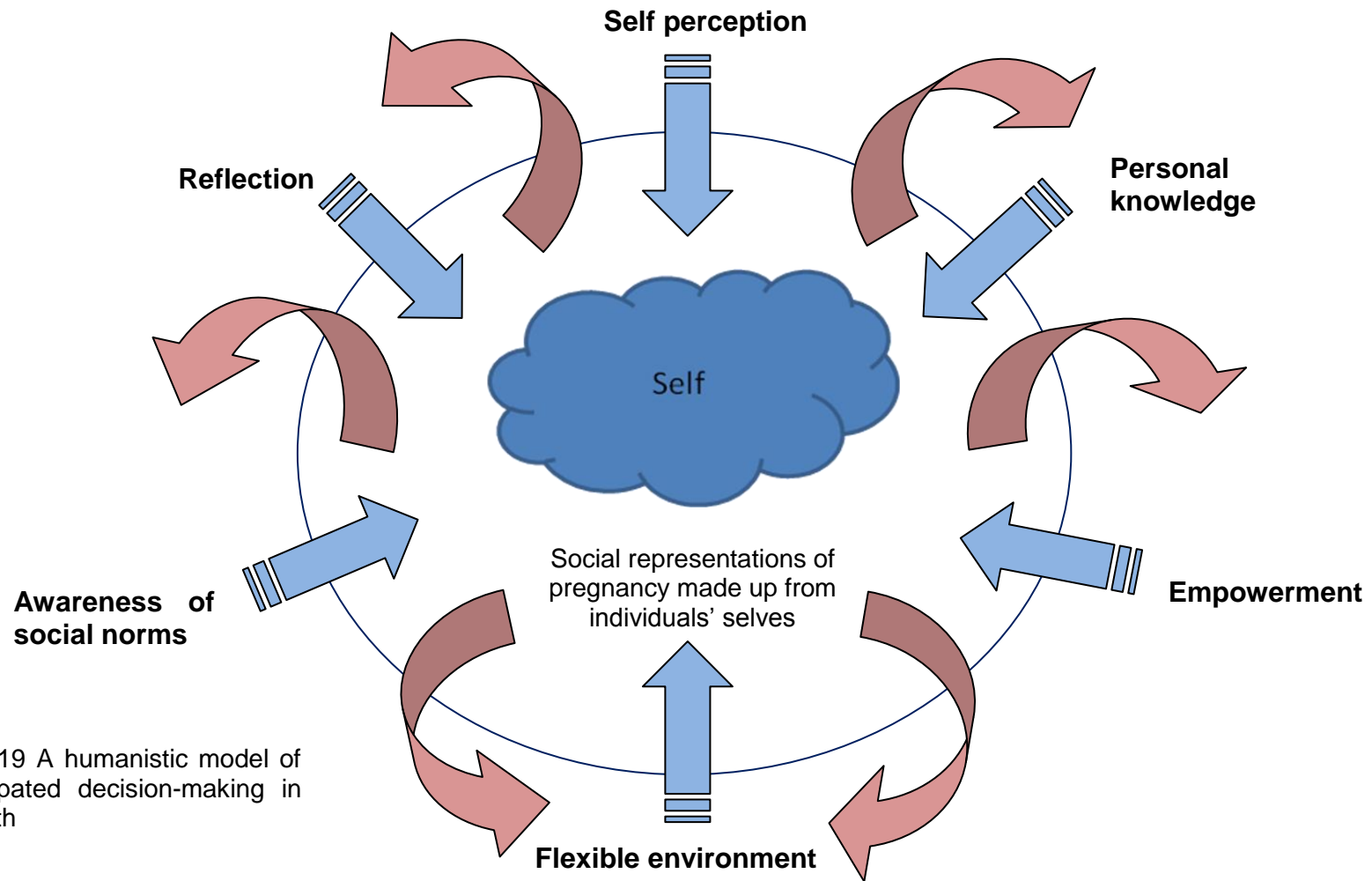
Figure 19 A humanistic model of emancipated decision-making in childbirth
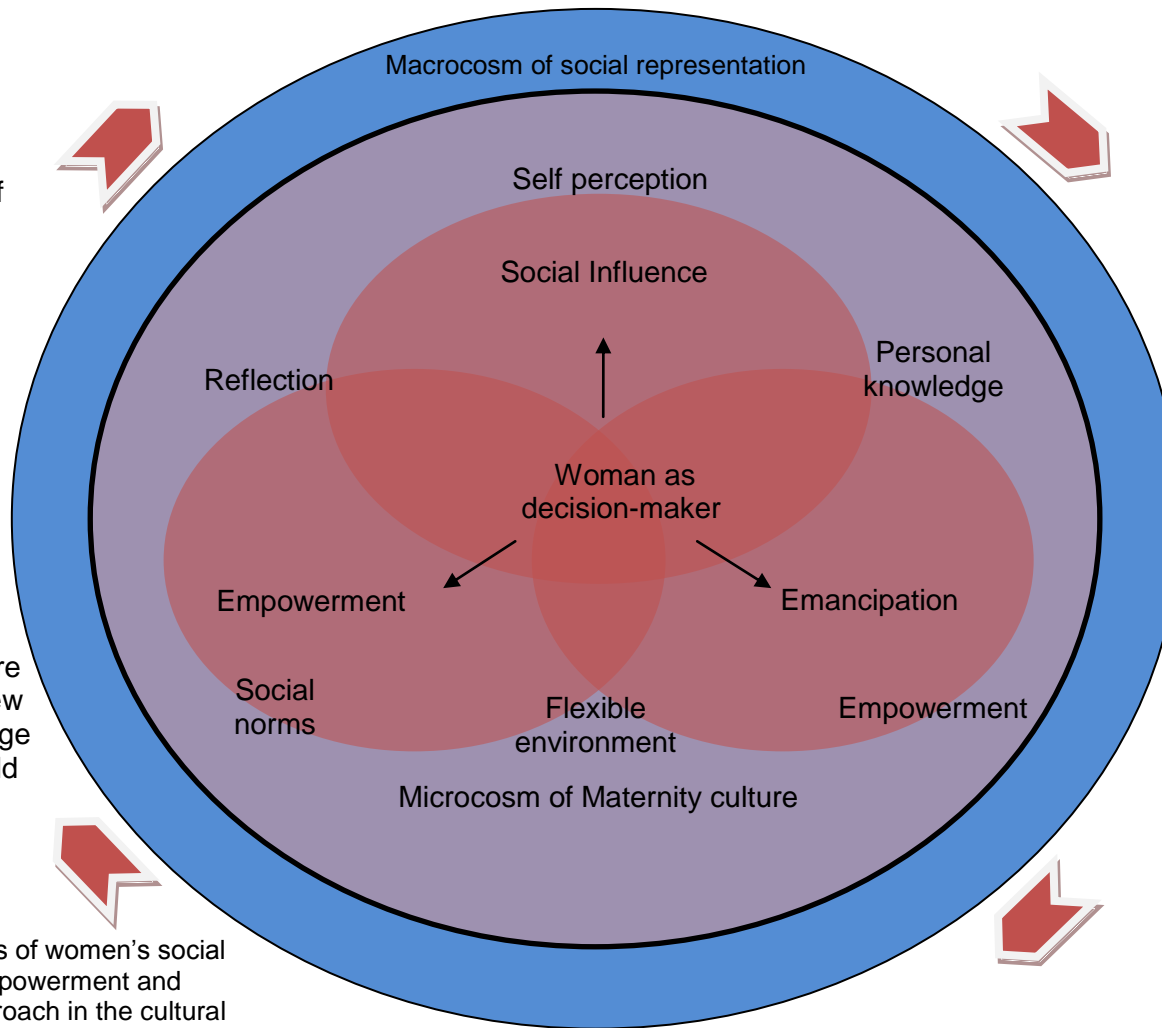
Flexible environment

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This approach to decision-making in childbirth needs to become embodied within everyday midwifery practice. The bottom-up approach is not only positively influential for women; their self identity as women and as mothers; but for midwives' individual self-identity; midwifery practice as autonomous practitioners, and for maternity culture (Kirkham 2010b, Symon 2006, Kirkham 2004, Kirkham 1999). This model of emancipated decision-making ultimately begins with women; facilitated by midwives in the relationships each holds for one another in a shared common goal. Moreover, is unique in adding to existing discourse on emancipation within healthcare (Williamson 2010, Wittmann-Price 2004) from a maternity perspective. Potentially women are able to empower midwives in midwifery culture, in sum the dual aspect of this model shape a structure for emancipation in women's birthing decision's, and in midwives' practice autonomy.

