Birth Place Decisions

A prospective, qualitative study of how women and their partners make sense of risk and safety when choosing where to give birth

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Abstract

For the past two decades, English health policy has proposed that women should have a choice of place of birth, but despite this, almost all births still take place in hospital. The policy context is one of contested evidence about birth outcomes in relation to place of birth, and of international debate about the safety of birth in non-hospital settings; partly as a consequence of this, 'birth place decisions' have become morally and politically charged. Given the perceived lack of consensus about birth place safety, this study sought to explore the experience of making birth place decisions from the perspectives of women and their partners, in the context of contemporary NHS maternity care.

Longitudinal narrative interviews were conducted with 41 women and 15 birth partners recruited from three English NHS trusts, each of which provided different birth place options. Initial interviews were conducted during pregnancy, and follow up interviews took place at the end of pregnancy and again up to three months after the birth. Altogether, 141 interviews were conducted and analysed using a thematic narrative approach.

This research contributes new knowledge about how birth place decisions are undertaken and negotiated, and about the extent to which some are excluded from these choices. Participants' beliefs about birth place risk originated in upbringing and drew upon normative discourses which positioned hospital as an appropriate setting for birth. Individual worldviews informed conceptualisations of birth place risk, and these were premised upon prioritisation of medical risks of birth, perceived quality of the maternity service or the likelihood that medical intervention would interfere with birth. These beliefs were often enduring and the overall tendency was for women to be increasingly conservative about their birth place options over time, but during their first pregnancies, participants views were most fluid and open to change.

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Abbreviations

ACNM	American College of Nurse-Midwives
ACOG	American College of Obstetrics and Gynaecologists
AIMS	Association for Improvements in the Maternity Services
AMU	Alongside Midwifery Unit (sited in a hospital with a consultant led unit)
BME	Black or Minority Ethnic group
DH	Department of Health
DHSS	Department of Health and Social Security
FMU	Freestanding Midwifery Unit (sited in a non-hospital community setting)
GP	General Practitioner (family community doctor)
HCC	Health Care Commission (now the Care Quality Commission)
MH	Ministry of Health
MSLC	Maternity Services Liaison Committee
NCCWCH	National Collaborating Centre for Women's and Children's Health
NCT	National Childbirth Trust
NHSQIS	National Health Service Quality Improvement Scotland
NICE	National Institute for Health and Clinical Excellence (previously National Institute for Clinical Excellence)
NIHR	National Institute of Health Research
NPEU	National Perinatal Epidemiology Unit
OU	Obstetric Unit (consultant-led)

PSSQ	Patient Safety and Service Quality research centre
POST	Parliamentary Office of Science and Technology
RCOG	Royal College of Obstetricians and Gynaecologists
WAG	Welsh Assembly Government
WHO	World Health Organisation

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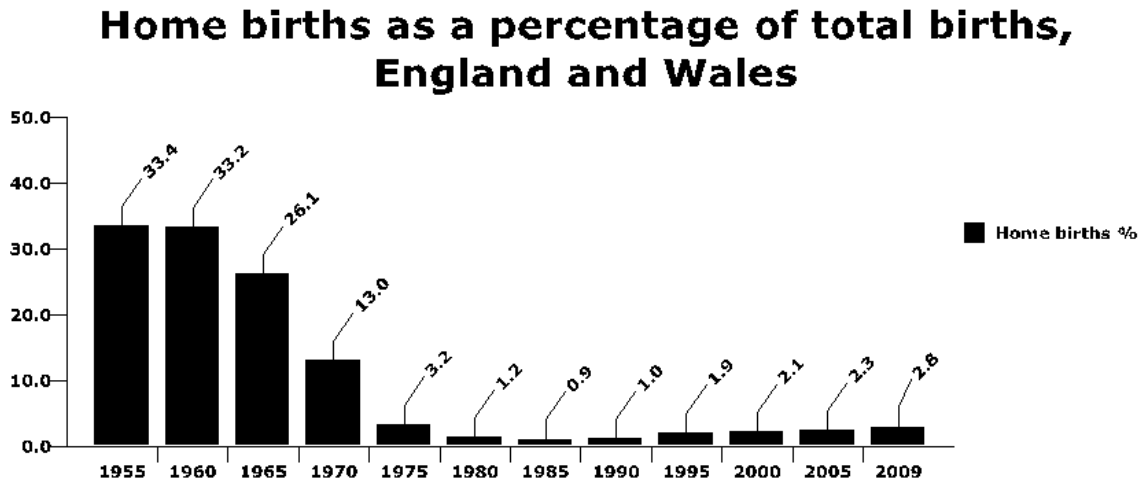
Introduction: Contextualising an interpretative study of birth place decisions

Over the past century, giving birth in the UK has changed considerably. Before the turn of the twentieth century, women usually gave birth at home, attended by family members or local midwives, who were often knowledgeable but whose work was unregulated. Birth could be a dangerous affair, as the high rates of death amongst women and their infants attest (Oakley 1984), and this continues to be the case today in many developing countries (e.g. Mehta et al 2001; Hogan et al 2010).

Infant and maternal mortality continued to be a major public health problem in the UK until the first half of the twentieth century, but the position now is very different. Maternal mortality is very low, at 14 per 100,000[1], as is perinatal mortality at 7.7 per 1000 total births (Lewis 2007, p.1; Euro-Peristat 2008). No single intervention explains the dramatic improvement that has taken place, but according to De Brouwere and Van Lerberghe's (2001) comprehensive review on this topic, political commitment to improving public health, technical advances to obstetric practice, the availability of high quality data and access to professional midwifery and medical care are all essential contributory factors. Two things are clear though; firstly, birth in the UK is now much 'safer' in terms of mothers and babies *surviving* (although problems with morbidity persist) and secondly, birth now takes place in hospital rather than at home (see Figure 1 below), although these two observations are not necessarily causally linked.

[1] 'Direct' and 'indirect' deaths related to pregnancy

Figure 1 Home births as a percentage of total births 1955-2009



Source: From 1955-1995 Macfarlane et al (2000, p.522-4), from 2000-2009 Birthchoice UK http://www.birthchoiceuk.com/BirthChoiceUKFrame.htm?Access.htm Accessed 7.7.11

With the exception of the Netherlands, where just over a quarter of births still take place at home (Pavlova et al 2009), the low home birth rate for England and Wales is unexceptional amongst developed countries. Seen within this context, English maternity care policy has followed an unusual route; after reaching near-total hospitalisation of birth, women's choice of place of birth returned to the policy agenda in 1993, where it still remains.

Recognition that 'safety' and 'hospital birth' have become entwined over the course of English maternity care history is the starting point for this research. Despite influential critical histories of childbirth (e.g. Arney 1982; Oakley 1984; Donnison 1988; Tew 1990) the predominance of hospital birth continues. Concerns about treatment efficacy and increasing rates of medical interventions have been raised by a range of interest groups, including obstetricians, midwives, and women's representative groups, and the work undertaken by these groups has informed maternity care policy (Sandall 1995). Yet a recurring theme in the empirical literature has been that although *some* women prefer to give birth at home, *most* would still opt for hospital birth (Barber et al 2006, 2007; Jomeen 2006, 2007; Pitchforth et al 2008, 2009)

Policy context

The Winterton report (Health Committee 1992) famously challenged the advice given by the Peel report (DHSS 1970) that women should give birth in hospital on the grounds of safety. The consequent shift in policy was published in *Changing Childbirth* which proposed that women should be offered a 'real choice' of place of birth, including birth at home (DH 1993, p.23), and the reasons for this change are discussed further in Chapter 1. Yet in the intervening decades, the home birth rate increased only fractionally. The aspiration to provide 'real choice' was later refined into 'choice guarantees' including 'choice of place of birth' in *Maternity Matters* (DH 2007a), and this choice was outlined as follows:

> Depending on their circumstances, women and their partners will be able to choose where they wish to give birth... The options for birth place are:
>
> - birth supported by a midwife at home
> - birth supported by a midwife in a local midwifery facility such as a designated local midwifery unit or birth centre
> - birth supported by a maternity team in a hospital
>
> (DH 2007a, Section 2.1 pp.12-13)

Although there is clear policy support for choice of place of birth, a tension between evidence and policy is demonstrated within the NICE *Intrapartum Care Clinical Guideline* (NCCWCH 2007). This document advises health professionals that the lack of evidence from well designed studies that are relevant to the UK means that the available data should be interpreted with caution, (NCCWCH 2007, p.53) and that:

> Women should be informed that if something does go unexpectedly seriously wrong during labour at home or in a midwife-led unit, the outcome for the woman and baby could be worse than if they were in the obstetric unit with access to specialised care
>
> (NCCWCH 2007, p.62)

Of particular concern to the authors was the trend suggesting that perinatal mortality rates *might* be higher 'when birth was planned at home' (ibid, p.53). The disjuncture between evidence and policy has important implications for how the *Maternity Matters* choice guarantee is implemented, and for the basis upon which women and partners are able to decide where to give birth. The UK-based evidence which gave rise to this concern was later published by Mori et al (2008a), and the methodology and conclusions from this paper were subsequently challenged (Gyte et al 2008, 2009). These publications attracted coverage in the national press, reaffirming the impression that home birth is contentious, despite reasonable quality epidemiological evidence to the contrary. A large scale cohort study has been commissioned to address this question by prospectively examining infant outcomes in relation to planned place of birth in England[2], but whilst the results of the cohort study are awaited, the decisions made by women, partners and health professionals are based upon contested evidence of safety.

What is the 'problem' with hospital birth?

If the safety of birth in non-hospital settings is contested, and the existing evidence contains gaps and uncertainties, then it is reasonable to ask why it should matter if women give birth in hospital, and how expanding maternity care to non-hospital settings might be expected to benefit women and babies. Two relevant debates are briefly outlined here; these concern the increase in hospital birth interventions, which in turn affect women's experience of birth, and the argument that such interventions are less likely to occur if women plan birth in a non-hospital setting. [3]

Johanson et al (2002, p.892) argue that increased caesarean rates have occurred without 'evidence of effectiveness', a view shared by the World Health Organisation, which proposed that caesarean section rates should not exceed 15% (Lancet 1985), on the basis that rates below this are found in countries with low perinatal mortality. In

[2] The NPEU Birthplace in England cohort study is part of the 'Birthplace in England' programme of research. https://www.npeu.ox.ac.uk/birthplace. This doctoral study is an adjunct study to the NPEU Birthplace research programme.

[3] See final section (p.17) for an explanation of terms used to describe different birth settings

England, caesarean rates increased from 12% in 1990 to 21% in 2001 (Parliamentary Office of Science and Technology 2002). UK research has sought to pinpoint the clinical rationales for caesarean rates in the England (RCOG 2001; Bragg et al 2010); these studies found the main reason for caesareans to be previous surgical birth, and Bragg et al (2010) concluded that attention should shift towards addressing variations in emergency caesareans during first labours.

A recent observational study in New Zealand demonstrated that women with straightforward pregnancies who plan to give birth in hospital obstetric units (OUs) have a 'higher risk of caesarean section, assisted modes of birth, and intrapartum interventions than similar women planning to give birth at home and in primary units' (Davis et al 2011, p.111). Planning to give birth in a non-hospital setting may then be beneficial to women, especially if they have straightforward pregnancies; birth interventions are also associated with postnatal morbidity including depression, perineal trauma and incontinence (Lydon-Rochelle et al 2001; Thompson et al 2002). Also, although the majority of UK women are healthy and have straightforward pregnancies, only 47% achieve a normal birth, where this is defined as birth 'without surgical intervention, use of instruments, induction, or epidural, or general anaesthetic' (NCCWCH 2007, p.1). The NICE guideline recognises that women are more likely to have a normal birth, an intact perineum, and to avoid epidural analgesia at home and in alongside midwifery units (AMUs), although the strength of this evidence is also subject to critique (NCCWCH 2007).

Mapping choice in maternity care

In the context of the policy imperative towards increasing choice of place of birth, the National Childbirth Trust commissioned a mapping study of maternity care as it is currently offered in the UK (NCT 2009). This report defined choice in relation to what alternatives were available locally, and the amount of time it would take women to travel to different units. Areas with home birth rates of 5% or more were judged to be providing genuine support for this option. These definitions were intentionally pragmatic, but by using these criteria the study identified that despite the *Maternity*

Matters guarantees, fewer than 5% of women in England had 'a full range of choice' at the end of 2009 (NCT 2009, p.5).

The premise for this study then is that choice of place of birth in England is promoted within a cultural context where hospital delivery remains usual and where the safety of birth in non-hospital settings is contested. However, recent social science and health services research conducted in the UK indicates that when women choose *not* to give birth in hospital, they do so for complex reasons (Madi and Crow 2003; Barber et al 2006, 2007; Houghton et al 2008; Jomeen 2006, 2007; Pitchforth et al 2008, 2009). Research conducted in the US, where private obstetric care is the predominant model, suggests that some women positively value medical care, including interventions for pain relief (even, in some cases, operative delivery) because this reinforces their cultural acceptance of technology and belief in the scientific, medical model of birth (Davis-Floyd 1994).

Existing literature suggests that social class, education, age, moral positioning, professional/home-based employment status, partner influence and beliefs about birth risk all contribute to the decisions women make (e.g. Davis-Floyd 1994; Zadoroznyj 1999; Viisainen 2000, 2001; Hundley et al 2001; Houghton et al 2008; Pitchforth et al 2008, 2009), and that the socio-political and cultural contexts of maternity care are also of central importance (DeVries et al 2001; Viisainen 2000, 2001; Donner 2003; Liamputtong 2005; Murray and Elston 2005). Influences upon birth place decisions are therefore likely to be complex, and findings from other countries need to be considered carefully to determine whether they hold true in the context of English maternity care[4]. These considerations placed the study within a strong socio-cultural framework, with the aim of exploring the experience of deciding where to give birth in the contemporary context of English maternity care.

[4] The focus of this study is England; different health and maternity care policies are pursued in the other devolved nations.

A note about 'birth place' terminology

One of the difficulties affecting discussions of different birth place settings is the variation in terms used. The following terms have been adopted by the NPEU Birthplace in England research programme, and for purposes of consistency, these are also used throughout this thesis:

- Planned home birth
- Birth in a midwifery unit - either 'freestanding' (FMU), or 'alongside' (AMU), where care is led by midwives
- Birth in an obstetric unit (OU), which is consultant-led.

Definitions of these terms are provided in the glossary (Appendix G), along with other potentially unfamiliar terminology relating to pregnancy and birth. Also in common with the NPEU Birthplace in England research, classifications of pregnancies as straightforward or complex are consistent with the advice in the NICE *Intrapartum Care Clinical Guideline* (NCCWCH 2007 pp. 64-66) which remained current throughout the research study.

Citations

References in this thesis have been cited according to Harvard conventions, using their final publication dates. However several papers were pre-published online in advance of their eventual publication date, or shared at conferences beforehand. For this reason, some citations in the background chapters have very recent publication dates; where this occurs, the cited research has informed the conduct of this research, and was available in pre-publication format during the course of the study.