What is represented here by the theoretical concepts are women's social field in a bottom-up approach in the cultural microcosm of maternity culture that has potential to change the maternity culture it sits within. Figure 20 overleaf represents this concept. This provides a complete vision for what was initially illustrated at the beginning of this thesis in figure 3 on page 83 in representing the social structure that surrounds the culture of midwifery.

WOMEN'S DECISION-MAKING

Self identity determines how she will be socially influenced; whether she strikes out on a pathway of independence and does not succumb to the majority or whether she follows the pathway of compliance and unable to free herself in the process

Self identity demonstrates: emancipated decision-making as a resultant of coercion and she is emancipated and empowered in her decision-making. May be empowered by another in an equal relationship; the midwife has the power from bottom-up in maternity culture and equal relationally with the woman

Macrocosm of social representation

Self perception

Social Influence

Reflection

Personal knowledge

Woman as decision-maker

Empowerment

Emancipation

Social norms

Flexible environment

Empowerment

Microcosm of Maternity culture

Change in maternity culture by way of practise from new knowledge. Knew knowledge enters the wider social field change occurs as social norms are broken down

Change occurs from at core 'the woman as decision-maker' causing a ripple-effect of change in maternity culture and within the wider social field

Figure 20 Relational concepts of women's social field: social influence, empowerment and emancipation bottom-up approach in the cultural microcosm of maternity culture

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Summary

This chapter has aimed to provide a transparent and honest account, drawing out the connections between findings and the significant concepts within the literature on women's decision-making and the influences that surround this. The limitation in not having a social representative group of home birthing primips has been acknowledged. The following chapter presents conclusion to this thesis and highlights implications. Following the discussion, chapter 10 will address recommendations for future research.

Chapter 9: Conclusion

Introduction

A clinical practice encounter provided the rationale for this study. Questioning what had occurred in this situation in the context of care I wanted to understand what impact midwives have on the decisions women make about birth.

The literature review on decision-making illustrated a lack of understanding about influences that surround women as they decide where to birth their babies, moreover, a paucity of women's voices. The inquiry set out to answer three questions that were answered in the preceding chapter. Study limitations were discussed at points within the thesis in the applicable sections, research design and discussion chapters. This chapter briefly lays out salient points that the inquiry has identified reinforcing their importance for midwifery practice.

Reviewing the literature on decision-making and exploring social influences confirms that women still are not offered a full range of choices. There is evidence within this inquiry that women perceive 'far too much choice' and that this can often be confusing. Moreover, these women opt-out to avoid certain choices available to them. For women in this geographical area, choice to opt-out of certain options was clearly removed with the closure of the birth centre. If choice of hospital obstetric unit was not offered to women as an available choice, much like the birth centre facility is not presently would this be perceived differently in an arena of choice? This represents the flip-side in an already non-flexible service that purports to offer choice.

Perhaps it is more fitting to have an opt-in to consultant led care and epidural service, rather than an opt-out to a natural environment. What is required is a service that has an equal partnership between a service and service users where emancipated decision-makers are fostered, acknowledged and empowered. The midwife-woman relationship directly affects the birthing process and is an attribute to emancipation. It supports and cultivates emancipated decision-making and a more positive experience. This is an equal partnership of respect and friendship through a shared philosophy.

In normal birth, if service provision was to consist routinely of natural environments such as birthing centres and home birth services, but included option of transfer to the obstetric unit in the event of professional concerns or desire for pharmacological pain relief those women who require medicalisation would have the choice or recommendation to book to the hospital. Women who did not wish to birth at home would book to the birth centre because it is closest to their birth philosophy. Some consider the birth centre as 'in a hospital' anyway which provides them self-assurance to some degree. Service changes that concentrate on this shared understanding would provide more flexible environments which are necessary for some to enable *selves* to work toward emancipated decision-making.

A full range of choice is not offered to women; many have alluded to this in highlighting the difficulties and barriers (Jomeen 2012, Jomeen 2007, Kightley 2007, Hollins Martin 2007a, Edwards 2005, Kirkham 2004, Beech 2003, Mander 2001). Maternity culture should openly acknowledge this to women as they make decisions for themselves. Flexibility should be provided in how women's birth choice, even if not openly available, for example, in a lack of birth centre provision, can this be best addressed in offering best alternatives as women view them. A model of emancipated decision-making could provide that flexibility. This inquiry identified the reality that, for those who do not ask, and if they are not provided with the information of the range of options, they choose closest to their philosophy. There is a need to provide opportunities for women to right the wrong perceptions. These are often misrepresented in reality and critical to the misrepresented philosophy these women use in the decision-making process. If we do not provide opportunities for putting right such misconceptions, these could permeate a social field where normal practices become distant. Perhaps answers in changing perceptions within the social field, reside within the social field itself and the pregnant group members themselves.

Developing a culture of birth provision one of birth centre and home birthing services as routine could be instrumental for transforming social norms. Obstetric units providing care only for those who require it could assist the financial agenda. Agendas that dictate health budgetary constraints are often responsible for reduced resources and cutting services that are seen as confining choices. If non-technological approaches are potentially cheaper options (The Royal College of Midwives 2010) then this should be an intention of midwifery and obstetric service provision. Knowledge transfer

between women and maternity culture requires this understanding in a financial climate that has become too costly to manage. Limitations faced for practice if change does not occur denotes practice culture that will continue on this path. Policy and guidelines for choice and decision-making will be perceived by women as choice and free choice will remain unachievable in any realistic mode. The consequence of this status quo indicates practitioners will continue to experience being burnt out and disempowered (Kirkham 1999) and feeling they are unable to make a positive difference for the women they care for.

In a broad social context we can never truly exercise free choice if we consider Milgram's assumption that some form of obedience is the basic element of human life and some system of authority is required of all communal living. But we all have alternatives in a system and are free agents in which to have self authority over what happens to us in maternity care choice. If choices are not available, women still perceive choice open to them for example, hospital A, or hospital B. Consequently, is choice how one perceives it and how it is presented to us, hence we make decisions believing we have choice in this respect. This is choice in one respect, but purely choice between two hospitals. Yet women perceive this as choice despite it simply being choice between two same environments and not choice of options in how to birth. Under the pretext of choice, this is not free choice; however, is something women can have freer choice of if they have the knowledge of it, despite it not being offered up front. Free choice is about having options and not being given options, such as, being allowed to have the option. Some women do not perceive choice in this way, whilst some are aware they are only offered certain choices and how they are coerced into choice. According to Wittman-Price's (2004) the outcome of emancipation is 'free choice'. In view of the broad social context Milgram considers (1963) that we can never truly exercise this, within a maternity context this is about women having freer choice to act as free agents and have self-authority over what happens to them in maternity care choice.

Asch (1955) proposes those who strike out on the path of independence don't usually succumb to the majority and those who follow the pathway of compliance are unable to free themselves in the process. SR5, the homebirth multips are representative of Asch's independents in a situation where things needed to change, and did so without question and regained their equilibrium, proving these women to be independent

individuals that held fast their decisions because of staunch confidence in their own judgement. SR7, initially thought as non-conformers, are emancipated decision-makers in a culture where they perceive power as given and taken; emancipated because of *selves* as determined, assured individuals with a same staunch confidence that emerged from experienced oppressive situations in their social lives. They appear to hold a sense of power central to their self-identity and do not give this up under group pressure. The relationships with their midwives meant the midwives empowered them. Because they were emancipated and empowered in self-identity, they were able to act independently. These social representative women are the gold standard and midwifery and maternity culture should acknowledge them as such. Accepting this would equalise the power of the powerful medical other in maternity culture.

SR1, SR3 and SR6 (hospital primips, multips and postnatal conformers), were those who set off on the pathway of compliance, unable to free themselves, or not wanting to in the process and yielding to group pressure because of perceived pain and fear. Some women were less self-assured, less self-determined and were more likely to have, what Asch (1955) illustrates as a deficiency in themselves; drawing parallels with Janis's (1971) work on group think as women did not wish to be seen as disloyal to the judgements of the professionals, hence the powerful experts as they are perceived by women.

If knowledge was extended and reflection part of a design process, as part of a new concept model of maternal emancipation; women would experience greater self-esteem, autonomy and control, achieved through encouraging and building self-determination and self-assurance in pregnancy identity, that naturally situates them potentially as emancipated decision-makers in care about what matters to them. But when women have no knowledge for example of homebirth and no ability for this to be discussed amongst the 'pregnancy group community', women will continue to have 'no knowledge' and the context in which they further rely upon for their decision-making may never be explored. The profile of peer support and empowerment needs to be raised, with regard to the possibility this has for elevating the profiles of certain birthing practices.