Chapter 1: Birth place decisions in policy and practice and research

Introduction

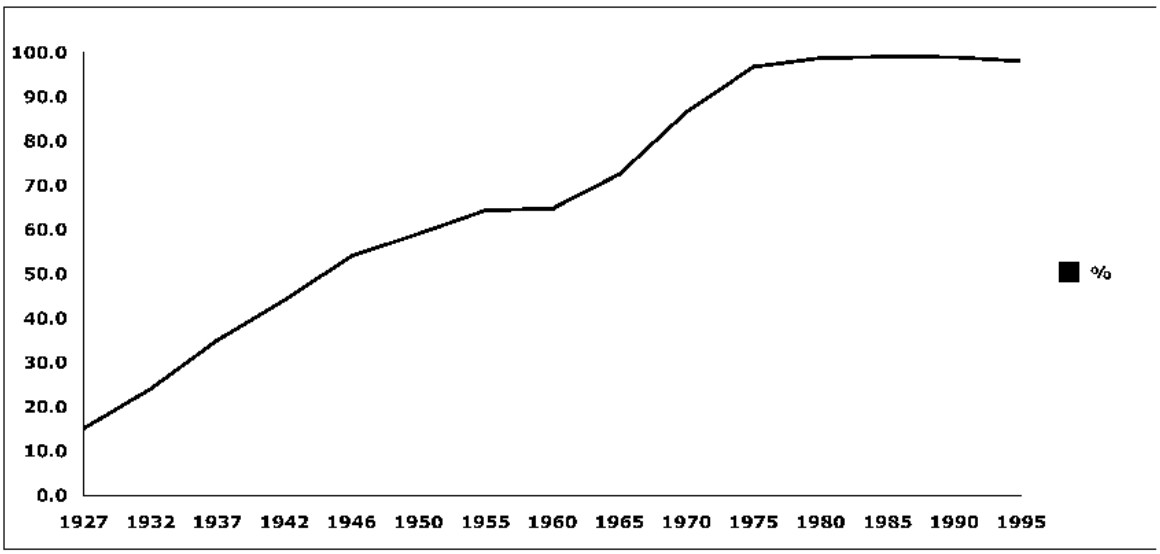
This chapter outlines the context of birth place decisions in the UK in relation to maternity policy over the last 50 years. The first part of the chapter reviews historical trends in place of birth, and considers the contribution of research to policy, practice and national debate about the appropriateness of choice in relation to birth place. Later in the chapter, changes that took place following publication of *Changing Childbirth* (DH 1993) are considered. Through expanding the discussion to include international evidence about birth place preference, the following chapter then contextualises the acceptability of birth in hospital and non-hospital settings in England in relation to practices in different geo-political contexts and considers the impact of UK and international research on English policy and professions.

UK birth place policy: from the Cranbrook report[1] to *Changing Childbirth*

During the course of the twentieth century, birth moved from home into hospital. As Figure 2 (below) shows, this change started between the wars and levelled out during the late 1950s; after this time, the rate of hospital birth rose again more steeply, reaching the near-total hospitalisation by 1975.

[1] All references to the Cranbrook report, the Peel report and the Winterton report refer to documents by their unofficial names. These reports have been colloquially named after the chairs of the committees which authored them.

Figure 2 Hospital birth rates as a percentage of total births in England and Wales 1927-1995[2]

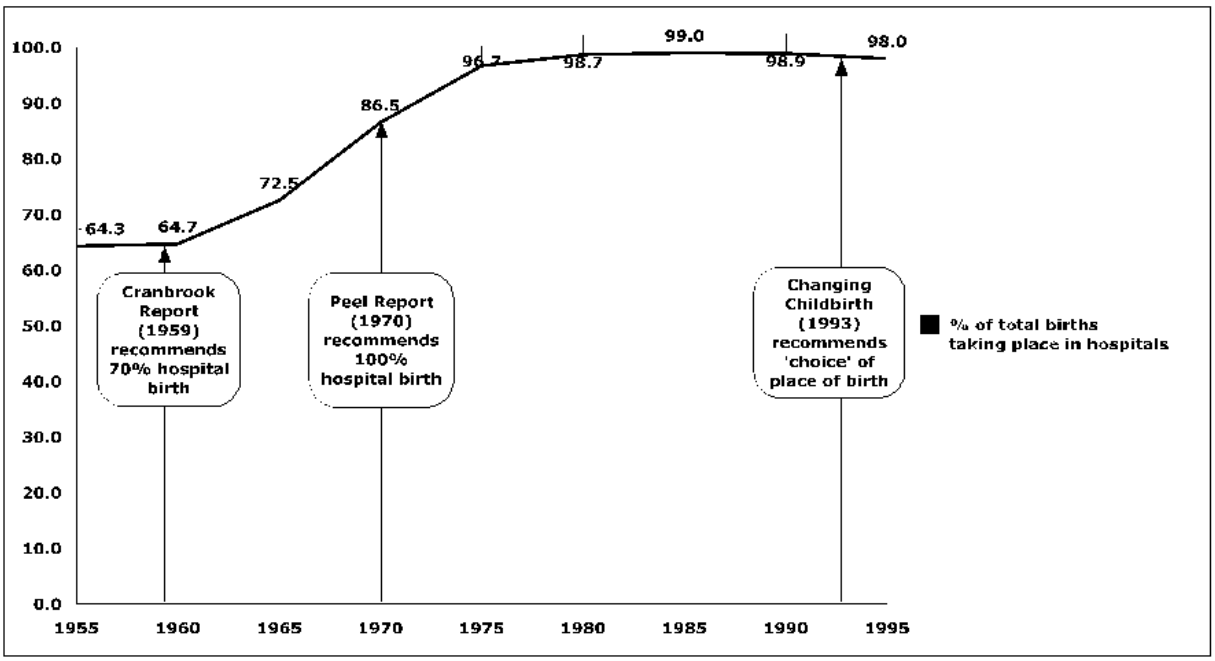


Source: Macfarlane et al (2000, p.220) and Macfarlane and Mugford (2000).

This chapter considers the changes that took place after 1959, when the Cranbrook committee was charged with reviewing maternity services. The review was recommended after the 1955 Guillebaud enquiry into the cost of the NHS expressed concern about the way responsibility for maternity care was divided between three sectors (hospitals, local authorities and GP executive councils) with substantial regional variations in services. The Royal College of Obstetricians and Gynaecologists (RCOG) had argued that these divisions caused competition rather than co-operation, and suggested unification under obstetric management. By this stage, the RCOG already supported 'institutional confinement … for all women' on the basis that this provided 'maximum safety' (Ministry of Health 1959, p.5), but the Cranbrook committee was not convinced by this argument.

[2] The sources cited collate national statistics. However hospital birth data was not collected routinely until 1954, hence the figures before this date are drawn from different sources, and refer to births in several institutions (hospital, nursing homes, maternity homes, poor law institutions) and should be considered illustrative rather than accurate.

Figure 3 Percentage of total births taking place in hospital in England and Wales 1955-1995



Source: Mugford and Macfarlane (2000, pp.523–4).

The Cranbrook report: hospital birth and the 'balance of advantage'

The Cranbrook committee, chaired by the Earl of Cranbrook, met 41 times over three years, and consulted widely amongst professional organisations representing medical and midwifery interests, hospital boards and women's groups, also inviting written and oral evidence through advertising in the national press (Ministry of Health 1959, Appendix 1). The committee's report recommended 'sufficient hospital maternity beds to provide for a national average of 70 per cent of all confinements to take place in hospital' on the basis that this 'should be adequate to meet the needs of all women in whose case the balance of advantage appears to favour confinement in hospital' (Ministry of Health 1959, Appendix 1, paragraphs 70 and 329).

At the time, this was an incremental change because the rate of hospitalisation had already reached 65% (see Figure 3 above), and represented a compromise between the Guillebaud recommendation of hospital provision for 50% of births,[3] and the RCOG's preference for hospital birth for all.

[3] The Guillebaud committee's proposal of 50% is cited in the introduction to the Cranbrook report (Ministry of Health 1959, p.5)

The report took account of the near-total hospitalisation of birth in other developed countries, but considered that differences in 'social environment and traditions' prevented reliable comparisons (ibid, paragraph 5). Instead, the committee acknowledged that around 10–20% of UK women prefer home birth, and agreed that this conferred 'important physical and psychological advantages'; these were thought to include reduced fear of labour, improved mother-baby relationship and breast feeding, reduced risk of infection to the baby, less disruption to family life and better continuity of caregiver (ibid, paragraph 55). The discussion blamed 'inter-war propaganda on maternal mortality' for increased demand for hospital birth, but also cited the 1952–54 *Confidential Enquiry into Maternal Deaths* (Ministry of Health 1957), and data on the use of 'obstetric flying squads', to argue that preventable deaths *were* occurring during home births, mainly due to failures to select women appropriately. The recommendation of 70% hospital birth was intended to provide for women with known or foreseeable 'abnormality', including women with four or more children, those over the age of 35, women requiring admission on social grounds (such as poor housing) and 'all primigravidae not included in the above groups' (ibid, paragraph 70). The guidance balanced the support from proponents of home birth with the Royal College of Obstetricians and Gynaecologists' (RCOG) stance in favour of hospital, a position that was likely influenced by obstetric practice in the US, where rates of hospital birth were much higher than in the UK.[4]

Little more than a decade later, the Peel report (DHSS 1970) concluded that 'the resources of modern medicine should be available to **all** mothers and babies, and we think that sufficient facilities should be provided to allow for 100% hospital delivery' (ibid, paragraph 277, emphasis added). Chaired by Sir John Peel, a consultant obstetrician and then president of the RCOG, this committee reached their position after meeting 13 times, and took evidence only in the form of reports prepared by professional bodies; no opinions were sought from the general public. The committee argued that although the Cranbrook report had given 'detailed guidance on the proper selection of women' for home delivery, this was clearly not being implemented, citing the 1958 Perinatal Mortality Survey's evidence of a 25% rate of hospital transfer

[4] US hospital birth rates were 79% in 1945, rising to 97% by 1960 (Declercq et al 2001, p.10).

amongst women expecting their first baby, and a perinatal mortality rate that was 'three times the national survey average' (ibid, p.9 paragraph 27).[5] Campbell and Macfarlane (1990, p.218) argue that the Peel report effectively withdrew policy support for home delivery through the recommendation of 100% hospital birth provision, but in fact the report's authors claimed to 'accept the view of the Royal College of Midwives and Chairman of Local Medical Committees that wishes for home confinement should be respected, provided, of course, that there are no medical or social contra-indications' (ibid, paragraph 249). The RCOG's support for home birth is noticeable by its absence in this statement, and the college's aim of universal hospital birth appeared to have been achieved, but the Peel report's failure to substantiate the claims of improved safety of hospital with appropriate data subsequently provided an opportunity for a sustained critique of this position.

Consulting women on birth place choices

When this period of policy history is discussed in academic or professional texts, an argument is commonly made that the shift to hospital birth took place without reference to women's preferences. For example, Oakley (1984) and Tew (1990) both critique the rise of medicalisation in antenatal and intrapartum care respectively, but neither considers the role of women's increasing desire for pain relief during labour. Tew (1990, pp.15–18) argues that women were 'bombarded from all sides' by 'admonitions that to give birth anywhere [other than hospital] was to endanger their own and their baby's life' leading women to "acquiesce" and concede that "doctor knows best"'. Similarly, Beech claims that women were not consulted about where they wished to give birth:

> No-one asked the mothers if they would prefer to give birth in hospital and no evidence at all was presented to support the claim that hospitals were safer than women's own homes.
>
> (Beech 2006)

[5] Although conducted in 1958, publication of the Perinatal Mortality Report was delayed until 1963, and therefore was not available to the Cranbrook committee.

Whilst it is true that the Peel committee did not consult widely, there is sound evidence that the Cranbrook committee did so. Both reports also refer to increasing *demand* for hospital birth, from women and from the public more generally, as women's groups and progressive doctors campaigned for wider access to hospital beds for poorer women, for whom analgesia was rarely provided at home (e.g. Beinart 1990, p.122; Rivett 2011).[6] Surveys published during these decades also suggest it is time to reappraise the assumption that women's views were not sought. Although this research was not often of high quality, the discussions these papers engendered support Chamberlain et al's (1997) contention that the shift to hospital birth occurred as much in response to an inter-professional struggle between community and hospital doctors as an attempt by doctors to wrest control of birth away from midwives. The debate also reveals that evidence from service users was garnered to support and to critique policy, but not to design or influence services, so in effect, the involvement of women was subservient to debates within and between professions.

Research into birth place choices following the Cranbrook report: frivolous 'demands' and 'preferences'

In 1960, Ian Gordon, an Area Medical Officer, and Thomas Elias-Jones, a consultant pathologist, published a paper entitled, *Place of confinement: home or hospital?* (Gordon and Elias-Jones 1960). This paper took issue with the Cranbrook committee's conclusion that there was 'unsatisfied demand' for hospital birth (ibid, p.52), based on their survey of local women which showed that around 80% who had experienced both home *and* hospital birth preferred to give birth at home. This stimulated a debate in the *British Medical Journal* (BMJ) which lasted over a year (Fowler and Sweet 1960; McDonald 1960; Tweedie and Tweedie 1960; Wauchob and Roberts 1960), and correspondents often based their contributions on their own local surveys of women who had used maternity care. Wauchob and Roberts (1960) surveyed 89 women who had had babies in both settings, and Fowler and Sweet (1960) surveyed 51 women in antenatal care, both agreeing that around 80% of mothers preferred home birth.

[6] 'Only 20% of women delivered at home received any form of pain relief, usually as gas/air, and only half of those in hospital' (Rivett 2011).

McDonald (1960) added that although 80% of Ealing women *preferred* home birth, only 24% actually *chose* it. These authors were providing maternity care through Local Authorities, and challenging what they correctly perceived as the shift towards hospital, consultant-based maternity care. Gordon and Elias-Jones' survey was in fact a question inserted into a separate observation study, designed to establish rates of neonatal staphylococcal infection in hospital and community confinements respectively,[7] and to demonstrate that hospitals increased the risk of neonatal infections.

Dugald Baird, a consultant obstetrician already renowned for his work addressing social inequalities in maternity care in Scotland, published a point-by-point refutation of Gordon and Elias-Jones' paper (Baird 1960, p.642), arguing that in Aberdeen, where hospital birth was widely available, only 15% of women wanted home confinements.[8] When Baird outlined women's *reasons* for preferring home birth his position became clear; he argued that only affluent women were in a position to choose hospital, and that poorer women were pressed by circumstances into selecting home birth, because going into hospital would mean 'abandoning several children to the care of husbands, relatives or strangers' (Baird 1960, p.642).

In Baird's view then, providing the choice of home birth perpetuated unequal access to hospital-based maternity care, and socio-economically deprived mothers were at particular risk of being denied the care they needed. Elias-Jones and Gordon (1960, p.1366) published a response in which they reasserted their view that the evidence put before the Cranbrook committee was flawed. They agreed that there ought to be sufficient provision of hospital beds for those with 'valid reasons', but argued that this was less likely to occur 'if a misguided attempt is made to provide hospital beds for

[7] This study was published separately in *The Lancet* (Elias-Jones et al, 1961, p.573), and concluded that the use of communal nurseries in hospitals was putting infants at unnecessary risk of infection. The paper recommended that when hospital confinement is considered for 'less substantial reasons [than obstetric indication], such as domestic or social convenience' it might be more prudent to encourage home delivery to prevent neonatal infections.

[8] This statement is also interesting in that it demonstrates that in some areas, particularly cities, hospital birth is already much more prevalent than the national figures suggest. The higher incidence of hospital birth in cities is also remarked upon in the Cranbrook Report (MH 1959).

those who are wrongly supposed to demand them for non-medical – and even frivolous – reasons'.

The gendered language of preference

This debate is interesting for a number of reasons, not least that there is marked consistency with current policy, including the preoccupation with maternal choice (which during this era was termed a 'demand', and might be considered either *valid* or *frivolous*, depending on the mother's circumstances), with normality in pregnancy and birth and its relationship to hospital-based care, and with providing the best quality care within contemporary economic and political constraints.[9] In keeping with the times, the values that authors expressed were generally patriarchal; for example, Gordon and Elias-Jones (1960, p.53) claimed that 'most doctors are agreed that the first confinement should be in hospital, whatever the mother's preferences may be'.

The use of the term 'preference' appears important in this context, because it carries connotations of politeness and careful consideration; the act of preferring is feminine in the sense that it expresses wishes without conveying *insistence*. Throughout the papers cited above, women's 'preference' is juxtaposed with the concept of 'unsatisfied demand', a phrase borrowed from the Cranbrook report, which implies the more aggressive activities of claiming or arguing. The concept of women's demands may be positively linked to the 'strong voice' of the suffrage movement, but its use in this debate is troublesome, because 'demand' can also suggest a childish or unreasonable insistence. Women in the GP and Local Authority doctors' surveys were usually couched as having preferences (feminine and accepting), but became problematic when they 'frivolously insist upon' and even 'demand' hospital care (Elias-Jones and Gordon 1960, p1366). From Baird's perspective however, which also appears somewhat paternalistic from a contemporary viewpoint, these same women are victims of a system that denies them the specialist care that they require.

[9] The UK birth rate reached a high of 890,000 in 1962, considerably higher than it stands at present.

Class and gender in responsibilising narratives

Later sociological research by Topliss (1970) aimed to understand why 'high risk' women were still being booked for home births, and was undertaken at a time when perinatal mortality had *not* dropped to the extent expected, despite hospitalisation of birth. In relation to this conundrum, Tew (1990) discusses the belief amongst obstetricians at the time that persistence in high perinatal mortality rates occurred because women were still being granted home confinements despite pregnancy risk. This caused obstetricians to widen the 'risk criteria' for hospital birth (ibid, p.258), so that medical criteria (rather than social criteria or maternal request) were prioritised within clinical birth place decisions.

GPs however remained unconvinced that hospitals could provide beds for so many women. Following interviews with 88 family doctors, Topliss (1970, p.71) identified that only about half thought that there were sufficient numbers of maternity beds to meet demand for hospital birth, and 'that if a patient came to them expecting a second, third or fourth child, with no record of obstetric or medical difficulties, any request for a hospital confinement was strongly discouraged as "utterly unrealistic"'. Interviewees were also asked where their own wives gave birth, and this insightful question revealed that GP's wives were much more likely to have a hospital birth of a second, third or fourth baby than the city population generally (57.3% hospital birth vs. 37% average), and far less likely to have a home birth (32.5% vs. 53%). Analysis of preferences from a group of mothers who were interviewed either before or after giving birth (n=382) hinted that wealthier mothers tended to give birth in hospital, and Topliss suggested that the 'higher educational standards' of these women meant that they were 'more easily ... redirected to hospital' because they could understand more clearly the explanations provided by their GPs (ibid, p.74).

There is of course an inconsistency here. On the one hand, GPs report that their healthy, multiparous patients are unlikely to qualify for hospital birth, but then Topliss argued that the best explanation for over-representation of more affluent women in hospital beds is that these same women are persuaded by their GPs of the risks of birth. According to this logic, and those of the earlier medical authors, middle class

women *demand* hospital care for which they are not eligible, *or* create fashions for home birth, putting themselves and their babies (and those of their working class counterparts, should they follow suit) at risk of preventable fatalities. Working class women have numerous babies despite the medical and social risks this incurs, and resist both hospitalisation and education. The recurrence of these themes establishes that the contemporary concerns with class, gender, choice and voice have been part of the place of birth debate throughout the history of NHS maternity care services.

The shift towards safety as a key justification for hospital-based care

One important difference between the early survey research and Topliss' later (1970) study is that women's reasons for preferring hospital birth had changed. In Gordon and Elias-Jones's survey (1960, p.53), the reason given by most women was that hospital allows 'more rest'. In Fowler and Sweet's (1960) study, mothers preferred hospital delivery because they couldn't get enough help at home, and again, safety was a second consideration. But in Topliss' sample, half of whom were pregnant (and therefore negotiating where they would give birth), 'medical safety' was the reason given by 67.5% of mothers who preferred to give birth in hospital. This difference suggests that a sea-change occurred during the decade between the Cranbrook report and the Peel report, and that during this time, women (and GPs) started to demonstrate concerns with medical or obstetrical risk to secure a hospital birth. The reasons for this preference increasing remain unclear, but belief that hospital was safer, so strongly espoused by obstetricians at the time, must be considered an influence. The following extract from a *Lancet* editorial in 1963 provides an example of how the arguments were framed during this decade:

> If prenatal mortality and morbidity are to be reduced the maternity service must be based on properly equipped and staffed hospitals where obstetricians, general practitioners, and midwives work in close harmony. There is no place for isolated or detached units. These facts should be placed clearly and repeatedly before the public, and every effort made to enlighten women (particularly those in 'high-risk' categories) about the need for medical care in pregnancy. Good antenatal care and safe delivery in a

> hospital fully equipped and staffed to deal with any emergency **can prevent family tragedies once thought to be unavoidable.**
>
> (Lancet 1963 p.1208, emphasis added)

The closing argument made in this editorial is particularly powerful; the risk is now avoidable, so deaths can be attributed to substandard decisions, including the decision to give birth at home, by GPs, midwives and mothers. A similar trajectory is found by ethnographic researchers working in countries which have developed obstetrician-led models of care more recently (e.g. Donner 2003; Liamputtong 2005). In these settings, obstetric hospitals have quickly come to symbolise modernity, hygiene and rescue from traditional practices, and hospital birth becomes a mark of social aspiration and success, even when maternal mortality and surgical complication rates remain high, at least in comparison to more developed countries (Mehta et al 2001; Hogan et al 2010).

Summary

The debate reviewed here supports the argument that women's views *were* consulted in relation to birth place preference during the decades when birth increasingly took place in consultant labour wards. However, analysis of the way in which these findings were used suggests that the interests of hospital and community medical professions were privileged, and that the views of women were deployed in an attempt to support professional agenda. Through exploring this historical literature, it becomes clear that the pursuit of 'what women really want' (Lazarus 1997) was already a gendered discourse by 1960, and, as Tew (1990) has also argued, the current concern with risk and safety originates in the early realisation that 'medical safety of hospital birth' was a policy lever *par excellence*, with or without actual evidence that outcomes for women or babies improved in hospital; however, as later research also demonstrated (e.g. Declercq et al 2001) women's preference for hospital birth was also growing, in response to the new debates about birth safety, and access to pain relief. It is also clear that medical professions, scholars and policy bodies have each claimed the preferences of women as tools of their discourse whilst obscuring the complex

subjectivities that these invoke, and that divisions of class and gender have long been used as rhetorical devices in this debate. The decade after the Peel report saw hospital birth increase sharply, and the policy position continued unchanged until the reviews instigated by John Major's Conservative government in the early 1990s, which took place during a period of increasing professional and consumer engagement with the women's experiences of maternity care.

The 1980s: A decade of challenge to the medicalisation of birth.

During the 1980s, concern about the medicalisation of birth and increasing caesarean rates led to critiques of maternity care in both academic and lay domains (Rylko-Bauer 1990, p.171). Much of the initial debate took place in the US, in the wake of the consumer and civil rights movements. US sociological and ethnographic enquiries began to focus on maternity care (Friedson 1970; Arms 1975; Jordan 1978; Arney 1982; Rothman 1982; Martin 1987; Davis-Floyd 1992). The resulting publications shifted the discussions of place of birth, the power of the professions and rates of medical interventions from academic enquiry into political and consumer debate.

A similar process occurred in the UK, where Ann Oakley published *Women Confined* and *The Captured Womb* (Oakley 1980, 1984), each of which critically examined how women were treated during pregnancy and birth. Campbell et al (1984) analysed perinatal mortality in relation to intended place of birth, and Margaret Tew (1985) published a follow up to her earlier (1977) epidemiological analysis of perinatal mortality in hospital and at home birth. Sally Inch, a midwife and NCT antenatal teacher, published *Birthrights: a parents' guide to modern childbirth* in 1982, and outlined the concept of a 'cascade of intervention' (ibid, p.244). This book was perhaps pivotal, allowing data about birth place safety and the effectiveness of interventions to enter into lay discourse via an accessible publication aimed at both parents and antenatal teachers. Soon after this, Campbell and Macfarlane (1987) published their early synthesis of birth place evidence *Where to be born? The debate and the evidence* and Chalmers et al's (1989) *Guide to Effective care in pregnancy and childbirth* arrived at the end of the decade.

Yet until Wendy Savage's case was publicised in the mid 1980s, there was little real debate about place of birth. Wendy Savage's support for home birth challenged mainstream obstetric orthodoxy, but her suspension and the resulting public enquiry demonstrated that her position was one of relative isolation within her profession. Nevertheless, an alliance was forming, and in 1987, the first 'International Conference on Homebirth' was held in London, with Wendy Savage, Michel Odent, Marjorie Tew, Sheila Kitzinger, Luke Zander, Janet Balaskas and Beverly Beech (AIMS) all present (McConville 1987, Cox 1988). A collaboration between obstetricians, midwives, GPs, epidemiologists and natural childbirth advocates who held a similar perspective on birth was novel, and whilst the RCOG did not support home birth at this time, the consensus that hospital maternity services were failing to provide good quality care had powerful professional and academic advocates, all of whom were prepared voice public support for a new approach to maternity care.

The Winterton report and *Changing Childbirth*

The 1991–1992 Health Select Committee were again asked to review maternity care, after consistent reports that women were receiving poor quality of care during pregnancy and birth (Winterton 2000), and in the context of the emerging professional and lay consensus which supported this view. As Declercq (1998) details, this consensus was supported by the emergence of good quality clinical evidence (e.g. Chalmers et al 1989) and by the effective activism by childbirth consumer groups, some of which achieved representation on the select committee. The committee was chaired by Nicholas Winterton, a Conservative MP, and took advice from the Royal College of Midwives (RCM), independent midwives, obstetricians and paediatricians. The subsequent Winterton report (Health Committee 1992) famously challenged the Peel report's recommendation of 100% hospital birth, arguing that 'the policy of encouraging all women to give birth in hospitals cannot be justified on grounds of safety' (Health Committee 1992). Although the committee's recommendations were rejected by the RCOG, an expert group, chaired by Baroness Cumberledge,

parliamentary under-secretary of state for health, was subsequently formed to investigate further.

That the expert group was chaired by a minister rather than an obstetrician, and included the president of the National Childbirth Trust, but no 'Royal College' representatives, demonstrates the shift in power from professions to the state being wrought at the time. The expert committee accepted the finding that there was 'no clear statistical evidence that having babies away from general hospital units is less safe for women with uncomplicated pregnancies'. In reaching this conclusion, they drew upon on Campbell and Macfarlane's (1987) *Where to be Born; the Debate and the Evidence,* which reviewed observational studies in the absence of clinical trials. The committee's report, entitled *Changing Childbirth*, warned that safety was not 'an absolute concept' but one which, '[if] used as an over-riding principle, may become an excuse for unnecessary interventions and technological surveillance which detract from the experience of the mother' (Department of Health 1993, pp.9–10). Women should therefore be given a 'real choice' of place of birth, underpinned by good quality information and opportunities to discuss their options with health professionals (ibid, p.23–25). This, it was anticipated, would lead to better experiences for women and greater satisfaction with birth; and although satisfaction with health care is notoriously difficult to gauge (e.g. Crow et al 2002) these sentiments have been echoed in subsequent policy directives (e.g. Department of Health/Department for Education and Skills 2004, p.27).

After the 1990 *Community Care Act*: choice and equity in maternity care

Changing Childbirth emerged during an era where orthodox obstetric practice was broadly challenged, but an opportunity for change was further supported by the incumbent Conservative government's policy prioritisation of choice. This approach had its antecedents in the 1990 *NHS and Community Care Act* (HMSO 1990) which introduced internal markets into health and social care in an attempt to improve public sector service quality and efficiency through choice and competition (Le Grand and Bartlett 1993; Le Grand 2007; Greener 2009). This policy model is premised on the argument that choice empowers all consumers through the possibilities of customer

'exit' acting as an 'invisible hand' within the provider economy (Hirschman 1970, p.16). However, following two decades of choice-oriented public sector policy, a countervailing view is that choice may in fact deepen inequities. Clarke et al (2007); Dixon and Le Grand (2006); and Fotaki (2010) all allege that whilst choice has *some* potential to reduce inequalities, there is gathering evidence that consumerist policies ignore the structural inequalities which predispose particular groups towards greater difficulties in accessing and benefiting from health services.

The implementation of *Changing Childbirth* (Department of Health 1993) positioned maternity care firmly within a purchaser-provider model, with informed choice, including choice of home birth, as a mechanism for improving service quality and responsiveness (ibid, p.25). However, the committee also set aside evidence about widening equalities in health and maternity care (Sandall 1995), and through doing so failed to take account of class differences in perinatal mortality or to consider steps that might reduce these.

The (non) impact of *Changing Childbirth*

Changing Childbirth is often referred to as a watershed moment, when policy changed direction and women regained the right to choose where to give birth (Jomeen 2006; Smith et al 2010). The new policy certainly stimulated debate in the printed media (e.g. Hunt 1992; Hall 1993; Williams 1993) and the inclusion of change indicators provided some opportunity for exploring the extent of policy implementation at local level, although these were manifestly subject to different interpretation by health providers (Dopson and Locock 2002). The changes required were also organisationally complex, and perceived by some as politically driven rather than evidence-based (Ferlie et al 2000). With the benefit of hindsight, it appears that *Changing Childbirth* left the extent to which women exercised choice of place of birth virtually unaltered. Women's perception of *having* a choice seemed to increase; national surveys showed that 17% felt they had a choice of home in 1995 (Audit Commission 1997; Garcia et al 1998), increasing to 38% in 2006 (Redshaw et al 2007) and 57% in 2007 (Health Care Commission 2008), but only a marginal increase in home birth rates took place, and midwife-led birth centres across England remained subject to closure and temporary

suspension of services (Redshaw et al 2011). So although policy support for choice might have increased, uptake of alternative settings for birth expanded only marginally. Campbell and Macfarlane's estimate that about 10–15% of women 'would opt for a home birth given a free choice' (1987, p.56), had not yet materialised, suggesting either that preference for home was exaggerated in the studies used to determine this, or that women's choice was not entirely free.

Maternity Matters (Department of Health 2007a) built on *Changing Childbirth*'s unrealised aspiration to provide 'real choice' through creating choice 'guarantees', including choice of place of birth. This guarantee was outlined as follows:

> Depending on their circumstances, women and their partners will be able to choose where they wish to give birth ... The options for birth place are:
>
> - birth supported by a midwife at home
> - birth supported by a midwife in a local midwifery facility such as a designated local midwifery unit or birth centre
> - birth supported by a maternity team in a hospital
>
> (DH 2007a, Section 2.1, pp.12–13)

The policy proposed that women would have these choices by the end of 2009, but by the end of that year, marked differences amongst trusts in their provision of birth place choices persisted (Dodwell and Gibson 2009, NCT 2009) and although many trusts had started to establish AMUs, these were still not widespread.