Not all women view birth the same but perhaps this is as a result of lack in communication, knowledge and understanding. Some might always decide on a

technological birth with hospitals, doctors, pharmacological pain relief, however through engaging the six elements, fears may be broken down and allow for critical awareness. This thesis provides new knowledge of women's decision-making practices, informs what influences women in their decision-making and how these are made in light of understanding their fears and misconceptions.

Choice as a word, to be representative of what it professes to be in the discourses surrounding decision-making is not apt. Decision-making about birth preference as opposed to birth choices might be more of a reliable way to distinguish it. Choice may denote a choice between two or more alternatives, or to women as being given certain available options. Preference denotes the woman has examined what it is she prefers as a result of having options. This understandably puts her in the frame as the powerful individual in the process. Women do not always appear to know or be aware of their true preferences because these often comprise of inaccurate perceptions on which they make their decisions. Unless practice addresses these as core to the decision-making process, then nothing much will change. Choice is a component, but it is not the major focus in the process. It is the end-product of a process, the end result, not the beginning point. How the action is delivered or executed highlights it as the end-product of a complex activity of decision-making. Choice informed or otherwise, is not the fundamental centre of attention but how this may best be achieved is. This is why this inquiry underpins a theoretical model for emancipated decision-making which demonstrates a new way to distinguish decision-making and choice. Despite the choice discourse, numerous authors (Jomeen 2012, Kirkham 2004, Beech 2003, Mander 2001) have acknowledged the illusionary nature of choice and what this thesis adds is a further layer of exploration that illuminates the reasons why this might be the case.

Given a small amount of information, women construct meaning in their own minds in part, from what they perceive from their own experiences and knowledge, but also on the experience of others. The vignettes illustrated women situate themselves as if they were living an experience, as if they had to make the choice. Women perceived the scenarios as they appeared themselves, either as independently striking out on the path of independence or the pathway of compliance and unable to free themselves in the process.

For the majority experience is paramount. For others who do not share this perception, this could be possible with self-realisation of a fuller knowledge on which to found decisions. Whether it is a waterbirth, doctor and epidural or home experience, because women would make decisions at the end of an emancipatory decision-making process, this is likely to be more informed following critical understanding and analysis. It is not the aim of midwifery practice to confine or coerce women in to choosing socially constructed 'gold standards of birth', which are historically set apart from the obstetric paradigm and perceived as social norms. Practice should rather be focusing on breaking down these fears and misconceptions that women have knowledge or perceived ideas of. Encouraging women to think from a self-perceptive approach is more in keeping with midwifery philosophy of childbirth. This levels the power between, women and professionals so they maintain equal partnership within the common goal.

If we cannot know until we've experienced it and every experience is unique, then it is *not* this 'knowing' and 'needing to know' that is required to make choices. As it is impossible to experience every experience, it is about 'knowing selves' and understanding we cannot know, but can be accepting of that notion and knowing and understanding the body's ability to cope with this process, and engage with the experience as a 'being in time' becomes the prevalent issue. Hence, following self-intuitions and not self-expectations midwifery practice has the ability and perhaps a duty to facilitate this process and empower emancipated decision-making.

It is clear that women can develop emancipation in decision-making. It is not just the *self* that does this in isolation but the *self* is the driving force. This must occur in synchronicity with others from whom they want to support them. This is down to the relationship that has developed between them. Midwives are observed by women to be key supporters and this brings the debate about the midwife-woman relationship full circle amid the thoughts of Tinkler and Quinney (1998), Kirkham (2004) and Hunter and Berg et al (2008). It is this special quality that can empower women in their journey. Not all women wanted or perceived the need for a known midwife to facilitate self-determination in decision-making. For some however, a known midwife remains crucial for the complex care some women require and for voicing desires in the care experience. Self-identity, consisting of the aspects of *self* unlocked from the hermeneutical cycle, represents her life's journey and in continuing through her maternity journey towards motherhood. Whether this is consciously or unconsciously

known to her, a catalytic effect caused enough of an impact to result in a changed *self*, causing *self* to internalise something as an intrinsic belief, and enables this to continue in the 'absence' of the supportive other. A point of emancipation is reached in exercising these behaviours in her maternity decision-making.

Where woman book to birth is not indicative of whether they are emancipated or not, rather it is self-determination that does. However, it is at the point of change in a situation, and one where it can be perceived on an imaginary continuum of self-determined emancipation that this is tested. How women question and deal with this change at this point, in a situation of competing influences is the definitive factor of emancipated decision-making. Differences in women appear to be in how they deal with change in a changing situation. Whether they submit without question in this changed situation, who to, and from what point on this imaginary continuum, or whether they remain constant and self-determined in this new situation; one where this remains a jointly respectful, equal relationship with a shared common goal in the light of a shared risk situation.

Transfer to hospital from home or birth centre illustrated a perceived changed circumstance where care would be handed over to another midwife based within the obstetric unit. It is dependent on where the woman situates self at this point on her imaginary continuum and what happens in this changed situation, whether her self-determination regresses and she is compliant to the dominant, or whether she remains constant in her determination. The answer is determinant upon whether in her perception, this remains an equal respectful, relationship with this 'other' professional and she is empowered to continue along her continuum and remain self-determined. A key consideration is that her midwife should not be relinquished from her care in view of transfer. Care should be maintained at all costs by this same midwife; where the midwife-woman relationship is already rooted. Moreover, due to competing elementary themes of external influence, and the situation having now very much changed, where different aspects of self come into play, it is in this changed situation her known midwife can help maintain stasis; one where the equalisation of power remains constant and she feels and remains an equal partner in her care. Women who spoke of contingency comprehend that they are still able to decide what it is they want, in light of risk factors becoming apparent and still perceive themselves in the driving seat despite change. However, perhaps for some in the antenatal period, the ability to maintain continuous

dialogue throughout pregnancy between them and their lead midwife, even when care is provided by other professionals, might be enough to maintain self-determination in those who are working towards emancipated decision-making and continue along the continuum.

Conceptually women present either as emancipated or non-emancipated decision-makers at given points on a continuum of emancipated decision-making. This is some point between compliance where negative social influence can cause negative effects on their decision-making, and influence that causes positive effects unrestraint and setting *self* free from such constraints. Dependant on her perceived reality of constraint within her experience, her self-determination and self-assurance, determines a point at which her behaviours become evident. Where she begins and where she ends up, depends upon the characteristics of *self,* the external influences that interplay, and fundamentally the supportive other. This demonstrates how the *self* changes as she continues the journey to motherhood and with this interplay, she can experience a lasting long term positive impact on the journey of *self* in a wider social sense. She is changed by the experience, birth is a transformative experience; and experiences of becoming a mother must be recognised by policy and practices relating to birth (Bergum 1989).

For some women more than others, positive impact appears due to the awareness of a greater self-identity, dependent upon and modified by external influences throughout their life's journey and own perceptions of reality constructed throughout the course of life's events. How *self* handles these is a key constituent. Human influence dictates we move to and fro in situations surrounded by these external influences, competing with aspects of *self* and is definitive to whether one moves forwards to emancipation in decision-making, or backwards to compliance. Hence, continuing in the same, or changed polar direction and fundamental to the foundation of experiencing positive or negative influence on her aspects of *self* within pregnancy, birthing, postnatal and womanhood journeys.

This research exposes how women make decisions about where they want to birth before they have any contact from a healthcare practitioner and that this decision is not changed as a result of ten months of gathering information, learning, sharing and reflecting. These decisions are often made on erroneous assumptions. On this basis

whilst they are made on misconceptions, change in the *'self's'* understanding may never change and birthing practices will not either. Change on mass is unlikely to occur but for change to begin, this has to come from those who desire it, and have the self-determination to do it. The postnatal non-conforming women illustrate the characteristics for achieving this. Perhaps these women should be midwifery's gold standard and setting the example for others to be an authoritative voice.

Relationships with a key professional proved to be important; both for women who are self-determined in their choices, who through restraints, have developed emancipated decision-making practices, and those who choose to surrender themselves unquestioningly into the care of these others. Insight into women who conform to professional advice illustrated that self-surrendering does not occur in all circumstances to all professionals, but the potential to be coerced by those who do not know her and who could dictate what will happen in absence of principle professionals is a known reality.