Although *Maternity Matters* confirmed ongoing support for choice of place of birth, a tension between clinical evidence and policy guidance was revealed on publication of the NICE *Intrapartum Care Clinical Guidelines*, which advised clinicians that, in relation to place of birth:

> Women should be informed that if something does go unexpectedly seriously wrong during labour at home or in a midwife-led unit, the outcome for the

> woman and baby could be worse than if they were in the obstetric unit with access to specialised care.
>
> (NCCWCH 2007, p.62)

Of particular concern to the guideline authors was the trend suggesting that perinatal mortality rates *might* be higher 'when birth was planned at home' (ibid, p.53), and this had important implications for decisions about where to give birth. The UK figures which gave rise to this concern were later published by Mori et al (2008a) in a paper which argued that whilst intrapartum perinatal mortality rates for completed home births are low, these are much higher for women who require transfer into hospital during labour. The methodology and conclusions of this paper have subsequently been challenged (Gyte et al, 2008, 2009). These publications attracted coverage in the national press, reaffirming the position of home birth as contentious and subject to disagreement between experts. Nevertheless, some areas *have* increased rates of home birth; the current range for English local authority areas is 0–11.5%, but this figure is inflated by high home birth rates in the South West region, which have always been considerably above average.[10] Around 5% of births in England now take place in AMUs and FMUs (HCC 2008), but to put this in historical context, 12% of births took place in non-OU community settings in 1979, dropping to 1.4% by 1992 (Macfarlane et al 2000). Although the combination of GP and midwife beds in community hospitals is not truly comparable with present day AMU and FMU births, there is some evidence of a returning trend towards births in non-OU settings that are away from home and provided by NHS hospital-based staff.

The pursuit of normal birth; disentangling policy and philosophy

Constitutional devolution in the UK in 1998 led to separate maternity policy guidance being published in Wales (WAG 2002, 2005), and Scotland (NHSQIS 2009) and each of these countries has since focused on reducing interventions through establishing normal birth pathways, ahead of promoting choice per se.

[10] National home birth rate for England is 2.69% for 2009; rates in the South West areas with highest home birth vary from 9% to 11.5%; in 1998, these same areas had rates from 3.9% to 9.1% in 1998, again much higher than the 1998 England average of 2.2% (Birthchoice UK http://www.birthchoiceuk.com/Frame.htm).

Although *Changing Childbirth* (DH 1993) did consider rising intervention rates problematic, *Maternity Matters* (DH 2007a) concentrates on improving quality through choice, rather than enabling normal birth, although it is arguable that this is implicit because choice of non-hospital settings for birth is specifically provided, at least to those whose circumstances makes this feasible. Although *Maternity Matters* did not discuss normal birth, the case for reducing interventions was made contemporaneously by professional and consumer representative groups.

The recent UK consensus statement on normal birth (Maternity Care Working Party 2007) unites a broad range of professional and lay actors in a campaign to reduce interventions, particularly rising rates of operative deliveries, by increasing support for normal birth. A separate Department of Health policy document published immediately before *Maternity Matters* presented a *clinical* case for service reconfiguration (Shribman 2007), and this does problematise birth interventions:

> Birth is safer than ever before, but there has been an increase in medical intervention and specifically caesarean section rates .... In 2004, **less than half our women (48%) had a 'normal' birth** without the aid of instruments such as forceps or epidural anaesthesia. Also, caesarean section rates have risen from three per cent in the 1950s to 23% today.
>
> (Shribman 2007, p.2, emphasis added)

Shribman's (2007) guidance also details health inequalities, although this is restricted to maternal mortality (ibid, p.7). In keeping with Labour policy at the time, the 'joined up' solution was maternity service reconfiguration, with multi-disciplinary partnership working. Hence the 'clinical case' for change weaves 'safety,' 'care quality', 'health inequalities' and 'reducing interventions' into a single argument:

> ... change is vital if we are to ensure the **safety** and **well-being** of **all** mothers and babies and that pregnancy and birth are **as normal an experience as**

> **possible for the majority of women**, whilst those with risks or complications also receive the **best possible care** wherever they live.
>
> (Shribman 2007, p.7, emphasis added)

This conclusion also contains aspirations towards the 'normal', although the phrase 'as normal an experience as possible' links this to women's *experiences* rather than to 'normal' birth specifically. This may indicate that the concept of 'optimal' birth is being used here (Murphy and Fullerton 2001; Sheridan and Sandall 2010), which is intended to re-focus attention away from normal birth for few women and back towards *all* birth experiences, including those of women with complex pregnancies.

Reflections over time: The UK policy trend towards pluralism in maternity care

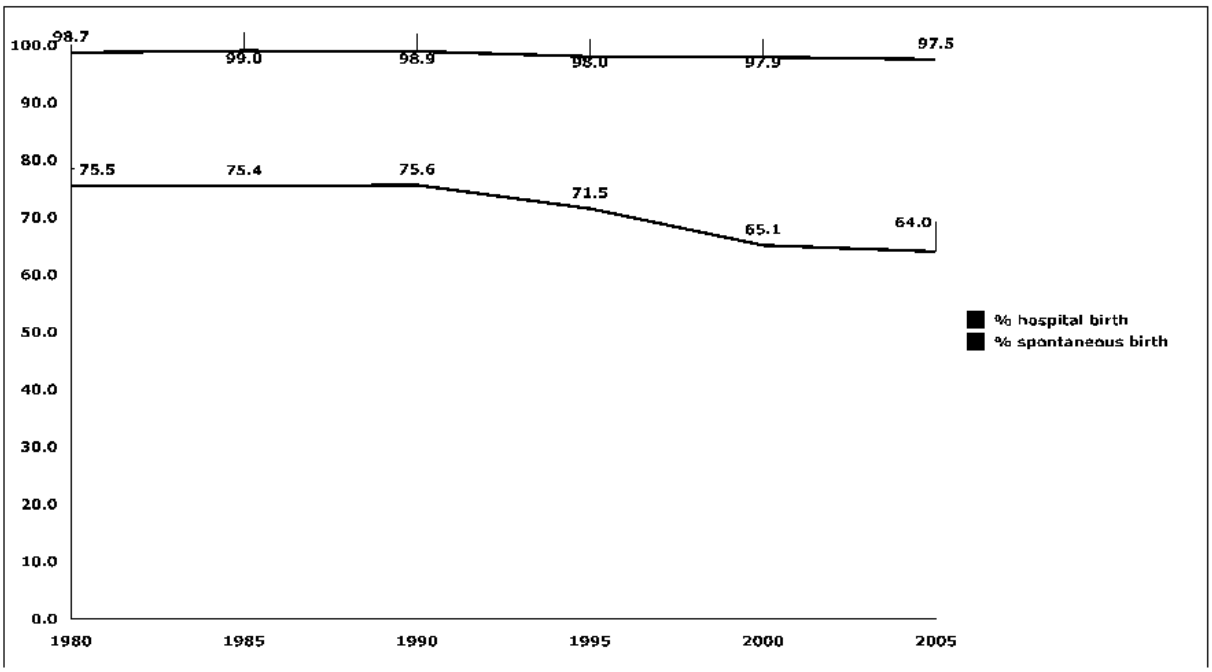
Although it is fifty years since the Cranbrook report was published, contemporary policy contains markedly similar themes. Supporting birth in a variety of settings is important; birth in non-hospital settings may be better for *some* (carefully selected) women, and birth in hospital benefits those with more complex needs. In retrospect, the Peel report period represents a single departure from pluralism in maternity care. As discussed previously, the decades after the Peel report featured a growing consumer response to medical birth and a critique of universal hospital birth (e.g. Tew 1977, 1985, 1990; Kitzinger and Davies 1978; Oakley 1984; Campbell and Macfarlane 1987) which was informed by US sociological research (e.g. Friedson 1970, Arney 1982, Martin 1987; Annandale 1988, 1989),[11] and comparative anthropology (e.g. Arms 1975; Rothman 1982; Jordan 1993). The public health critiques have subsequently been used by policy makers, midwives and consumer groups to support the argument that whilst women want safe births, they also want fewer medical interventions and better support for normal birth (e.g. Department of Health 1993; Olsen 1997; Beech 2006; Hunter 2010; Werkmeister et al 2008; NCT 2009), but although these arguments have become influential, there is, as Murphy-Lawless (1998, p.30) puts it, a continuing failure '... to account for women's reliance on and relationship to obstetric medicine'.

[11] Annandale's work during this period was US-based, although her later work is on the UK.

Declining rates of spontaneous birth

In the intervening decades, rates of 'spontaneous' birth *have* reduced, but this change has not necessarily happened in tandem with hospitalisation. Figure 4 below charts the decline of spontaneous birth, illustrating that this remained stable, despite high levels of hospitalisation, until around 1990, when instrumental birth rates markedly increased. The information in Figure 4 uses statistics published by the Health and Social Care Information Centre (HSIC), whose definition of 'spontaneous' birth includes all vaginal births which are achieved without ventouse or forceps instruments. This definition is wider than the recently developed consensus definition of 'normal' birth, which includes only vaginal births which occur without induction of labour, local anaesthesia for pain relief, episiotomy, instrumental or caesarean (MCWP 2007).

Figure 4 Spontaneous birth rate and hospital birth (England 1980-2005)[12]



Source: Health and Social Care Information Centre (2010) Method of delivery Table 9 1980–2005.

[12] Rates prior to 1980 are not available, but tables in Macfarlane et al (2000, p.530) suggest that the rate of caesarean and instrumental deliveries rose from 13.1% in 1970 to 20.5% in 1980, and that the spontaneous birth rate was 72.5% in 1973, shortly after the Peel report was published.

Using a more stringent description than either the HSIC's definition spontaneous birth, or the consensus definition of normal birth (MCWP 2007), Downe et al (2001) propose that only about a quarter of hospital births can be described as physiologically 'normal', if this means birth without any obstetric interventions at all. Downe et al's (2001) definition of a physiologically normal birth excludes vaginal births which involve induction of labour, acceleration of labour, artificial rupture of the membranes, epidural anaesthesia or episiotomy (ibid, p.603); this is similar to the MCWP definition, but additionally includes any use of acceleration (or 'augmentation') during labour.

The established critique of hospital birth argues that hospital is the site of 'medical management' of birth, which leads to a 'cascade of intervention' (see Inch 1982, p.244) and in turn to instrumental and surgical birth (cf. Rothman 1982; Davis-Floyd 1994; Lane 1995; Machin and Scamell 1997; Kitzinger 2005; Murphy-Lawless 1998; Edwards 2005), but this thesis fails to account for the delay between full hospitalisation of birth in the 1970s and the drop in spontaneous birth rates, which occurred later, from the 1990s onwards (see Figure 4). It is further troubled by evidence of divergent intervention rates amongst developed countries with ostensibly similar approaches to the medical management of birth in hospitals.[13] The critique also provides little guidance about what a 'normal birth' or a 'hospital birth' is now, particularly in the context of the UK where AMUs, FMUs, OUs (with midwife and/or obstetrician-led care) and NHS home birth all co-exist.

The reconfiguration of English maternity care therefore leads to a unique situation of plural service provision involving a mixture of professional models, philosophies and places, but with little knowledge about *how* decisions are embarked upon, and which factors might influence women and their partners in this variable domain. Nevertheless, a considerable body of research does exist, and this draws upon

[13] Comparisons are difficult because of the lack of published data, but the second US *Listening to Mothers* survey (Declercq et al 2006) found that 44% of births are induced in the US, compared to 21.2 % in UK, and the US caesarean rate is 34%, compared to 25.1% in the UK. (UK figures from 'Birthchoice UK' website http://www.birthchoiceuk.com/Frame.htm, derived from the Information Centre for Health and Social Care (2010) Maternity Statistics, England: 2009–10. Statistical Bulletin (2010), reproduced with permission).

women's birth place decisions in a range of geo-political, historical and cultural contexts; this literature is reviewed in the next chapter.

Chapter 2: What do we know about birth place preferences?

Introduction

According to *Changing Childbirth*, if women are to make a 'real choice' then they need 'unbiased information' and opportunities to discuss the alternatives that are open to them with health professionals (Department of Health 1993, p.11), but this is difficult to assess if, as the low uptake of alternatives implies, 'real choice' is not perceived by women to be available. In order to determine what is already known about birth place preference and to explore the extent to which research undertaken in other times and places can or should inform UK policy and practice, research on this topic is reviewed in this chapter.

The reviewed studies are grouped according to the birth place options available, and an important clarification is that this distinction is undertaken from the perspectives of women and their partners, rather than the provider context per se, so that although the US (for example) has a predominant model of private obstetric care and hospital birth, research about women who felt their only option was hospital is included in one section, whilst research with US women who felt they had a choice of home birth is considered separately. Accordingly, the literature is reviewed under the following three headings:

- Research conducted with women who felt their options were limited to choosing between hospitals
- Research conducted amongst women and partners when their options included either hospital or home birth
- Research conducted with women and partners who felt their options included hospital (OU), AMU/FMU and home

Choosing between hospitals

The discussion which follows privileges UK research into hospital choice, but also contextualises this by exploring the international literature on this topic, and identifies the contribution of this body of knowledge to UK maternity care.

UK research into choice between hospitals

Although published in 1998, Green et al's *Great Expectations* research into women's expectations and experiences of childbirth was actually undertaken in 1987, and their findings were shared with the 1992 Health Select Committee, influencing the Winterton report. The research was conducted within a single English region, and in the context of the time, 'choice' meant deciding between two or more hospitals (although in fact the hospitals included both consultant and GP units, for some women at least). The survey found that 46% of women did not feel they had a choice of place of birth, although 93% were 'happy with where they were booked, or at least did not express any dissatisfaction with this' (ibid, p.52). This finding echoed Porter and Macintyre's (1984) earlier study into satisfaction with different forms of antenatal care, which concluded that, from the perspective of women, 'What is' (that is, whichever kind of service was provided) 'must be best'. Explanations for women's broad satisfaction with services that were known to vary in quality included gratitude for having a healthy child, deference, conservatism, politeness and having an 'accepting nature' (Porter and Macintyre 1984, p.1200).

Green et al (2003) followed up their survey by conducting a subsequent study (*Greater Expectations*) where they claimed that women's *expectations* had changed over the intervening period, and that the increased rate of interventions seen since *Changing Childbirth* were demand-led rather than imposed by defensive medical practice or medico-legal concerns, as others have argued (e.g. Annandale 1989; Porter et al 2007; O'Connell and Downe 2009). First time mothers, they suggested, had become more anxious about pain during birth, and women were increasingly willing to accept interventions which require hospitalisation, such as epidural anaesthesia (Green et al 2003, p.12). This argument placed the responsibility for rising interventions with

women but offers little explanation about why women's anxiety might have increased during this time. That there was also a mismatch between what women *appeared* to want and what women's representative groups *claimed* that women want is also evident, but this is also not explored within the research.

Choosing between hospitals: international research

Studies undertaken in a range of European countries and the US explore the experiences of women who felt their only choice was hospital, although some hospital models included 'birth rooms' (similar to AMUs in the UK) or options for midwife-led care. These studies primarily explore two different aspects of choice, which are:

- how women choose between different hospitals (Zadoroznyj 1999; Combier et al 2004), and
- why women value hospital birth (Davis-Floyd 1990, 1994; Christiaens and Bracke 2009)

Choosing between different hospitals

Zadoroznyj's (1999) study was conducted to explore why only a minority of women in one Australian city opted to give birth in their local hospital. Her interviewees were middle-class and working-class women who had chosen not to give birth in their nearest hospital; in this context, social class was linked directly to choice, because most middle-class respondents had private insurance and therefore greater choice of providers than working-class women, whose options were limited to public hospitals. Following narrative analysis of the data, Zadoroznyj (1999) concluded that, in contrast to earlier research by Nelson (1983) and Martin (1987), a first birth constituted a Giddensian 'fateful moment', after which women's identities shifted from fatalism towards empowerment (Giddens 1991a, p.143; Zadoroznyj 1999, p279). Zadoroznyj argued that social class was an important and neglected factor in birth research, which Nelson (1983) had also suggested when her US study revealed that working-class and middle-class women pursued different birth ideologies. According to Nelson (1983, p.284), working-class women wanted 'more passive birth experiences with more

medical intervention' and 'middle class women wanted ... active, involved births free from medical intervention'.

Combier et al's (2004) research into how French women chose between hospitals is closer to the UK context, because France has national insurance-based maternity care. French women who want private care have to meet these costs, unless they have taken out separate private health insurance, and the same is true in the UK, where just 0.5% of births take place in the private sector (POST 2002). Combier et al's (2004) study identified that for French women, accessibility and proximity were the main criteria used to make a choice, although quality and reputation of the hospital were an important consideration. Women of 'high socio-economic status' were found to value 'technical quality' of the maternity unit (ibid, p.2287), but differences in the number of hospitals available to women, and competition for beds in some units led the authors to conclude that determinants of choice should not be considered without reference to local contexts.

Preferring hospital birth

Like Combier et al (2004), Davis-Floyd (1994) observed that 'affluent ... white middle class' US women, seemed to prefer 'their highly technologised obstetric experiences' (Davis-Floyd 1994, p.1128), and sought to understand why this was the case when medical interventions were so widespread. Whilst Zadoroznyj (1999) and Combier et al (2004) distinguished between working and middle-class women's experiences, Davis-Floyd's work was seminal in recognising that preferences varied even within a socio-economically homogenous group of women. By applying the anthropological concept of 'separation' through 'conceptual distinction' to her analysis, Davis-Floyd (1994, p.1126) connected her observations about birth place preferences to women's' deeper, structural beliefs. Hospital birth women, Davis-Floyd argued, sought separation from the pain and physicality of labour through epidural anaesthesia, and this was entirely congruent with their broad acceptance of the 'enlightenment' ethos of technological success. They employed professional experts to manage birth and trusted medical knowledge as authoritative, and their structuring models and beliefs about birthing were quite different from those of equally affluent home birth mothers.

Looking more broadly at aspects of satisfaction in relation to place of birth, Christiaens and Bracke (2009) compared Belgian women's birth satisfaction scores with those of Dutch women. Hospital birth is the norm in Belgium, whereas a quarter of births take place at home in the Netherlands, so the authors expected to find higher satisfaction amongst Dutch women. However, they found that although women planning a home birth were most satisfied, Belgian women were overall more satisfied with their home *and* hospital births than their Dutch counterparts. Christiaens and Bracke (2009) sought to explain this as a consequence of different birth cultures, arguing that in the Netherlands, hospital birth is associated with complications and emergency transfer, whilst Belgian women believe hospital is the safest place to give birth. Also, women in the Netherlands are not at liberty to choose hospital if complications are not anticipated. The authors concluded that the ideology of birth should be considered to contribute to birth experience, alongside the actual birth setting, whether this is home or hospital.

Choosing between OU and home birth

Research into home birth preference has been conducted in the UK, in several other European countries and in the US. This literature is reviewed below and the extent to which home birth attracts policy or professional support is explored as a contextualising factor.

Research into home and OU birth choice in the UK, in a supportive policy context

As discussed in Chapter 1, UK policy changed in 1993, allowing women to choose their place of birth, and national surveys show a gradual increase in women's reports of being offered a choice of home birth. A handful of small studies were also published (Glasier and Anderson 1992; Johnson et al 1992; Jones and Smith 1996; Fordham 1997). These studies bring to mind the papers published at the time of the Cranbrook report; they were local studies which were conducted by health professionals, but instead of challenging the shift towards hospital, this time the authors argued that few women 'really' wanted to give birth at home. The discussion was no longer confined to

the *Lancet* and the *BMJ* but published more diffusely across a range of professional journals, and the subject of the research had also changed; surveys recruited women who had given birth, or of childbearing age, or on general practice registers, or even nulliparous and accessing family planning services. For some researchers at least, all women were considered to have credible views on place of birth, although partners were not invited to participate. In keeping with the pursuit of market efficiencies in health policy during the 1990s, women were described as 'local consumers' with 'wishes' (Jones and Smith 1996, p.140), 'views' and 'preferences' (Johnson et al 1992, p.225; Fordham 1997, p.77), whose expectations and experiences in relation to choice and control ought to be explored. The studies estimated preference for home birth between 3% and 15%, and discursively positioned 'home' and 'hospital' as belonging to oppositional ideologies.

The pursuit of efficiency in health care meant that health economics methods were increasingly used to determine birth place preference, to aid service planning in the policy context of client choice. Longworth et al's (2001) study asked pregnant women to make trade-offs between different birth place scenarios, and doing so 'revealed three distinct groups': preference for home birth, preference for hospital birth, or a willingness to trade between these (ibid, p.410). A similar study by Hundley et al (2001, p.261) suggested that although women *say* that 'more homely, less interventionist' settings are important to them, they actually *choose* scenarios which represent a more medical approach and careful monitoring. As McDonald had first inferred in 1960, women's 'preferences' and 'actual choices' were perhaps not the same thing at all. In their discussion, Hundley et al (2001, p.261) propose that 'women may have thought that it would be unacceptable to state explicitly that they preferred greater intervention'.

Three qualitative studies also explore the choice of hospital or home birth from the perspective of UK women (Madi and Crow 2003; Edwards 2005; Dagustan 2009). Madi and Crow (2003) interviewed women planning home birth (n=13) and hospital birth (n=20) in southern England to discover what women believed their options to be, and what preferences they held. They found that women who were planning a home birth

were more likely to be multiparous and usually knew someone who had a positive experience of home birth, whereas those planning a hospital birth assumed that this was their only option.

Edwards' (2005) feminist, post-structuralist research drew on interviews with thirty women who had given birth at home. This substantial study explored women's decisions at length, in the contexts of their family lives. Working from the perspectives of her participants, Edwards (2005) observed that when women chose to give birth at home, this was a personal, ethical decision which reflected the subjective realities of their lives. They acknowledged medical risks, but balanced these against the risks to themselves and their families when the process of giving birth was disrupted or re-located away from the home. Their concept of birth safety went beyond medical outcomes, and incorporated the concept of home as a place of safety and the integrity of the family unit. Edwards (2005) recorded women's accounts of negative experiences when hospital equipment was imported into their homes by midwives, and argued that the infiltration of medical protocols into home birthing means that women's control is constrained at home as well as in hospital, and that NHS midwives are similarly bound by the 'clock time' logic of observing progress in labour, wherever they may be practising (Edwards 2005, p.119[1]). Edwards' findings suggested that NHS home birth may be unacceptable to some women, and that alternatives such as independent midwives may prove too expensive; for some women, the only other option is to embark upon a 'free birth' with no midwifery presence at all.

Dagustan (2009) interviewed 13 women to discover why few took up the option of home birth, and concluded that the hegemonic medical model actively prevents women from choosing to give birth anywhere other than hospital. Her participants believed that hospital was the right place to give birth, even when their own experiences created dissonance with this view. Like Zadoroznyj (1999), Dagustan observed that difficult or negative birth experiences meant that women chose another obstetrician or hospital next time, or negotiated a more speedy recourse to interventions in the event that problems arose. Although Zadoroznyj (1999) took this

[1] See also McCourt (2009)

as evidence of increased control and agency, Dagustan's analysis was that experiencing hospital birth, even where this is unpleasant or negative, has the effect of confirming the apparent *necessity* of being in hospital; the 'cascade of intervention' counter-narrative was seemingly absent. Interventional birth stories were recounted as 'rescue narratives' with hospital staff cast in leading roles, and mother and child victims of the vagaries of nature. Drawing on a Foucauldian account of birth governance, Dagustan (2009, p.30) concluded that:

> ... the current minority take-up of home birth is allowed – and even encouraged ... It is seen as a quirky and risky choice, but one that is permitted and controlled ... Indeed this framing of home birth, together with a vigilant policing of the boundaries, might be said to strengthen rather than weaken the hegemonic discourse.

These studies suggest that choosing home birth in the UK remains problematic and morally uncertain despite support from policy and professional bodies. The position of home birth mothers in UK may then not have changed as much as the policy intent would suggest, because social acceptance of hospital as the right place to give birth in the UK acts as a responsibilising constraint which prevents women from even exploring what their personal preferences might be, and for some women, NHS home birth management may conflict with their own birth ideologies.

Choosing home birth in the Netherlands

The Netherlands is considered an exception to the rule of hospital birth in developed countries, and Dutch maternity care has also been considered a case study in good outcomes, strong political and cultural support for home birth, an independent midwifery workforce and good postnatal support through home care assistants (Sandall et al 2001). However, Dutch statistics show that home birth has reduced from 68.5% in 1968 (Wiegers et al 1998) to 29% in 2009 (Pavlova et al 2009) and, as Christiaens and Bracke (2009) discuss, the Dutch system does not always provide women in the Netherlands with a choice between hospital and home. In common with Green et al's (2003) observations about UK women, Dutch women seem increasingly

to want access to medical pain relief during birth (Pavlova et al 2009), which appears to be contributing to the rising preference for hospital birth in the Netherlands.

In response to this changing situation, Netherlands research into home birth preference has been conducted to explore the decline in home birth, rather than to understand societal resistance to this. In contrast to the international studies discussed earlier, Wiegers et al's (1998) survey found that demographic factors such as age and education did *not* affect home birth preference in the Netherlands, except when women lived in highly urbanised areas, where higher education was linked to preference for home birth, but rather that 'social factors, especially the confidence of significant others in home birth ... were by far the strongest predictors of choice' (Wiegers et al 1998, p.1505). Pavlova et al's recent (2009) discrete choice experiment found that 44% of women expecting their first babies planned a home birth, and the authors described this as a 'strong preference' for home birth (ibid, p.27). In common with other research into home birth, Dutch women preferred home when they believed birth to be a physiologically normal process, and a social, familial event.

Home birth in the UK may be sanctioned by policy, and by professional consensus, but it remains an option rarely chosen by women, and despite historical support for home birth in the Netherlands, rates there are declining, and the good outcomes of Dutch maternity care are also being disputed (e.g. De Jonge et al 2009; Evers et al 2010). Home birth in both countries appears to be troubled, yet research in other countries where there is still little support for home birth suggests that this option will always be preferred by some.

Giving birth at home, in a hostile political context

Despite the near-total hospitalisation of birth in many developed countries, a persistent finding is that a small minority[2] of women pursue home birth despite the lack of policy or professional support, and researchers have endeavoured to understand why women choose home birth, when this runs counter to the received wisdom of the time.

[2] Cheyney (2008) and Boucher (2009) estimate this minority to be 1–2% in the US.

Following early research with both home and hospital selecting women in the US, McClain (1983 p.1857) argued that women select a place of birth and then 'discount the risks and magnify the benefits of the chosen birth service, and exaggerate the risks and minimise the advantages of the rejected services'. This insight is useful, but is derived from a quantitative analysis of qualitative interview data which originated from a purposive sample, and so the validity of these data must be considered tentative and have subsequently remained untested. McClain's theoretical claims remain interesting though, and these include her argument that women's strategies depended 'more on avoiding risks than on obtaining benefits' (1983, p.1861).

A distinguishing feature of later papers is that women who opted for home had to do extra identity work to demonstrate that they were responsible for their health and their pregnancy (Abel and Kearns 1991; Davis Floyd 1994; Viisainen 2000; Cheyney 2008), and that home birth is associated with moralising, blame and stigma in political contexts where it is not supported. Viisainen (2000, p.794) explored the experiences of home birth couples in Finland, which has public sector health care, and a hospital birth rate of 99.9%. She found that respondents balanced the medical risks of home birth against the iatrogenic risks of hospital interventions during labour, but became enmeshed in the moral jeopardy of electing to have a home birth where this is considered risky, dangerous and even illicit. Open accusations of irresponsibility were common, and parents described being treated 'like a leper' by health professionals (Viisainen 2000, p.808).

The reasons women gave for preferring home birth despite such censure are consistent in each study, and together are indicative of a 'parallel knowledge system' for birth (Jordan 1997, p.56). Women wanted to have personal control during labour, to avoid interventions (and an environment where these might be imposed upon them), to have continuity of known care-giver, and the opportunity to give birth in their own surroundings, with their partner and family present (Davis Floyd 1994; Cheyney 2008; Boucher et al 2009). These findings are consistent regardless of the political context where the research takes place. Home birth preference has long been

associated with middle-class mothers, and all the studies mentioned here were conducted with white, affluent, educated women. Following his survey of Australian women, Cunningham (1993, p.475) similarly concluded that home birth mothers were more likely to be 'older, more educated, more feminist ... better read on childbirth and more likely to be multiparous', even though home births actually took place in the lowest *and* highest income groups amongst his respondents.

Nelson (1983, p.295) linked what she termed the 'middle class' model of birthing to 'four social movements: the natural childbirth movement, feminism, consumerism and 'back to nature' romanticism'. Davis-Floyd (1994, p.1133) observed a diversity of philosophies amongst home birth mothers, and differentiated between women who believed in natural, integrated birth in the family setting, and those who were more prosaic and sympathetic to technology as a safety net, despite preferring home as a setting for birth. Cheyney (2008) and Davis-Floyd (1994) both argued that the 'what if' safety discourse is difficult to resist, and Cheyney (2008) reached a position similar to Viisainen (2000) through arguing that US home birth women need to perform as moral subjects in the face of societal opposition to home birth. Testaments from women who would *like* to give birth at home, but who show equanimity about being admitted to hospital have proved difficult to assimilate within the home/hospital explanatory model, and the researchers' open advocacy of natural birth may be a contributory factor here, but these ambiguities have nevertheless been carefully documented, if not explained.

Preference for more alternatives

Almost all Swedish women give birth in hospital, and following a national longitudinal cohort study (n=3283), Hildingsson et al (2003) report that 1% would consider home birth and 9% birth centre care. In a regression analysis, preference for home birth was associated with desire to have a friend or baby's siblings present, to avoid pharmacological pain relief, dissatisfaction with medical care and also with low levels of education. Commenting on this last and unexpected finding, the authors reveal that univariate analysis showed that women who were interested in home birth were more

likely to be single parents and smokers and hence were 'socially disadvantaged' (Hildingsson et al 2003, p.19).

Summary: choosing between home and hospital

Research conducted in the UK suggests that women prefer hospital birth as the safer option, even when there is mature policy support for home birth. The minority who prefer home birth are considered to want this for the same reasons, and (with the exception of the Netherlands, where home birth is still constructed by researchers as a normative preference), these are consistently linked to a middle-class model of active birth without medical interventions. However, two researchers (Davis-Floyd 1994; Cheyney 2008) also found differentiation amongst home birth mothers' birth ideologies, which was difficult to account for within the class-based explanatory framework. In Belgium, Christiaens and Bracke (2009) identified that women were more satisfied with birth when this takes place in a setting which is ideologically normative in a given country.

Birth place decisions: OU, AMU, FMU or home?

The final category of studies relates to research amongst women who were in a position to choose between OU, AMU/FMU, and home birth. This research suggests that birth place choices are proliferating, even though alternatives to hospital labour ward care are not always popular with women and their partners.

Barber et al (2006) conducted interviews with 20 women who were able to choose between OU, AMU and home birth, partly to identify why few women opted to use their local AMU, and discovered that women regarded hospital as the safest place to give birth, especially in a first pregnancy, and that they found it difficult to have confidence in the alternatives because different midwives gave them conflicting advice.