Chapter 10 Recommendations: research and practice

As a significant outcome of this inquiry the need to develop and implement a model of emancipated decision-making that should be incorporated in midwifery practice was identified. This is necessary for women to be able to achieve free choice in child birthing preferences. It is recommended for post doctoral study that the proposed model should be utilised and facilitated through a new structure of antenatal birth education programme. Through the ideology of emancipation that not only will focus upon the six elements identified, but will incorporate peer empowerment to assist facilitation. Peer empowerment is representational of the social field and the pregnancy group women come to join. It respects the typologies of knowledge women possess and share within their social groups, and help facilitate self-perceptions as a result of shared experience.

This will be facilitated by midwives with women in partnership; women telling their stories as experts flanking midwives who women already perceive as experts. Experts are individuals who are very knowledgeable or very skilled within a particular area that involves specialised knowledge. Women are very knowledgeable and skilled in their lived experience of birthing their babies hence quantity of experience should not necessarily be viewed as the sole measure of experience as women perceive professionals.

There is an argument for earlier input from midwives as women find out they are pregnant and seek professional confirmation, they have questions and seek support at this early time. The concern in which women lack self-assurance and confidence in their bodies is not discussed here. However, these point to the fact quite transparently that wanting confirmation from professionals might be because they are eager to join the pregnancy group at the very earliest point. Moreover, indication that women want answers to questions at an earlier point than the service currently affords. This indeed is a critical time on a continuum of pregnancy decision-making for women, as they are well underway with considering their options. Moreover, reflects the controlling agenda that maternity care provides them in a non-flexible environment, itself confined to some extent in the political agenda. It must not be assumed that every woman attends all

information giving opportunities for parent education (Levy 2004), but what this study does highlight is that women seek the knowledge they want when they want it and this is before they meet with those who provide care.

This research illustrated all women were self-determined on where to give birth and decisions were made prior to any interaction with health professionals. Despite information and knowledge received in pregnancy this did not alter their decisions in pregnancy.

Reflexive final thoughts

The findings of this inquiry are fundamental to the decision-making and choice debate that appears firmly embedded in the agenda for maternity service delivery and has been since 1993 (Department of Health 2012a, Department of Health 2010, Department of Health 2007, Department of Health 2004, Department of Health 1993). Despite this, the discourses have remained arguably static over this time. It is my belief that debate about choice, informed or otherwise, is not the main concern, but the process of decision-making that in the nature of processing the six essential elements does foster informed decision-making, at best in a culture that is governed by a system of authority. If the process is one that has with it the full information in which women can truly make up their own minds without fear of sanctions being put upon them, then the end result, the decision women make, the choice they opt for, is merely the result of this informed emancipated process. Until now this approach has remained unexplored. This thesis provides this exploration and in so doing, adds to the body of existing knowledge that is fundamental to women's choices in childbirth and their decision-making in relation to the choices they are offered.

The voices of women have permeated throughout this inquiry and have been fundamental in the development of uncovering the complexities concerning women's decision-making in maternity care. They have been instrumental to original knowledge development and in what this thesis brings to the midwifery arena. It is in this that the 'whole' process and this thesis draw to a close. Women as 'parts' socially represent different pregnancy identities within a midwifery culture, fundamental in constructing this new knowledge as it appears in the 'whole'; and the researcher's 'part' by applying their voices to understanding the underpinning concepts addressed.

The decision to use women's voices early in the thesis is unconventional by traditional standards, perhaps even non-conformist. However, this inquiry has shown how insight into non-conformity, perceived at first glance, as being possibly incorrect and impermissible, fundamentally shows no difference and merely appears bold when it sits on the edge of traditional norms. If, as individuals we do not challenge traditional norms, we do not stand out from them and provide original ways to observe something. Moreover, what we encounter therefore as a result of this may never have come to light.

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Appendices

Due to anonymity and confidentiality the North of England trust letter heads have not been included on these appendices.

Appendix 1   NRES letters of approval

Appendix 2   Trust R&D letters of approval

Appendix 3   System in case of distress

Appendix 4   Procedure for storage of data

Appendix 5   Head of midwifery letter

Appendix 6   Clinic midwives Letter

Appendix 7   GP Letter

Appendix 8   Antenatal Information sheet and reply slip

Appendix 9   Postnatal Information sheet and reply slip

Appendix 10   Purposeful recruitment sample

Appendix 11   Recruitment time frame

Appendix 12   Researcher Policy

Appendix 13   Participant consent

Appendix 14   Antenatal interview guide

Appendix 15   Vignette: scenario 1

Appendix 16   Vignette: scenario 2

Appendix 17   Vignette question guide

Appendix 1 NRES letters of approval

REC
Research Ethics Office

Telephone
Facsimile:

27 July 2010

Mrs Carol Lambert

Dear Mrs Lambert

Study Title: **Evaluating Social Influence relating to women's decision making in a childbirth context.**
REC reference number: 10/H1304/16
Protocol number:

Thank you for your letter of 14 July 2010 responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information was considered in correspondence by a sub-committee of the REC A list of the sub-committee members is attached.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

<u>Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.</u>

For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research

governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where the only involvement of the NHS organisation is as a Participant Identification Centre (PIC), management permission for research is not required but the R&D office should be notified of the study and agree to the organisation's involvement. Guidance on procedures for PICs is available in IRAS. Further advice should be sought from the R&D office where necessary.

Sponsors are not required to notify the Committee of approvals from host organisations.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Investigator CV		04 May 2010
Investigator CV		
Protocol	2.2	01 April 2010
Research Certificate	1	23 June 2009
Recruitment Timeframe	1.1	01 February 2010
Letter to Clinic Midwives	2.2	01 April 2010
Postnatal reply	2.2	01 April 2010
Procedure for storage and transfer of electronic data		
REC application		05 May 2010
Letter from Sponsor	1	23 March 2010
Interview Schedules/Topic Guides	2.2	01 April 2010
GP/Consultant Information Sheets	3.3	01 July 2010
Participant Information Sheet: Antenatal	3.3	01 July 2010
Response to Request for Further Information		
Participant Information Sheet: Postnatal	3.3	01 July 2010
Participant Consent Form: Consent Form	2.2	01 April 2010
Questionnaire: Vignette Question Guide	1.1	01 February 2010
Questionnaire: Vignette Design	1.1	01 February 2010
Questionnaire: Antenatal Vignettes	1.1	01 February 2010
Nursing & Midwifery Council form	1	02 February 2010
Postnatal Interview Guides	1.1	01 February 2010
Letter to Community Midwifery Sister	1.1	01 February 2010
Antenatal reply	2.2	01 April 2010
Procedure for dealing with distress		
ID Badge	1	
Unfavourable Opinion Letter		02 March 2010
Contract of Employment	1	15 November 2009
CRB Check certificate	1	04 November 2009
Covering Letter		04 May 2010
Researcher Safety Policy	1.1	01 February 2010

Letter to Community Manager	1.1	01 February 2010
Letter to Head of Midwifery	1.1	01 February 2010
Flow chart	1.1	01 February 2010

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

10/H1304/16	Please quote this number on all correspondence

Yours sincerely

Dr ▇▇▇▇▇▇▇
Chair

Email: ▇▇▇▇▇▇▇▇▇▇

Enclosures: *List of names and professions of members who were present at the meeting and those who submitted written comments*

                        "After ethical review – guidance for researchers"

Copy to: ▇▇▇▇▇▇▇

Attendance at Sub-Committee of the REC meeting on 19 July 2010

Committee Members:

Name	Profession	Present	Notes
Dr ████████████	████████████	Yes	
Dr ██████████	████████████████	Yes	

14 April 2011

Mrs Carol Lambert

██████████

Dear Mrs Lambert

Study title: **Evaluating Social Influence relating to women's decision making in a childbirth context.**
REC reference: 10/H1304/16
Amendment number: AM01
Amendment date: 01 April 2011

The above amendment was reviewed on 08 April 2011 by the Sub-Committee in correspondence.

Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Flow Chart showing purposeful recruitment sample	2.2	01 April 2011
Notice of Substantial Amendment (non-CTIMPs)	AM01	01 April 2011

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

R&D approval

All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

10/H1304/16:	Please quote this number on all correspondence

Yours sincerely

Dr ▮▮▮▮▮▮▮
Chair

E-mail: ▮▮▮▮▮▮▮▮▮▮▮▮▮

Enclosures:	*List of names and professions of members who took part in the review*
Copy to:	*Mr* ▮▮▮▮▮▮▮▮▮▮▮▮▮ *NHS Trust*

NRES Committee ▮▮▮▮▮▮▮▮▮▮▮

Attendance at Sub-Committee of the REC meeting on 08 April 2011

Name	Profession	Capacity
Dr ▮▮▮▮▮	▮▮▮▮▮▮▮	Expert
Dr ▮▮▮▮▮	▮▮▮▮▮▮▮ REC	Expert

Also in attendance:

Name	Position (or reason for attending)
▮▮▮▮▮	▮▮▮▮▮

Appendix 2 Trust R&D letters of approval

NHS

Research & Development Department

31/08/2010

Mrs Carol Lambert

Dear Mrs Lambert

Re: R1056 - 10/H1304/16: Evaluating Social Influence relating to women's decision making in a childbirth context.

I am pleased to notify you formally that this study has been approved by the Trust and may proceed subject to the following caveats:

- That all REC conditions and caveats of favourable opinion have been adhered to.
- That specifically, the code of anonymisation at source will be undertaken as per ethics favourable opinion,
- That consent is only taken by suitably qualified members of the research team named on the delegation log with responsibility to do so.
- That data is stored and transferred in accordance with the Data Protection Act (1998) and you must ensure that all data collection, transfer and storage does not contravene ████ Confidentiality and Information security Policy http://intranet/policies/policies/134.pdf, specifically the Information Storage and Transfer Procedure. If you are in any doubt about adherence with this policy in relation to the above, please contact the R&D Office.
- That no patient identifiable data is sent outside of the research team at ████████ Hospitals NHS Trust (except where covered by the patient consent form).
- That no patient identifiable data is held on laptop computers (except where encrypted as per Trust policy).
- That the security of data transfer will be in accordance with the Trust policy on encryption and that data access controls are in place (individual user accounts and passwords).
- That it is made clear to participants that the interviews will be audio recorded and that no identifiable data about them will be published in the final report.
- That an appropriate mechanism is in place in line with the Sponsors instructions and Trust policy to check for any patient deaths prior to sending follow-up questionnaires or contacting participants for follow-up visits (where applicable).
- That, where applicable, appropriate counselling services are available to all participants and family members.
- That you adhere to the University of ██ and ███████ Hospitals NHS Trust policies for lone working: (section 3 of the ████ Security Policy http://intranet/policies/policies/110.pdf and the ethics submitted 'Researcher safety Policy').
- That you adhere to the ███████ Hospitals NHS Trust policy for situations where abuse or neglect of children is suspected http://intranet/policies/policies/278.pdf
- That you are aware of, and adhere to, all obligations placed on you as Principal Investigator with regards to your honorary contract with ███████ Hospitals NHS Trust.

████████ Hospitals NHS Trust conducts all research in accordance with the requirements of the Research Governance Framework, and the NHS Intellectual Property Guidance. In undertaking this study, you agree to comply with all reporting requirements, systems and duties of action put in place by the Trust to deliver research governance. In addition, you agree to accept the responsibilities associated with your roles which are outlined within the Research Governance Framework.

Please complete the table below and return a copy to R&D.

I would like to wish you every success with this project
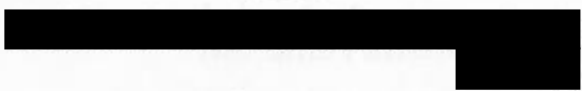
Yours sincerely

Research & Development Manager

Re: R1056 - 10/H1304/16: Evaluating Social Influence relating to women's decision making in a childbirth context.

PLEASE READ THROUGH THESE RESPONSIBILITIES AND SIGN AND RETURN A COPY OF THIS FORM	Initial Below
The study should follow the Ethics approved protocol. That all REC conditions and caveats of favourable opinion have been adhered to. The core approved documents are: protocol version 2.2, PIS version 3.3 and ICF version 2.2.	CL
That specifically, the code of anonymisation at source will be undertaken as per ethics favourable opinion.	CL
That consent is only taken by suitably qualified members of the research team named on the delegation log with responsibility to do so.	CL
All potential subjects should have enough information to make a free and informed decision about participation	CL
Participants should receive appropriate care while involved in the study;	CL
The integrity and confidentiality of clinical and other records and data generated by the study will be maintained in accordance with the Data Protection Act (1998) and associated Trust Information Governance policies.	CL
All serious adverse events must be reported forthwith to the ▇ Trust R&D Office and other authorities specified in the protocol.	CL
Any suspected misconduct by anyone involved in the study must be reported in accordance with ▇ Trust policy.	CL
The sponsor, Ethics and ▇ Trust R&D Office are notified, as appropriate, of any incidents (at this site or any other participating sites) as soon as the sponsor or site is made aware of them.	CL
Copies of Ethics and other annual progress reports must be forwarded to the ▇ Trust R&D Office.	CL
Copies of the end of trial notification and summary reports must be forwarded to the ▇ Trust R&D Office.	CL
Copies of all amendments with related approvals, applications and documents forwarded to the ▇ Trust R&D Office when appropriate. Amendments must be approved by the ▇ Trust R&D Office prior to implementation.	CL
That no patient identifiable data is sent outside of the research team at ▇ Hospitals NHS Trust (except where covered by the patient consent form).	CL
That no patient identifiable data is held on laptop computers (except where encrypted as per Trust policy)	CL
That the security of data transfer will be in accordance with the Trust policy on encryption and that data access controls are in place (individual user accounts and passwords).	CL
That it is made clear to participants that the interviews will be audio recorded and that no identifiable data about them will be published in the final report.	CL
That an appropriate mechanism is in place in line with the Sponsors instructions and Trust policy to check for any patient deaths prior to sending follow-up questionnaires or contacting participants for follow-up visits (where applicable).	CL
That, where applicable, appropriate counselling services are available to all participants and family members.	CL
That you adhere to the University of ▇ and ▇ Hospitals NHS Trust policies for lone working: (section 3 of the ▇ Security Policy http://intranet/policies/policies/110.pdf and the ethics submitted 'Researcher safety Policy').	CL
That you adhere to the ▇ Hospitals NHS Trust policy for situations where abuse or neglect of children is suspected http://intranet/policies/policies/278.pdf	CL
That you are aware of, and adhere to, all obligations placed on you as Principal Investigator with regards to your honorary contract with ▇ Hospitals NHS Trust.	CL
As Chief Investigator, I can confirm that all conditions of the REC have been adhered to and implemented accordingly. **Note- failure to do so will mean the trial does not have Trust authorisation.**	CL
Mrs Carol Lambert — Date 06 09 2010	Signature Chambers

Please complete the table above and return a signed and initialled copy to R&D.

NHS

Research & Development Department

09/05/2011

Mrs Carol Lambert

Dear Mrs Lambert

Re: R1056   10/H1304/16
Evaluating Social Influence relating to women's decision making in a childbirth context.

The Trust R&D department has received and reviewed the following document(s) which pertain to the above study:

- Notice of Substantial Amendment
- New Appendix A Recruitment sample flow chart V2.2
- Ethics Approval letter dated 14 April 2011

The Trust is happy to endorse the amendment(s) and for the study to continue with these changes. Please notify any other department who may be affected by the amendment(s) (ie Pharmacy, Labs or any other support services).

Yours sincerely

Research and Development Facilitator

Appendix 3.

version 3.3 7/2010.

Procedure in place in case distress caused by taking part in the study is experienced.

- If the participant becomes distressed or appears to become distressed the interviewer will stop the interview and ask whether they wish to continue.
- There will be time for the participant and interviewer after the interview to 'de brief' if the participant wishes to.
- Interviewer will ensure the participant has interviewer contact details and will encourage the participant to contact if she wants to.
- The interviewer, if contacted by the participant will re-enforce to her the support she can receive by approaching her GP or Midwife. Re-enforcement of the support services available, listed in the information sheet will be given once again. The interviewer will make it clear that any counselling the participant feels she needs should be sought from these sources listed and the interviewer is not able to provide this.
- Interviewer will ensure the participant has the relevant contact details of her GP, Midwife and other support networks available to her that are documented in the participant information sheet.

Appendix 4.

Version 3.3 7/2010

Procedure for storage and transfer of electronic data.

Advice was sought from the University of Hull as requested regarding the transfer and storage of electronic data. All data will be encrypted.

Encryption software will be downloaded to the laptop computer being used for data storage.

www.truecrypt.org will be the software used to create an encrypted volume where encrypted files will be stored. AxCrypt will be downloaded to the computer laptop and used for emailing individual encrypted files to supervisors. Supervisors will be notified of the code to access the data.

Appendix 5.