Houghton et al (2008) were also interested in women's preference for hospital birth, and conducted observations and interviews with women, their partners and with

health service staff. These authors found that midwives and GPs tended towards paternalism and that women saw hospital as the safest place to give birth, and held 'negatively distorted' views about risks. They also found that home birth was unacceptable to some couples, because 'if anything goes wrong, we have to live here' (ibid, p.62). This is very different to Abel and Kearns' (1991) finding that the home is a 'haven', and indicates that for some couples, giving birth in hospital protects the safety of their home environment from traumatic events. Houghton et al (2008) also identified that for many women, deciding where to give birth was a 'non-decision', often resulting from systematic assumptions on the part of staff, and contingent upon the process of care, which required early identification of a chosen hospital for scan and referrals.

Houghton (2008) and Jomeen (2007) also report findings from follow-up interviews; Jomeen (2007, p.487) concluded that choice was 'more of a luxury than a right, which can be rescinded by experts at any point in pregnancy or labour'. Although arguing that women are 'overwhelmingly complicit' in this because of their 'desire for a safe outcome', Jomeen (2007, p.488) suggests that being offered and then denied choice has negative emotional sequelae which persist into the postnatal period. Like Dagustan (2009), Houghton et al (2008, p.64) found that women's experience of hospital birth seemed to 'confirm the necessity of the hospital environment' rather than prompting them to consider alternative settings for birth.

Pitchforth et al's (2008) health economics study, although retrospective, had some particular strengths; the study recruited a large sample, had good response rates and the sub-group analysis used by this research group was informed by focus group data. In a later paper detailing their focus group findings, Pitchforth et al (2009, p.44) found that women reported having limited choice, and whilst some were 'active choosers', others accepted what was offered. Like Hundley et al (2001), these authors found that women's expressed and actual preferences were different, and that whilst there was initial preference for midwifery-led care, in practice women 'preferred delivery in a unit to home birth and consultant led care to midwife managed care' (Pitchforth et al 2008, p.560), valuing the 'ultimate safety net' that hospital was perceived to provide

(ibid, p.564). Pitchforth et al (2008) comment on the difficulty this poses for maternity care providers, because women preferred to have shorter travel times to a consultant unit, which is a particular challenge in rural Scotland (where the research was conducted), but also potentially problematic in England where contemporary policy favours 'networks' of providers, with tertiary centres serving large geographical areas and smaller, low risk units available locally (DH 2010; RCOG 2011).

Few international studies discuss choice between OU, AMU and home, although papers by Mackey (1990) and Cunningham (1993) from the US and Australia respectively, are exceptions. Cunningham's (1993) survey is methodologically problematic having sampled a high proportion of home birth and birth centre advocates, but the survey found that 73% of women expecting their first baby preferred hospital birth, 61% overall (that is, women expecting their first *or* second and subsequent babies) preferred hospital, 9% preferred birth centre and 31% preferred home, although the home birth rate in the area at the time was 0.5%.

While the US is considered to be a bastion of obstetric practice, homely 'birth rooms' with care provided by nurse-midwives, are often available in US hospitals, a change which has come about in response to consumer critique of high levels of medical interventions during birth in the US (Cheyney 2008). US women who participated in Mackey's (1990) US study were able to choose between OU and a hospital birth centre 'room'.[3] Just over half planned to use the birth room, believing it would be a comfortable and relaxing environment with fewer interventions, where women had more control. Those who preferred to give birth in traditional delivery rooms wanted this either because they were satisfied with their previous labour experience, or that they were worried problems would arise, despite being considered low risk. Mackey (1990, p.185) recounts that a long labour, a large baby or 'loss of control' were the events these women feared. Respondents defended the hospitals they had chosen in relation to 'horror stories' about other local hospitals, where husbands would not be allowed, or where the hospital was thought to be 'backward' (ibid, p.180), indicating the importance of good quality, responsive care. Interestingly, Cheyney's (2008) US

[3] Mackey describes this as a setting similar to an AMU.

respondents, all of whom wanted home birth, did not consider 'birth rooms' to be a genuine alternative to hospital OU, but rather perceived these as simulacra where homely décor masked intent towards obstetric interventional practice.

Summary

This discussion has outlined what is already known about how women and their partners made decisions about where to give birth, and identified gaps in the evidence, and these are drawn together here. This body of international research adds to what is known about women's birth place preferences; it outlines the significance of social class, local contexts, birth ideologies and cultures to birth place choices. Zadoroznyj's (1999) conclusions that the first birth is a 'fateful moment' which changes how women perceive childbirth control , and that orientation towards control is related to social class, but changes in subsequent pregnancies, have not been explored in other contexts, and the same is true of Davis-Floyd's (1994) analysis of competing childbirth knowledge systems amongst women in the US. Nelson's (1983) findings about different birth ideologies amongst working and middle- class women sound contemporary, despite being written almost 30 years ago. Surprisingly, none of the interpretative studies which analyse birth place choice in relation to social class have been conducted in the UK. Viisainen's (2000) work with Finnish home birth couples has resonance with Edwards' (2005) UK study, but these studies only consider the position of women and partners who wanted a home birth, and whilst we might hypothesise that women will similarly encounter moral jeopardy if they want to give birth in other non-hospital settings, this is under-explored.

The difficulty is that countries where birth place research has been conducted are often those with a dominant model of obstetric care and a mixture of private and public provision, where intervention rates during birth are high and where alternatives to avoid hospital are subject to a politicised and moralised debate, but the UK proves to be a somewhat different case. Publicly funded alternatives to OU have been available throughout the history of NHS maternity care, although these alternatives have waxed and waned between home, GP and midwife units, and home birth has

historically been presented as a more risky alternative to hospital birth. The UK also has a less interventive model of obstetric practice and different obstetric culture to the US,[4] and benefits from consensual interprofessional support for home birth and normal birth, although this concept is not always communicated well to women and their partners.

Yet, in historical terms, the same themes recur: hospital is safest, home is safe for some; choice is good, but women and midwives sometimes make poor choices which might lead to 'avoidable tragedies'; the basis for conflict is inscribed into gendered historical debates about the appropriateness of preference about birth place. There is ample evidence that preference for OU birth persists because women believe that hospital birth is safe. For most women in the UK, hospital remains the 'right place' to give birth, but the reasons for this, beyond fears for safety, are not well understood; research that explores at depth preference for hospital from the subjective positions of women and their partners is thus long overdue.

There is also uncertainty in the literature about the socio-demographic profile of women's birth preferences. An accepted notion suggests that home birth is a middle class preference, but in practice, women from affluent groups are more often the subjects of research on this topic, effecting a bias in the evidence base which has disproportionately informed the consumer debate. International survey research suggests that there is interest in home birth from other socio-economic groups (Cunningham 1993; Hildingsson 2003), but this finding is not well known.

There is little evidence about preference for AMU or FMU, or about whether women in UK and their partners are helped to discern the different models of care provided in these settings, and even less that tackles the perceptions of birth partners and their contribution to these decisions. This will become more important given the recent expansion of these alternatives, pointing to a need for in-depth research about perceptions and experiences of AMUs and FMUs the context of English maternity care.

[4] See also van Teijlingen et al (2009)

Looking at the body of knowledge overall, research in both UK and other countries tells us that women generally feel very responsible for the decisions they make during pregnancy, and in situations where their preferences are not culturally sanctioned, need to take on moral identity work in response to accusations of irresponsibility from health professionals, friends and family members. Recent UK evidence suggests that birth place decisions are complex, and that women consider both birth safety and care quality when deciding where to give birth, but little is known about perceptions of risk and safety in alternative birth settings. Finally, given the policy support for choice, it is important to understand why many women feel they have no choice, and why those who feel this way nevertheless prefer to give birth in hospital.

The next chapter situates these issues within the socio-cultural construction of risk, and also explores choice in the context of medicalisation, the cultural reproduction of social norms, and the meaning and practice of identity work in the context of making birth place decisions.

Chapter 3: Choice, risk and agency in birth place decisions

Introduction

The policy and empirical literature discussed in Chapters 1 and 2 charted the shift to hospital birth in the UK and the critiques that this change provoked. In this chapter, socio-cultural changes and alterations to clinical practice which may have acted in concert with the hospitalisation of birth are discussed.

Despite the critiques of hospitalisation, women's general preference for hospital birth has been increasingly documented, and this seems to be accompanied by a heightened sensitivity to risk despite the relative safety of birth in the UK, at least when this is defined in terms of maternal and infant mortality. This societal phenomenon of anxiety in the face of overall security has been described by Taylor-Gooby (2000, p.3) as the 'paradox of timid prosperity'. That this is relevant to birth place decisions becomes evident where the literature indicates that hospital birth remains popular, even amongst healthy women with low risk pregnancies, and that women experience satisfaction with hospital birth, at least where this is culturally normative (e.g. Christiaens and Bracke 2009). Achieving home birth has a troubled history, where aspirations to give birth at home become associated with positive experience for the few who achieve this but may lead to disappointment for others if transfer to hospital care becomes necessary. Providing choice of place of birth may then have pitfalls, especially if, as Jomeen (2007) suggests, those who feel they are offered a choice which is later denied experience negative emotional sequelae.

Overall, the earlier chapters show that individual beliefs, social class, ideology and culture are each likely to contribute to birth place decisions, but that evidence about these is partial, and fragmented across different historical, national and cultural contexts of maternity care. This chapter situates these themes within socio-cultural perspectives of choice, risk and agency, in order to generate theoretically informed

research questions which pertain to the choices women and their partners make in the contemporary context of English maternity care.

First of all, the conceptual basis for providing choice is examined, in relation to NHS health care generally, and maternity care specifically, to explore the relationship between consumerist choice policy and experience of choosing health care options. The exercise of choice within the constraints suggested by the medicalisation thesis is also explored in relation to contemporary UK maternity care.

Social science theories have a long tradition of informing and underpinning research into pregnancy and birth. The literature relating to birth place preference reviewed in Chapter 2 encompasses a broad range of theoretical disciplines; sociology and comparative anthropology have made particularly strong contributions. However, because this research is an enquiry into lived experiences of choosing where to give birth when settings are associated with different levels of risk and safety, socio-cultural explanatory theories which seek to explore '... the ways in which people conceptualise and experience risk as part of their everyday lives' are used here as a theoretical focus for the study (Lupton 1999a, p.6), and the insights which Douglas and Wildavsky's (1982) 'cultural theory of risk selection' (hereafter referred to as 'cultural theory') may bring to bear on this issue are appraised under the heading 'Socio-cultural perspectives of risk'.

Whilst Douglas and Wildavsky's (1982) cultural theory has relevance to birth risk perceptions, this has less to offer in terms of analysing the influence of power, ideology and normative cultural discourses. The centrality of these concepts to birth place decisions is clear within the empirical and conceptual literature, and to address these points, Bourdieu's (1984, 1990) theories of capital and the imposition of culturally sanctioned 'tastes' and values are also evaluated. These ideas contribute a means of analysing subjective experiences and responses to constraint and agency, and provide a framework for understanding cultural discourses as 'fundamental principles ... which tend to be viewed as inherently true and necessary' (Webb et al 2002, p.96).

The concept of patient choice and the medicalisation thesis

The concept of choice in health policy after 1990

Following the 1990 *NHS and Community Care Act* reforms (HMSO 1990), GPs and health authority 'purchasers' were the sole executors of choice, because they were considered to act as 'principal agents' through securing the best services for their patients. Individual choice emerged later, in response to Blair's New Labour consumerist reforms (Clarke et al 2007; Propper et al 2005; Fotaki et al 2008; Greener 2009).

Le Grand (2007, p.105) argues that for choice to succeed in the public sector, a number of conditions must be met. Competition must exist ('real' alternatives must be available), good quality information for purposes of comparison must be provided and 'cream skimming' (the preferential selection of clients with low needs by services) 'must be avoided' (ibid, p.105). As Dixon et al (2010, p.xiii) point out, the policy conceptualisation of consumer choice '... requires that patients are aware of their ability to choose, want to choose and think choice is important'. This is because 'the standard neoclassical model of a perfect market involves well-informed, rational consumers acting in their own best interests by systematically choosing which goods and services to buy, and who to buy them from, in a way that maximises their well-being ('happiness' or 'utility')' (ibid, p.9). Consumer oriented choice policy therefore introduces a model of 'patients *qua* consumers' (Lupton 1997b, p.373) which is derived from neo-classical economics. Although this account perhaps over-simplifies the application of economics theories to health care, there is broad agreement that the consumerist model is based on a concept of rational actors making informed decisions (e.g. Fotaki et al 2005; Le Grand 2007).

If individual choice has evolved relatively slowly within NHS health policy, this at least provides opportunity to reflect on the impact of providing choice on patient experience, and a series of reviews has considered this. However, these also relate to particular sectors and specialties; for example, 'choice at the point of referral' between primary care (GP) and secondary care (Robertson and Dixon 2009; Dixon et al 2010)

and older people's care (Fotaki et al 2005).[1] The issues that affect choice in other sectors are different to those in maternity care; unlike many outpatients, women who are pregnant may *not* be willing to choose non-local hospitals, because they may need to attend frequent hospital appointments and envisage having to travel during labour when they are experiencing pain and discomfort, and proximity to home is known to be an important factor in women's hospital choices (e.g. Combier et al 2004; Pitchforth et al 2007, 2009). Attempts to redistribute decision making power in favour of patients are also seen in emerging 'shared decision making' models, which have been developed for medical interactions that involve decisions about complex treatment scenarios (e.g. Charles et al 1997, 1999; Elwyn et al 2000; Joosten et al 2008), but these approaches have yet to be evaluated in obstetric or midwifery practice.

Nevertheless, this literature does provide some insights into patient responses to choice, and participation in decisions. Fotaki et al's (2005) extensive review found that patients' decisions were influenced by their beliefs, values and expectations, their personal characteristics and any life history of discrimination, as well as previous experiences of receiving health care. Common themes were that the conditions of choice (as outlined by Le Grand 2007, above) were *not* being met (Fotaki et al 2008; Robertson and Dixon 2009), particularly in terms of limited information and low availability of alternatives. Patients generally reported that being listened to, and treated with dignity and respect, was more important than being given a choice of providers per se (Propper et al 2005; Robertson and Dixon 2009; Fotaki et al 2005; 2008; Thorlby and Maybin 2010).

Fotaki et al (2008, p.181–2) have subsequently argued that choice policies create 'winners and losers', and that 'patients appear less likely to want to exercise choice when they are in a state of uncertainty, vulnerability or distress, preferring then to delegate choices to a trusted medical advisor'. Lupton (1997b) constructs a similar argument in relation to Australian health care by proposing a distinction between the 'discourses of consumerism', and those of 'liberal humanism'. According to Lupton, it is the latter which are employed by advocacy groups seeking to challenge the state by

[1] This review also included 'individualised care'.

campaigning for equitable access to high quality care, and focusing debates on patients' rights. Lupton (1997b, p.379) also argues that although individuals may acknowledge health care as a commodity, recent socio-cultural research on consumption demonstrates that commodities have '…"use value" or need-fulfilling value for the consumer but also … an "abstract value", consisting of the cultural, symbolic and emotional meanings around the good …' and that 'abstract values' include 'body work and affective exchanges'. Patients then experience a tension between behaving like 'independent' consumers, and wishing to relinquish control at times of distress, when there is a need to 'invest trust and faith' in health professionals (ibid, p.380).

It was arguably concerns of this nature, rather than attempts to broaden choices between providers, which brought choice onto the agenda of maternity services policy. The 1991–1992 Health Select Committee addressed maternity care specifically because there was widespread concern amongst consumer groups about the negative experiences of poor quality, fragmented and dehumanising care that women were recounting (Winterton 2000; Bourgeault et al 2001), and *Changing Childbirth* (Department of Health 1993, p.iii) announced the need for 'a service that is respectful, personalised and kind, which gives [women] control and makes them feel comfortable'. Subsequent surveys of maternity care experiences have looked at the broad *experience* of care, rather than choice specifically, although choice continues to be regarded as an important element of control (e.g. Audit Commission 1997; Redshaw et al 2007; HCC 2008).

This line of reasoning suggests that although consumer choice is available to women, the reasons for wanting choice and control over childbirth originated in a humanist critique of excessive medical interventions during birth rather than a consumer oriented demand for choice of provider. Nevertheless, women increasingly report having the option of choosing between different alternatives (if not between models of care), and it might be argued that consumerist policy achieves the desired ends by different means. However, this fails to explain why some women consistently report having 'no choice' of place of birth, and overlooks that women continue to experience

wide variations in maternity care quality (HCC 2008), suggesting that choice of place of birth involves something more than having a set of options provided. The next section reviews the debate about the medicalisation of birth, and considers the implications this has for women's opportunities to choose between different birth places, models and professions in the context of English maternity care.

Choice and constraint in maternity care

Authoritative knowledge and the medicalisation of birth

Critical accounts of the shift of birth from home to hospital frequently associate medicalisation with this change (e.g. Oakley 1984; Martin 1987; Tew 1990). Tenets of the medicalisation thesis are considered here from a cultural-symbolic perspective, to examine the link between medicine, midwifery and 'authoritative knowledge' (Jordan 1997), and to explore the impact of these upon choice of place of birth.

Medicalisation

The birth medicalisation thesis amalgamates feminist, governmentalist and risk theorisation and contends that medicine understands women's bodies through an androcentric, mechanistic model, and that this is the foundation of an oppression of women through their pregnant bodies, as obstetricians assume control of women and birth in order to manage and correct anticipated failures (Rothman 1982; Oakley 1984; Martin 1987; Davis-Floyd 1994; Lane 1995; Murphy-Lawless 1998). According to Foucauldian governance theory, obstetric practice has gradually broadened its scope from the 'abnormal' to surveillance of 'normal' pregnancies so that the individual is never free from *potential* risk (Arney 1982; Oakley 1984; Armstrong 1995; Tew 1990; Lane 1995), as a consequence of which, women become responsibilised for the outcomes of pregnancy (Miller 2005; Jomeen 2006; Cheyney 2008). Davis-Floyd (1990) extends the reach of this thesis through arguing that 'technocratic' obstetrics represents a 'microcosm of American society', where the metaphor of the machine is applied to individual bodies, to society and to the universe, in order to maintain a 'cohesive and consistent system of conceptual categories' (ibid, p.177). These

disciplinary traditions differ substantially, but coalesce in agreement that the profession of medicine holds an excessive level of power over birth.

Davis-Floyd (2001) later outlined two alternative approaches to 'technocratic' birth knowledge, both of which are purported to offer more personalised, integrative care to women, and described these as the 'humanistic' and 'holistic' models. The humanistic model arises when nurses and physicians try to make medicine more 'relational, partnership oriented, individually responsive and compassionate' (ibid, p.S10). Within this model, the body is a functioning organism rather than a failing machine, and clinicians consider the emotional and social aspects of care alongside the biological. The holism model is however the 'ultimate heresy' of medicine; holism depends on the unity of mind-body-spirit, and calls for a 'whole person' approach, 'nature is best and can be trusted … pain is part of the labour process … intuition and inner knowing are authoritative …' (Davis-Floyd 1994, p.1136) and healing may be spiritual as well as physical (Davis-Floyd 2001, p. S17). In her earlier work, Davis-Floyd presents humanism as more of a different way of 'doing' technocratic medicine, and holism as an oppositional 'integrative' approach, practised by women and selected 'home birth' midwives;[2] the holistic model does acknowledges a role for obstetric medicine in birth, but this is secondary to women's inner knowledge, and accessed only if the woman or midwife decide this is required. An assumption is made that birth support provided through these models by midwives to women will necessarily be more empathic and less interventive, although this contention is arguably founded in the feminist ideology which underpins these approaches rather than being based upon empirical evidence (Sandall 1995; Annandale 2009).

Medicine and alternative approaches in the UK

Scholars from a number of countries have advanced the argument that birth has become overly medicalised, but (with the exception of DeVries et al 2001) most do not differentiate between the different approaches to obstetric and midwifery care that

[2] US home births have until recently been attended by traditional 'lay' midwives, rather than by qualified nurse-midwives, although this is starting to change in some states, with increases in direct entry midwifery qualifications (Daviss 2001).

become evident when intervention rates are compared. The recent US *Listening to mothers II* survey showed that medical practitioners are the primary health professional at 89% of US births; midwives only attended 8% of births (Declercq et al 2006, p.28) and the professions of nurse-midwifery and obstetrics are divided on home birth, with the American College of Nurse Midwives (ACNM 2005) supporting this, whilst the American College of Obstetricians and Gynaecologists does not (ACOG 2008). In the UK, obstetricians and midwives have contributed systematic research evaluations of pregnancy interventions and provided evidence which contributes to the limitation of these (e.g. Chalmers et al 1989; Downe et al 2004; Alfirevic et al 2008; Hatem et al 2009; Hodnett et al 2010), midwives provide care for all women in labour, labour interventions are generally lower than in the US, and home birth for women with straightforward pregnancies is supported and provided through the public sector (RCOG/RCM 2007).

Alternatives to medicalised care in the UK

Midwifery practice is clearly sanctioned in the UK, through publicly funded, universal NHS maternity care that is provided by both midwives *and* obstetricians, yet it has been argued that the development of midwifery autonomy has ultimately been limited by the shift to hospital birth. Page and Sandall (2000) reflect on the need for a re-creation of midwifery as an autonomous profession which provides evidence-based care through relational continuity-of-care models, including care from a known midwife during labour and birth. The professional project of 'new midwifery' (Sandall 1995, Page and McCandlish 2006) is premised upon both clinical evidence and a compassionate approach; the proposed model is both theoretically informed and humanistic. However, the pursuit of midwifery as an autonomous and relational practice has particular drawbacks that have remained unaddressed; Sandall (1995) noted the potential division between 'professionalising elites' and 'rank and file' midwives (1995, p.206) that partial 'caseload' practice creates, and argues that increased autonomy is associated with rapid burn-out when little control over workload is available.

Mainstream midwifery in the UK

Despite these initiatives, UK mainstream midwifery continues to foster a medicalised approach to birth which more closely resembles Davis-Floyd's (1994) technocratic model of birthing. Recent studies have attempted to explore the reasons for this phenomenon; O'Connell and Downe's (2009, p.594) meta-synthesis of midwifery practice[3] found that 'real midwifery' (facilitating a normal birth without interventions) has an idealised status amongst midwives, but that hospital birth was in practice a clinical event:

> Apparently of necessity, skills that were prioritised by the hospital culture were the ability to manage birth actively ... to be able to use technology and intervention in the care of labouring women ...These competencies were more valued than providing a woman-centred approach to care.
>
> (ibid, p.599).

Porter et al's ethnographic study of midwifery practice (2007, p.528) found that midwives made decisions on the basis of local 'policies and procedures' rather than through 'collaboration with mothers', as others have also found (e.g. McCourt 2006). Purkis (2006, p.112) suggests that in response to medical dominance over midwifery practice, a 'boundary practice has emerged', which she memorably labels 'medwifery', and as a consequence of this, '... midwifery practice has atrophied'. In this context, it is unsurprising that Edwards (2005), Barber et al (2006), Jomeen (2006), Dagustan (2009), Dodwell and Gibson (2009) and NCT (2009), each recount that women's choice of place of birth continues to be limited in the UK, partly by limitations to the alternatives that are available, but also by the ideological constraints imposed by medicalised practice.

The overall picture appears confused. UK policy, practice and professions promote choice and individualised care, but technocratic medical care persists; professions aspire towards power-sharing yet limit this through promulgating medical

[3] This review was international, but North American studies were excluded because midwifery practice there was considered non-comparable to the publicly funded models of midwifery in other studies.

authoritative knowledge. In fact, support for alternatives is lukewarm in obstetric discourse, and the subtle (and historical) positioning of hospital as 'safe for all' and alternatives as 'safe for some' is likely to be important in this context.

Despite being a co-signatory to the consensus statement on home birth (RCOG/RCM 2007), the Royal College of Obstetricians and Gynaecologists' (RCOG) response to the NICE *Intrapartum Care Clinical Guideline* (NCCWCH 2007) states that the profession's favoured alternative to hospital birth is 'co-located midwifery units which guarantee access to a multidisciplinary team of experts, should the need arise' (RCOG 2007). Home births together with 'stand alone' midwifery units (FMUs) are linked by the RCOG to emergency transfers to hospital, which 'tax' the ambulance service. AMU birth centres have expanded since 2007 (Redshaw 2011), whilst numbers of freestanding units have remained stable, suggesting that hospital trusts also favour AMUs over FMU or home birth provision. This implies that birth in hospital OUs (or in hospital based AMUs) is sanctioned by the RCOG, and that 'out of hospital births' are positioned as more precarious, risk imbued and resource dependent, which generates a set of constraints upon choosing these alternatives. In relation to choosing home birth, Edwards (2005, p.89) cites Smythe's (1998) argument that:

> No choice is a free choice when others have feelings, beliefs and values about the choice that is made. The choice becomes much more than 'I will do this or that'. It is about 'will doing this bring other consequences with it, will it harm a relationship, will it offend, will it create barriers to on-going help?

A counter-argument to the medicalisation critique is made by Fox and Worts (1999), who, like Davis-Floyd (1994) observed that medical care is preferred by some, and interpret this as an act of agency on the part of women. Fox and Worts (1999, p.335) acknowledge that the medicalisation thesis is theoretically well grounded, but point to the lack of empirical support. Following their own research with a diverse sample of Canadian women, the authors find that some women report feeling 'positive' rather than 'alienated' after interventive births, particularly through achieving pain relief during birth. Creating an expectation that women 'ought' to want control over birth may then amount to a different kind of constraint upon women's choices, and risks '...

blaming women themselves for their medicalised and thus alienated birth experiences' (ibid, p.330).

The impact of discourses of risk attached to different birth places on individual worldviews is revisited later in the discussion, but the UK context suggests a number of constraints upon birth place choice. Medicalised practice is perhaps less interventive than the US model, yet is perpetuated by doctors and midwives in mainstream hospital settings where medicine provides dominant authoritative knowledge, and midwifery knowledge appears subjugated, even by midwives (O'Connell and Downe 2009; Purkis 2006). Continuity of care models, home birth and freestanding birth centres propose a more humanistic model, but these are marginalised areas of practice, and the substantive contribution of 'real midwifery' is difficult to ascertain. The holistic model outlined by Davis-Floyd (1994) does not appear within UK mainstream midwifery[4], suggesting that the alternatives lie between *either* technocratic medical care in hospitals, *or* humanistic medically-oriented care practiced by midwives *or* doctors in a range of settings. These debates inform the first key research question, which proposes a prospective enquiry into individual birth place decisions, to explore the ways in which women and partners make sense of these models and discourses and the influence of social, cultural and professional views upon the decisions that are reached.

Both medicalisation and its alternatives can be positioned either as constraints upon birth place choice, or as routes to empowerment, depending on the ideological position of the proponent. Evidence that many women perceive hospital to be safer for birth, whilst some prefer the security of home, suggests that both constructs have purchase in contemporary birth place decisions, and that women adopt various positions in response to risk discourses, but it is unclear how this might come about, or the extent to which birth risk discourses are open to reinterpretation by individuals.

[4] Private sector independent midwives and 'doulas' may provide care using a holistic model, but currently, independent midwives operate outside the public sector, and are unable to obtain professional indemnity for home births; for the purposes of this discussion, independent midwifery is considered to be beyond 'mainstream' practice; it remains an important resource for affluent UK women however.

This indicates the need for a theoretical model of risk responses which accounts for different conceptualisations of risk within the population, and for an approach to understanding individual agency and social constraint. The following section explores socio-cultural perspectives of risk, particularly the insights offered by Douglas and Wildavsky's (1982) cultural-symbolic approach to risk theorising, and evaluates the potential contribution of this theory to the research. .

Socio-cultural perspectives of risk

In her review of contemporary risk theory, Lupton (1999a) discriminates between two distinct perspectives of risk. The first of these she terms the 'technico-scientific' approach, which conceptualises risk as identifiable and calculable in probabilistic terms (1999a, p.18) and provides 'a basis for recognising and for interpreting experience of [a given] risk...' (Taylor-Gooby 2002, p.110). Socio-cultural accounts of risk attempt to move beyond abstract data and incorporate social, cultural and historical contexts when accounting for risk, and individual responses to risk.

Socio-cultural risk theorists encompass a range of epistemological positions, which Lupton (1999a, 1999b) describes as existing along a continuum between 'realist' and 'strong constructionist' approaches (1999b, p.35). In relation to birth place choices, existing literature provides evidence for real, objective safety risks, as well as disputes about the extent to which these are heightened through biomedical rationalities, or downplayed within a natural model of birth, inferring that the risk, as an 'objective hazard or threat ... is inevitably mediated through social and cultural processes and can never be known in isolation from these processes' (Lupton 1999a, p.35). Lupton (ibid, p.35) describes this as a 'weak constructionist' perspective, and associates this with Mary Douglas' anthropological work, and the subsequent contributions of her colleagues and followers.

Lupton's distinction between socio-cultural accounts by epistemological positioning usefully indicates proximal theoretical perspectives. These include the 'reflexive risk society' and 'modernity' theses associated with Giddens (1991a), Beck (1992), Beck

and Beck-Gernsheim (1995), and the 'governmentality' thesis, which draws upon Foucault's insights into discourses of power (Foucault 1977, 1991). These have contributed significantly to the fields of risk and reproduction in social science (e.g. Arney 1982; Armstrong 1995; Lane 1995; Weir 1996; Ruhl 1999; Miller 2005; Roy 2008; Fahy et al 2008; Godderis 2010), but being oriented towards theorising macro-social change, their analytic standpoint usually proceeds from a societal level rather than upon the 'micro-context of risk meanings' that is central to this enquiry (Lupton 1999a, p.27). These accounts are therefore conceptualised as complementary to the overall cultural-symbolic stance of this research, but employing a different level of analytical focus.

Socio-culturally informed research can operate at both individual and group level, as researchers seek to explore how 'specific actors (or sub-groups) within a certain socio-cultural setting construct their risk understandings as part of their interactions with others, albeit within a the broader frame of social structures' (Lupton 1999b, p.27). Douglas and Wildavsky's (1982) cultural theory framework provides a model for thinking about how particular risks are perceived and 'selected'. The authors adopt a 'weak constructionist' approach to risk, through arguing that risks are 'real', but that 'acceptable risk is a matter of judgement, and nowadays judgements differ' (ibid, p.194). By proposing a level of analysis that recognises both subjective perceptions of risk and the ways that these both respond to and help generate shared beliefs and values, cultural theory has potential application to better understanding the UK context of societal constraints related to choosing a place of birth described above.

Charting an unfashionable path:[5] cultural-symbolic accounts of risk selection

'Cultural theory' developed from Mary Douglas' early anthropological work into pollution, hygiene and symbolic categories of separation (2002, 2003[6]). Douglas (1982) situated her work within cultural anthropology and the search to identify a unifying theory of cultural patterns across groups and peoples. During her later collaboration

[5] Douglas (1982, p.185) '*...the unfashionable path I wish to tread...*', referring to her search for 'cultural typologies'.