Letter to Head of Midwifery (version 1.1 2/2010)

Dear   ,

I am Carol Lambert, a midwife researcher form the University of Hull and hold an honorary contract within the ███ and ██████████ NHS trust. I am hoping to undertake a research study that aims to explore the experiences and perceptions of women as they make decisions about birth choice options and I am asking for your help and support in this. Your help and support are both crucial to the success of the study. It will explore individual experience and influences that may affect women at this decision making time and explore how social influence might affect birth experience.

The study will involve the recruitment of twenty antenatal women and six postnatal women from two geographical clinics within the trust. Community Managers, Community Midwifery Sisters and clinic Midwives at the selected clinics for sample recruitment will also receive a letter informing them of the study and asking for approval to undertake this within these clinics. The study is designed to have limited impact on midwives' working and will involve them giving out an information letter when they see women, either at an antenatal appointment or on a postnatal visit.

If there are any safety issues the midwives feel regarding any potential recruits both antenatal/postnatal for the study, i.e. where the woman or myself may come to harm by entering private homes, they have been asked to advise women to be interviewed in the clinic setting as the study does not want to exclude any women from taking part.

It is hoped to use the results of this research to inform future maternity practice both locally and nationally and results may be published in a healthcare journal. It is intended to hold an informal feedback session following the completion of the study to present the study results to which you will be invited. This study has been approved by the local Research Ethics Committee and the ███ and ██████████ NHS Trust. If you have any questions or concerns about this study please don't hesitate to contact me. I would like to thank you for your support.

Carol Lambert M: ██████████

Yours Sincerely

Appendix 6.

Dear Midwife,

I am Carol Lambert, a midwife researcher form the University of Hull. I am undertaking a research study that aims to explore the experiences and perceptions of women as they make decisions about birth choice options and I am asking for your help and support with this. Your help and support are crucial to the success of the study. It will explore individual experience and influences that may affect women at this decision making time and explore how social influence might affect birth experience. I would be grateful for your help in assisting in the recruitment of women into this study.

It is hoped to use the results of this research to inform future maternity practice both locally and nationally. This study has been approved by local Research Ethics Committee and the██ and ███████████ NHS Trust.

Recruitment: antenatal women.

Due to financial constraints with regard to funding interpreters for non English speaking women and the additional costs incurred in the support of leaflet/ information production, it is not feasible in the financial climate to include non-English speaking women in the study. It is regretful that some women who may have something valuable to contribute to the study must be excluded under financial grounds. The study aims to recruit twenty women from two geographical areas, ten women from each area. It will involve you placing a patient information sheet with attached reply slip and stamped addressed envelope into the patient tracker just prior to clinic beginning,

this maintains patient confidentiality. This will be for every English speaking woman attending clinic for their 27-28 week – 36 week appointment. On your part, it requires you giving the information sheet to the woman during her appointment and informing her about the study, briefly outlining what it is about and that they can post the reply to be contacted, by the researcher, if they may like to participate or want to discuss it further. This should take no more than a few minutes. I will attend clinic prior to commencement of appointments to ensure you have enough information leaflets, to answer any questions regarding recruitment and to complete an audit sheet, used by the researcher to audit the number of letters given and at what gestation appointments. This is purely for research study records.

Recruitment: postnatal women

The study aims to recruit six English speaking postnatal women who have had risk factors identified in the antenatal period and were advised on place of birth. This will involve on your part, giving her the information leaflet at your routine postnatal visit, informing her briefly about the study and that she may complete the reply slip and post in the stamped addressed envelope to the researcher at the University of Hull if she might like to participate. I would be grateful if you could keep a record in your work diary of the amount of information letters given out to women in the recruitment period.

If there are any safety issues you feel regarding any potential recruits both antenatal/postnatal for the study, i.e. where the woman or myself may come to harm by entering private homes, please would you ask these women if interested in taking part to be interviewed in the clinic setting as the study does not want to exclude any woman in sharing her valuable experiences.

It is hoped to use the results of this research to inform future maternity practice both locally and nationally and results may be published in a healthcare journal. Any quotes in the educational thesis or journal articles will be completely anonymised so that no participants can be identified. It is intended to hold an informal feedback session following the completion of the study to present the study results to which you will be invited. If you have any questions or concerns about this study please don't hesitate to contact me. Carol Lambert M: ▮▮▮▮▮▮▮▮▮▮

Yours sincerely

Appendix 7.

GP Letter (version 3.3 7/2010).

Date

Dear Dr ....

I am writing to inform you that .... who is a patient at this practise has consented to take part in the Social Influence Study within this Trust.

The research study will involve the recruitment of twenty antenatal women and six postnatal women from two geographical clinics within the trust. The aim of the study is to explore the experiences and perceptions of women as they make decisions about birth choice options.

This study has been approved by the local Research Ethics Committee and the ███ and █████████ NHS Trust. If you have any questions or concerns about this study please don't hesitate to contact me on my mobile number ████████ or by any other means via the details provided.

Yours Sincerely

Carol Lambert

Doctoral Researcher, BSc (Hons) PG Cert, RM, RN.

What are the possible disadvantages by taking part in this research?

Recalling memories or experiences in the interview may cause distress to you. The interview will be stopped and I will ask whether you wish to continue. Following the interview, if you feel you need to speak to anyone about the experiences you have recalled, there are specialist mental health link midwives that you can contact. They can be contacted by ringing the Antenatal ███ ward 6███8/6███9, or Postnatal ███ ward, the Community Midwifery Office or Antenatal clinics at either ███████ ███████, or ███████ Hospitals. All contact numbers are printed in your hand held maternity records.

Other sources of support for contact are your GP or Midwife or the House of Light, registered charity that supports both antenatal and postnatal women Tel:0800 043 2031. Website: www.pndsupport.co.uk

Safeguarding Children.

I have a duty as a Midwife to safeguard and promote the welfare of children and to work closely with other colleagues and agencies if I have concerns about the welfare of a child. If I have any concerns about the welfare of a child it is my duty to share these concerns under the procedures of the ███████████ Trust policies for promoting and safeguarding the welfare of children.

What happens after the research study?

It is intended to hold an informal feedback session following the completion of the study to present the study results to which you will be invited. If you feel unhappy with any aspect of this study you can contact me and I will do my best to answer your questions. If you remain unhappy and wish to complain formally you can do this by contacting the Patient Advice Liaison Service (PALS) on ███████.

How do I get involved?

Please complete the attached slip and post using the stamped addressed envelope provided if you would like me to contact you regarding this study. Thank you for taking the time to read this information sheet. If you are not contacted this means enough participants for the study have come forward and I would like to thank you for your interest.

Women's decision making and birth

Antenatal Participant Information Sheet

Researcher: Carol Lambert
Tel. ███████

This study has been approved by the local Research Ethics Committee and the ███████████ NHS Trust.

July 2010

Invitation

I would like to invite you to take part in my research study. Before you decide I would like you to understand why the research is being done and what it will involve for you. Your midwife is happy to discuss this leaflet and study with you at this point on my behalf. This should take about 5 minutes. Talk to others if you wish. You may contact me if there is anything not clear.

What is the purpose of the study?

I will explore women's individual experiences and feelings as women make decisions about where to have their babies and explore how social influence might affect these experiences. I hope to use the results of this research to inform future maternity practice both locally and nationally.

Who is doing the research?

The study will be conducted by myself a midwife researcher from the University of Hull. This research forms part of an educational qualification that I am undertaking. I am qualified by education, training, and experience to perform the tasks in this study. I am unable to give you midwifery care or advice relating to your pregnancy as I no longer practice in my clinical role, but will advise you to seek advice from your midwife or doctor.

Why have I been invited?

Your thoughts and experiences are valuable in helping maternity services to provide women centred services that offer real choice. You have been invited because you are between 27 and 36 weeks pregnant. There will be 20 antenatal women and 6 postnatal women recruited for this study.

Do I have to take part?

It is up to you to decide to join the study. I will describe the study and go through this information. If you agree to take part, I will then ask you to sign a consent form. If you do not wish to take part this will in no way affect the standard of maternity care you receive. You are free to withdraw at any time without giving reason. This will not affect the standard of care you receive.

What will I have to do?

The interview will be friendly and an informal discussion and will be led by your thoughts and feelings. There are no right or wrong answers. The interview will be tape recorded to allow for all your valuable information to be processed and analysed thoroughly after the interview.

What will happen to me if I take part?

Taking part in the research involves agreeing to an interview lasting up to one hour. The interview will take place after your 36th week of pregnancy at either the clinic where you normally have your antenatal appointments or in your home if it is more convenient for you, but somewhere where the interview will not be interrupted. You will not be able to be identified by anyone other than the researcher. The confidentiality of records that could identify you will be protected, respecting your privacy and confidentiality rules in accordance with the applicable regulatory requirements. Tape recordings will be destroyed once the interviews have been copied into written format. Results may be published in a healthcare journal but you will not be identified in anyway. It may be necessary for illustration to use quotes from interviews in my academic work but you will be completely anonymized. Once the interview is transcribed this will be returned to you to check that the information accurately reflects your views.

Please turn over the page

Appendix 8. Antenatal information sheet (reverse) version 3.3

Appendix 8. Antenatal reply slip

Antenatal Information sheet (version 2.2 4/2010)

Please complete slip and post using the stamped addressed envelope to Carol Lambert University of Hull if you would like me to contact you regarding this study. If you are not contacted this means enough participants for the study have come forward and I would like to thank you for your interest.

NAME...

Contact number...

Please circle below the statements that apply to you.

This is my first baby   Yes   No

I am booking to the hospital for the birth   Yes   No

I am booking home or Birth Centre for the birth   Yes   No

Please detach my contact card for your receipt.

What are the possible disadvantages by taking part in this research?

Recalling memories or experiences in the interview may cause distress to you. The interview will be stopped and I will ask whether you wish to continue. Following the interview, if you feel you need to speak to anyone about the experiences you have recalled, there are specialist mental health link midwives that you can contact. They can be contacted by ringing the Postnatal ███████ ward 6████1/6████3, or Antenatal ████ ward, the Community Midwifery Office or Antenatal clinics at either ████████████ s or ████████ Hospitals. All contact numbers are printed in your hand held maternity records. Other sources of support for contact are your GP or Midwife or the House of Light, registered charity that supports both antenatal and postnatal women Tel:0800 043 2031. Website: www.pndsupport.co.uk

Safeguarding Children.

I have a duty as a Midwife to safeguard and promote the welfare of children and to work closely with other colleagues and agencies if I have concerns about the welfare of a child. If I have any concerns about the welfare of a child, it is my duty to share these concerns under the procedures of the ███████ ████████████ Trust policies for promoting and safeguarding the welfare of children.

What happens after the research?

It is intended to hold a feedback session following the completion of the study to present the study results to which you will be invited. If you feel unhappy with any aspect of this study you can contact me and I will do my best to answer your questions. If you remain unhappy and wish to complain formally you can do this by contacting the Patient Advice Liaison Service (PALS) on ███████████.

How do get involved?

Please complete slip and post using the stamped addressed envelope provided if you would like me to contact you regarding this study. Thank you for taking the time to read this information sheet. If you are not contacted this means enough participants for the study have come forward and I would like to thank you for your interest.

Women's decision making and birth

Postnatal Participant Information Sheet

Researcher: Carol Lambert
Tel. ████████████

This study has been approved by the local Research Ethics Committee and the ████████████ ████████ NHS Trust.

July 2010

Appendix 9. Postnatal information sheet version 3.3

Invitation

I would like to invite you to take part in my research study. Before you decide I would like you to understand why the research is being done and what it will involve for you. Your midwife is happy to discuss this leaflet and study with you at this point on my behalf. This should take about 5 minutes. Talk to others if you wish. You may contact me if there is anything not clear.

What is the purpose of the study?

I will explore individual experiences and feelings as women make decisions about where to have their babies and explore how social influence might affect these experiences. I hope to use the results of this research to inform future maternity practice both locally and nationally.

Who is doing the research?

The study will be conducted by myself a midwife researcher from the University of Hull. This research forms part of an educational qualification that I am undertaking. I am qualified by education, training, and experience to perform the tasks in this study. I am unable to give you any midwifery care or advice relating to your birth as I no longer practice in my clinical role,

but will advise you to seek advice from your midwife or doctor.

Why have I been invited?

Your thoughts and experiences are valuable in helping maternity services to provide women centred services that offer real choice. You have been invited because you have had some risk factors identified before your baby's birth and were given advice on where to have your baby. There will be 20 antenatal women and 6 postnatal women recruited for this study.

Do I have to take part?

It is up to you to decide to join the study. I will describe the study the and go through this information. If you agree to take part, I will then ask you to sign a consent form. If you do not wish to take part this will in no way affect the standard of maternity care you receive. You <u>are</u> free to withdraw at any time without giving reason. This will not affect the standard of care you receive.

What will I have to do?

The interview will be friendly and an informal discussion and will be led by your thoughts and feelings. There are no right or wrong answers. The interview will be tape recorded to allow for all your valuable information to be processed and analysed thoroughly after the interview.

What will happen to me if I take part?

Taking part in the research involves agreeing to an interview lasting up to one hour. Now that you have had your baby the interview will take place at your convenience at either the clinic where you normally had your antenatal appointments or in your home if it is more convenient for you, but somewhere where the interview will not be interrupted. You will not be able to be identified by anyone other than the researcher. The confidentiality of records that could identify you will be protected, respecting your privacy and confidentiality rules in accordance with the applicable regulatory requirements. Tape recordings will be destroyed once the interviews have been copied into written format. Results may be published in a healthcare journal but you will not be identified in anyway. It may be necessary for illustration to use quotes from interviews in my academic work but you will be completely anonymized. Once the interview is transcribed this will be returned to you to check that the information accurately reflects your views.

Please turn over the page

Appendix 9. Postnatal information sheet (reverse) version 3.3

Appendix 9 Postnatal reply slip

Postnatal information sheet reply (version 2.2 4/2010)

Please complete slip and post using the stamp addressed envelope provided to Carol Lambert University of Hull if you would like me to contact you regarding this study. If you are not contacted this means enough participants for the study have come forward and I would like to thank you for your interest.

NAME...

Contact number...

Please circle below the statements that apply to you.

I had some increased risk factors identified prior to labour and accepted the advice given to me about where to have my baby

    Yes   No

I had some increased risk factors identified prior to labour and didn't accept the advice given to me about where to have my baby

    Yes   No

Please detach my contact card for your receipt.

Appendix 10 Purposeful recruitment sample version 2.2

Flow chart showing purposeful recruitment sample (version 2.2 4/2011)

Antenatal women

Postnatal women

With health/pregnancy related risk factor highlighted prior to labour onset still receiving postnatal midwifery care

n = 6

n = 10

n = 10

5 Primigravida Women

5 Multigravida Women

5 Primigravida Women

5 Multigravida Women

3 women whose choice was seen to have gone against perceived safety and professional advice **And recruited from across the ▮▮▮▮ and ▮▮▮▮▮▮▮▮▮ Trust**

3 women whose choice was seen to have gone along with perceived safety and professional advice

n= 5 booking for birth centre/ home birth

n = 5 booking for hospital birth

Bookings irrespective of parity

* Parity denotes the number of previous babies born to the woman

n= 5 booking for birth centre/ home birth

n = 5 booking for hospital birth

Bookings irrespective of parity

Appendix 11 Recruitment time frame version1.1

Week	1	2	3	4	5
███ Recruitment	Antenatal & Postnatal women	Postnatal women			
Collection of replies	Antenatal replies	Antenatal replies	Antenatal/ Postnatal replies	Antenatal/ Postnatal replies	
████ Recruitment		Antenatal & Postnatal women	Postnatal women		
Collection of replies		Antenatal replies	Antenatal replies	Antenatal/ Postnatal replies	Antenatal/ Postnatal replies

Appendix 12

Researcher safety policy (version 1.1 2/2010).

Midwives will be asked to advise women who have any social issues who wish to take part in the study to be interviewed in a clinic setting. This is to avoid any potential dangers that may put either the woman or the researcher in danger from the researcher entering their homes, whilst not excluding any woman from the study.

The policy of leaving information with faculty Staff at the University regarding premises and times that the researcher will be at will be undertaken. The researcher will have a mobile phone and the number will be known to faculty staff. A telephone system will be maintained where the researcher will ring on completion of interview, within an agreed time frame and if the loop is not completed then staff will ring the researcher. A code word will be given by the researcher if there are serious issues and the police will be contacted if required.

Appendix 13 Participant consent form version 2.2

Participant consent Form for Social Influence Research Study.
Researcher Carol Lambert Registered Midwife and PhD Researcher University of Hull.

	Please initial	**Yes**	**No**
I have read and understood the participant's information leaflet and have had the opportunity to ask questions. I have been fully informed about the purpose of this research study by the researcher Carol Lambert.		☐	☐
I understand that my participation is voluntary and I am free to withdraw at any time without giving any reason and without my maternity care or legal rights being affected.		☐	☐
I understand that the information collected as part of this study may be looked at by individuals from the University of Hull relevant to where this research study is being undertaken and any quotes referred to in any academic works or publications will be completely anonymised and my identity will remain completely confidential.		☐	☐
I understand that relevant sections of my medical notes and data collected during the study may be looked at by individuals from ████████████ Hospitals NHS Trust, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records if necessary.		☐	☐
I understand this original consent form will be kept in my patient records, a copy is held in the researcher site files and I have a copy for my own records.		☐	☐
I give my informed consent to be a participant in the Social Influence study.		☐	☐

Name of Patient   Date   Signature

....

Name of Person taking consent   Date   Signature

....

If you have any concerns about the way you have been approached or treated in the course of this research you may contact the Patient Advice Liaison Service (PALS). PALS: Contact number ████
████

Appendix 14

Antenatal semi-structured interview

- Tell me a bit about your antenatal experience so far

- Who gave you the information about the choices available to you about where you could have your baby

- How did you decide where you wanted to give birth/How did you decide who you wanted to care for you in your pregnancy

- Tell me a bit about why you made that choice

- How did you feel about making that choice

- What in particular helped you make up your mind

- How does your partner feel about your choice about how you wanted to birth your baby

- How do your family and friends feel about how you want to give birth

Show vignette A and then vignette B. Ask related questions

Appendix 15 Vignette: scenario

Antenatal vignettes (Version 1.1 2/2010)

Scenarios shown independently of each other

Scenario 1

This is my second baby. I had a caesarean section last time as I did not progress past 9cm dilation.

I want and believe I can have a normal birth this time. It seems usual that women book to the hospital.

So I will.

Appendix 16 Vignette: scenario 2

. Antenatal vignettes (Version 1.1 2/2010)

Scenarios shown independently of each other

Scenario 2

This is my second baby. I had a caesarean section last time as I did not progress past 9cm dilation.

I want and believe I can have a normal birth this time. It seems usual that women book to the hospital.

So I'm not

Appendix 17 Vignette question guide

(Version 1.1 2/2010)

Vignette question guide.

- What do you think the woman in the scenario is thinking

- What do you think she means by that

- Do you think it is important to be in control in your birth

- What does being in control mean to you

- Do you think the woman in the scenario is in control

- Why do you think that

- What do you mean by that

Some people may think giving birth is 'risky' for the mother and baby, while some people may think it is perfectly normal and women are designed to give birth.

- Tell me how you understand what is meant by risk

- Tell me a little bit about what you think about the risks of birth

- Did this affect your decision of where to give birth

- Can you tell me why you think that

Appendix 18 Expert comments on vignette design

Vignette design: table showing expert midwifery advice from online forum.

(Version 1.1 2/2010)

I would recommend that the vignettes be quite carefully constructed (a) to reflect the real world as experienced by your participants and (b) to elicit quite precise information for example about how they would deal with a particular dilemma.
Try and be fairly precise in your description otherwise people will just say 'it depends' - although then you can probe as to what it depends on and why.
We would typically present one scenario and then, following discussion move on to a second one which is similar expect for one key piece of information to see if this changes people's responses. Repeat as necessary!
I think the elements of the vignette can come from anywhere - as long as they represent the thing you are trying to measure. I have developed vignettes from real histories, from critical incident tech interviews - in which midwives described cases - I then analysed them for all the various cues. And I've also just made them up based on my clinical knowledge.
I think that in your study the vignette needs to represent a woman conforming or not conforming - so you need to start by thinking what would best represent that concept, you need to get the correct words to represent conformity/non-conformity. Then you need to think of the rest of your vignette - the stem - other things that make this vignette realistic (in as much as it can be) and a bit about the context. Who is this woman and in what situation. You might want to have exactly the same woman and context and just vary the cues about the central thing you are studying.

Consultant Letter (version 2.2 4/2010).

Date

Dear Mr.............,/ Mrs..............

I am writing to inform you that ……….……..………….. is booked under you for antenatal care has consented to take part in the Social Influence Study within this Trust.

The research study will involve the recruitment of twenty antenatal women and six postnatal women from two geographical clinics within the trust. The aim of the study is to explore the experiences and perceptions of women as they make decisions about birth choice options.

This study has been approved by the local Research Ethics Committee and the ▮▮▮▮▮▮▮▮▮▮ NHS Trust. If you have any questions or concerns about this study please don't hesitate to contact me on my mobile number ▮▮▮▮▮▮ or by any other means via the details provided.

Yours Sincerely

Carol Lambert

PhD Researcher, BSc (Hons) PG Cert, RM, RN.

Appendix 20 Postnatal interview guide

Postnatal interview guide. (Version 1.1 2/2010)

Postnatal Semi Structured interview guide with discussion themes and some examples of questions under those themes

- Tell me a bit about your antenatal history

Theme: Risk

- Were there any risks in your pregnancy

- Can you tell me a little bit about those risks

- How were these identified as risks

Theme: Choice

- What were the choices made available to you about where you could have your baby

- How did you decide where you wanted to give birth/How did you decide who you wanted to care for you in your pregnancy

- Tell me a bit about why you made that choice

Theme: Practitioners

- Can you tell me who cared for you in your last pregnancy

- How did they react to the choice you made about your birth options

- How did you feel about that

Theme: The birth of your baby

- Looking back at the decisions you made about giving birth, how do you feel about them now

- Looking back would you change anything about your decision making about where you chose to have your baby

- How do you feel about your birth experience

Appendix 21 Aspects of antenatal self

Term related to self	Definition
Self	A person's essential being that distinguishes them from others, especially considered as the object of introspection or reflexive action. A person's particular nature or personality
Identity	The fact of being whom or what a person or thing is. The characteristic determining this.
Self-concept	An idea or mental picture of self, formed by combining all their aspects
Self-awareness	Conscious knowledge of one's own character, feelings motives and desires
Self-assurance	Confidence in one's own abilities or character
Self-determination	The process by which person controls their own life
Self-regret	Feeling of sorrow, disappointment or sadness over something
Self-regard	Consideration for oneself
Self-surrenders (submit)	The surrender of oneself or one's will to an external influence, an emotion etc.
Self-reliance	Reliance on one's own powers and resources rather than those of others
Self-confidence	Belief that we can have faith in or rely on someone or something. A positive feeling arising from an appreciation of one's own abilities.
Self-doubt	Lack of confidence in oneself and one's abilities.
Self-sacrifice	The giving up of one's own interests or wishes in order to help others or advance a cause.

Self-changes (changing self)	The action of changing. The instance of becoming different.
Self-less	Concerned more with the needs and wishes of others than one's own.
Self-blame	Assigns responsibility for fault or wrong to self.
Self-realisation	The attitude or practice of accepting a situation as it is and dealing with it accordingly
Independent self	Capable of acting or thinking for oneself
Fulfilled self	Gain happiness or satisfaction by fully achieving ones potential
Self-assumption	A thing that is assumed as true
Comparative self	Managed or judged by comparison, relative.
Self-preparation	The action or process of preparing or being prepared
Inquisitive self	Interesting in learning about things, curious
Self-expectation	A strong belief something will happen or be the case
Situated self	In a particular context
Self as pragmatist	Practical self dealing with things in a way that is based on practical rather than theoretical consideration
Intuitive self	Based on what one feels to be true even without conscious reasoning
Self-justification	Justifying something to oneself, proving to be right or reasonable

Self-expression	expressing something, conveying in words, gestures and conduct
Self-detachment	Detaching self, separating oneself
Self as advocate	A person who pleads the case on someone else's behalf or publicly supports or recommends a particular cause.

Appendix 22 Definitions of postnatal aspects of self

Term related to self	Definition
Self	A person's essential being that distinguishes them from others, especially considered as the object of introspection or reflexive action. A person's particular nature or personality
Identity	The fact of being whom or what a person or thing is. The characteristic determining this.
Self-awareness	Conscious knowledge of one's own character, feelings motives and desires
Self-assurance	Confidence in one's own abilities or character
Self-determination	The process by which person controls their own life
Self-reliance	Reliance on one's own powers and resources rather than those of others
Self-regard	Consideration for oneself
Self-surrenders	The surrender of oneself or one's will to an external influence, an emotion etc.
Self-doubt	Lack of confidence in oneself and one's abilities.
Self-confidence	Belief that we can have faith in or rely on someone or something. A positive feeling arising from an appreciation of one's own abilities.
Self-reflection	Think deeply or carefully giving serious thought or consideration.