[6] Douglas (2002) was first published in 1966, and Douglas (2003) was first published in 1990.

with Aaron Wildavsky, Douglas' (2003) 'grid-group' framework was incorporated into the co-authored cultural theory, which sought to explain how different *political* groups came to select specific risks for attention and action, whilst appearing to consign others as being less important (Douglas and Wildavsky 1982; Douglas 2006). Douglas and Wildavsky (1982) discussed their theory in relation to environmental risks and pollution, but since its publication, cultural theory has underpinned empirical work across a variety of disciplines.

Applications of the cultural theory of risk selection

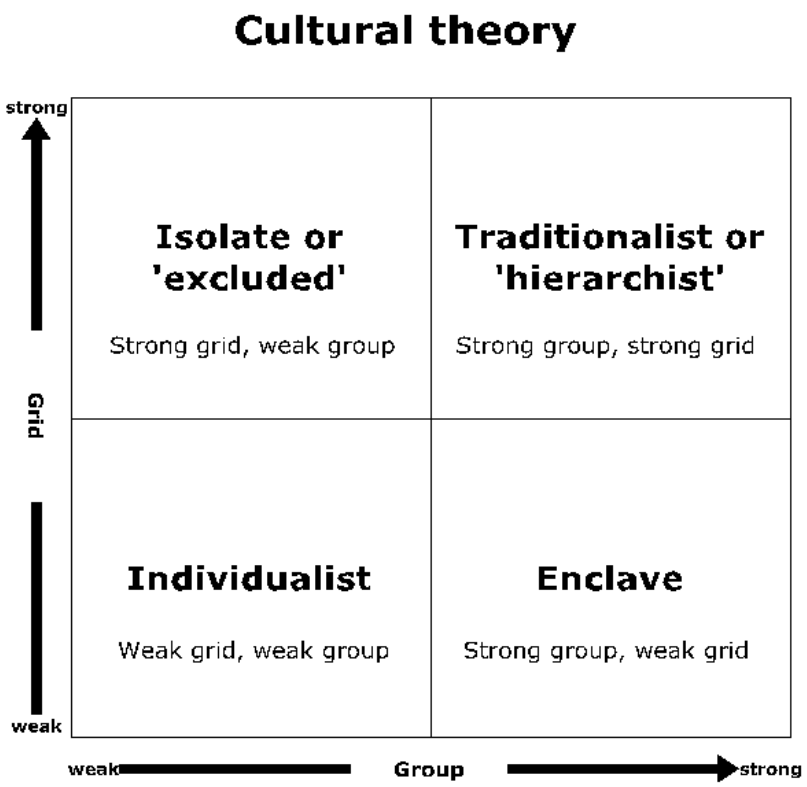
Thompson et al (1990) describe cultural theory applied to political science, ethical reasoning, and to anthropological questions in western cultures. Wildavsky and Dake (1990) conducted work into perceptions of environmental risks, and Douglas Caulkins and Peters (2002) applied cultural theory to cross-cultural research. Douglas (2006) describes a range of elaborations of the model by other researchers encompassing policy analysis, organisational cultures and religious groups, and most recently, Howard (2009) used cultural theory to explore teachers' preparedness to adopt ICT in the educational sector. Researchers have found cultural theory to be useful for exploring perceptions of risk in relation to different organisational contexts, and the concept of 'cultural bias', which describes the extent to which people are averse to particular risks, appears to have particular explanatory value (e.g. Wildavsky and Dake 1990; Howard 2009). However others have been more sceptical about the universalist claims of the framework and its theoretical origins (Spickard 1989; Wilkinson 2001; Douglas Caulkins 1999). These critiques are considered further below, but initially the basis of cultural theory is outlined, and its potential insights to exploring individual risk perspectives in relation to place of birth are appraised.

Grid-group cultural theory

Cultural theory explores cultural selection of risks through a two-dimensional framework that incorporates the theoretical constructs of 'group' and 'grid'. Describing these along a gradient from 'weak' to 'strong' generates four core 'quadrants' (see Figure 5 below). Both group and grid refer to different aspects of social context, and taken together they suggest the extent to which an individual experiences either

freedom or constraint, through being hemmed in by edicts imposed by others. Central to this argument is that each of the quadrants has a different 'cultural bias', or 'array of beliefs locked together into relational patterns' which predispose towards selection of particular risks (Douglas 1982, p.199; Douglas and Wildavsky 1982). Although Douglas and Wildavsky published cultural theory together, much of the theoretical basis for the model is described in fuller detail by Douglas in other texts, and these are also drawn upon here (Douglas 1982, 1992, 2006).

Figure 5 Cultural Theory



Source: based on Douglas' (1982) descriptions of group, grid and the four political cultures

Group and grid theoretical constructs

Douglas understood 'group' (the horizontal axis) to indicate the strength of loyalty ties an individual has to a social group, which could be a family, work or faith-based group. In her model, intermittent membership of several groups did not amount to 'strong' group belonging; this only occurred when a group had 'common residence, shared work, shared resources and recreation' (Douglas 1982, p.202). Nowadays, when work

and family life are fragmented and few live in faith groups, this dimension may appear diminished, but in a contemporary context, group might be understood as the strength of individuals' relations to their birth family, neighbourhood and any work, faith, social or activist groups they are associated with. Douglas (1982, p.207) also articulates a further aspect of group as the extent to which an individual is able to gain *access* to social groups that hold power and make decisions; for example by becoming a health professional or member of a policy making network.[7]

The vertical 'grid' dimension relates to susceptibility to external social controls, and increasingly strong grid suggests a social environment which leaves 'minimum scope for personal choice' (Douglas 1982, p.202). Douglas argued that strong grid means individuals have reduced autonomy, and are liable to *being* controlled by having rules imposed without opportunities for negotiation, rather than being *in* control of others.

The contribution of hygiene/pollution to cultural theory

As well as incorporating Douglas' grid-group framework, cultural theory proposes that 'pollution beliefs' are used to designate morally acceptable positions, and justify rejection of ideas that are not in keeping with the abiding worldview (Douglas and Wildavsky 1982, p.36). Drawing on Douglas's earlier work in *Purity and Danger*, Douglas and Wildavsky (1982, p.37) suggest that metaphors of pollution:

> ... function to keep some categories of people apart so that others can be together. By preserving the physical categories, pollution beliefs uphold conceptual categories dividing the moral from the immoral and so sustain the vision of the good society.

Douglas and Wildavsky (1982, p.37) also argue that allusions to moral or physical danger are often employed to indicate when a risk is being imposed, or a guideline transgressed. Of particular interest in the context of birth place decisions is their

[7] 'By definition ... [a 'high grid, low group' individual] is excluded from such groups as there may be' (Douglas 1982, p.207)

assertion that the boundary between voluntary and involuntary risk is based upon the concept of 'normality', and that this signposts responsibility:

> Blameworthiness takes over at the point where the line of normality is drawn. Each culture rests upon its own ideas of what ought to be normal or natural. If a death is held to be normal, no-one is blamed ...
>
> (Douglas and Wildavsky 1982, p.35)

The concept of pollution beliefs therefore has potential as a theoretical construct for analysing the ways in which individuals explain selecting particular risks for attention, and given the evidence in the birth place preference literature of differences in risk perception, particularly between home birth and hospital birth mothers (see Chapter 2), this insight is likely to add new knowledge about perceptions of birth place risk and safety.

Positioning the individual within the group

Douglas and Wildavsky's (1982) cultural theory relates to group cultures, and argues that groups vie for resources and support in a contested political landscape, so application to individual experiences might be considered problematic. However, Douglas was quite clear in her earlier and subsequent writing that group-grid analysis operates at the level of the individual *within* a group, which might mean any social context that requires people to account for themselves, and 'where moral judgements materialise into pressures ... to act in certain ways' (Douglas 1982, p.201). The relationship between individual and culture is also considered co-constituitive; individuals create and respond to meanings, and shape the culture of which they are part. This dual emphasis on person and context closely resembles Bourdieu's argument that world-views (habitus) are both instilled by, and develop from, lived experiences within social environments (Bourdieu 1990, p.56). Douglas and Bourdieu separately refer to Durkheim's (2001) belief that 'context' includes historical time:

> In each one of us, in differing degrees, is contained the person we were yesterday … it is even true that our past personae predominate in us, since the present is necessarily insignificant when compared to the long period of the past….
>
> (Durkheim 1938, quoted in Bourdieu, 1990 p.56)

In this respect, cultural theory differs from theories of risk reflexivity, which hold that in modernity, individuals construct their lives and identities in response to the 'loss of traditional security … and guiding norms' (Beck 1992, p.128) and identities become re-imagined as biographical works in progress, or reflexive 'project[s] of the self' (Giddens 1991a, p.5). Here, the emphasis is upon individuals as self-fashioning in the continual present, rather than as being rooted in history as cultural theory suggests, and reflexivity theorists argue that structuralist models simply fail to address the extent of recent western societal change, or to reflect the new reality of shifting subjectivities (Miller 2005). The notion that people can be assigned to quadrants is also problematic, as features of each might co-exist within individual personalities, and exercised in different ways according to the demands of varying social roles (Renn et al 1992). These challenges to symbolic risk perspectives are currently influential within risk social science, but it is also worth considering how cultural theory addresses these issues, and reviewing the extent of opportunity for fluctuation theorised by the model.

Cultural theory and birth place preference

The groups described within cultural theory relate to the four quadrants within the grid-group model (see Figure 5 above), and are derived from Douglas' earlier work (1982, 2003[8]). The quadrants constitute three political cultures, and a fourth group which is excluded from political exchange. Alluding to Weberian 'types of rationality', Douglas termed these political cultures as the 'frontier individualist/pioneer', the 'stern bureaucrat' and the 'holy man' or 'sectarian/enclave'[9] (2006, p.3), and the final group is the 'isolate/excluded' culture. The concept of rationality is important to

[8] Douglas' *Natural Symbols* (2003) was first published in 1970

[9] Enclaves are elsewhere referred to as 'egalitarians', but the terms adopted for use here are those which are most appropriate to the context of birth decision making.

cultural theory, because the framework is intended to demonstrate that different perspectives, although apparently conflicting and often at odds with each other, are rational in terms of the world-view adopted. Douglas (1982) explained the cultural groups by deliberately highlighting the extremes of each position to illustrate the comparisons being made, so in practice, more moderate positions should be anticipated.

The theoretical basis for these groups is discussed here, and their relevance to the context of individual birth place decisions is considered. The quadrants referred to are as illustrated in Figure 5 (see p.71).

'Frontier individualism'[10]

'Weak grid/weak group' individualists are considered to have high personal autonomy and thrive in competitive social conditions, a culture illustrated through the metaphor of free market ideology. Douglas considered that individualists experienced the least social constraint, not being tied by loyalty to other groups; she characterised these as 'trend-setters ... iconoclasts ... pioneers in taste and fashion' (Douglas 1992, p.109). Individualists favour autonomy, choice and competition, and place 'high value on personal privacy ... [which] accords with the cardinal ethic of individual value' (Douglas 1982, p.196). In terms of health care, individualists are 'idiosyncratic' about health advice and prohibitions and liable to be 'risk takers', in the context of health[11] or finance decisions, and initially, this group bears resemblance to the reflexive selves proposed by Beck (1992) and Giddens (1991a), but Beck's (1992) argument that late modern selves are sceptical about powerful knowledge discourses is not borne out. Rather, Douglas argued that individualists value professionalised knowledge and expect health professionals to be trained and accredited, but reserve the right to choose between competing services, because choice is part of expressing individuality (Douglas 1992, p.109). The cultural bias of this group is rooted in the value placed

[10] Douglas (1982, p.194)

[11] To clarify, the allusion to health risk arises in the context of a discussion about contagion in relation to HIV/AIDS (Douglas 1992, p.102–21).

upon the autonomous individual, and risks which threaten an individual actor's right to make choices or negotiate terms are selected above other kinds of risk for attention.

In the context of birth place decisions, the individualist culture would then be expected to embrace opportunities for choosing a preferred setting, and may be willing to select between providers and to opt for private sector services, but would find rigid protocols problematic; if medical management of birth is conducted in an inflexible manner, we might anticipate this to be a source of conflict. Yet given the cultural preoccupation with birth safety and the theorised respect for professional knowledge, it seems unlikely that even individualists will present as risk takers, or pioneers in alternative birth settings. The argument that individualists are free from social group bonds also seems problematic in this context, because pregnancy is a time of transition to parenthood, where strong social mores create normative expectations about both individual and couple behaviour (e.g. Miller 2005; Brannen and Nilsen 2006; Taylor 2010). The theoretical basis for this group is then difficult to equate with contemporary expectations of pregnant women, but it may be the case that this group is less sensitive to the cultural risk discourses discussed earlier.

The next two groups to be outlined are the 'traditionalist' and 'enclave' groups. These are different to individualists in that both are described as having higher group allegiance, but their theorised responses to external rules and controls are very different.

Traditionalist or hierarchist culture

This culture lies diagonally above the individualist quadrant, having strong group *and* grid features, and espouses preference for tradition and social order. Douglas (1982) conceptualised the traditionalist culture as being pressured to conform to established norms both by other group members, and by external rules. Their cultural bias towards order means that this group selects and prioritises risks that appear to threaten the long term continuation of the status quo, and new models of care may therefore not be well received.

Douglas considered that traditionalists accept the authority of established professions, and that this group 'faithfully models its knowledge of safety ... on what it considers to be **their** considered position', meaning the position adopted by health professionals (Douglas 1992, p.107, emphasis added). As a consequence, traditionalists adhere to medical advice, and place moral value on compliance with this, whilst rejecting folk remedies or alternative therapies. Recalling Jordan's (1997) conceptualisation of authoritative birth knowledges, the likelihood is that traditionalist individuals will judge obstetric management of birth to be more appropriate than non-medical alternatives. Although traditionalists are also thought to be respectful of hierarchies within and between professions, it is feasible that the perceived authority of midwives may to some extent counter this view.

Enclave culture

The enclave culture has strong group affiliations, and weak responsiveness to externally imposed rules; the culture exists within mainstream society but carves out an alternative version of the world. The cultural bias here is that mainstream (non-group) values pose a potential threat to the natural order of things, and so the same technological solutions that other groups embrace are selected as risks by enclaves (Douglas and Wildavsky 1982). In terms of health care, all professions are a source of suspicion, because 'authority is largely personal, in medicine as in politics' and learning acquired through experience is at least as valid as formal education (Douglas 1992, p.109). Enclave individuals prefer natural solutions such as healthy diet and exercise and are sceptical about technological solutions, including pharmacological medicines (Douglas 1992, pp.108-9). It seems likely therefore that enclave individuals might be attracted to home birth, natural, non-interventive birth practices, and to avoid pharmacological pain relief during labour. The opposition between traditionalists and enclaves in this model is clear; where traditionalists prefer medicine and value professional advice, enclaves appear reflexive and are likely to be sceptical about canonical knowledge.

Isolate or 'excluded' culture

The isolate cultural group has weak group belonging, and is subject to imposition of social control exerted by the other cultures. Theorised as being excluded from mainstream groups which generate or distribute power, and having minimal autonomy, Douglas (1982) nevertheless realised that this group might constitute a large portion of the population. This group is variously considered to be fatalist, victimised or capable of 'exploiting the rest of the system' (Douglas 1992, p.106). Easily dismissed, isolates 'attract no attention, no one asks for their opinion or takes them seriously in argument. Hence, their reputation for apathy ...' (Douglas 2006, p.6). We might anticipate that this is the group with 'no choice' of place of birth, but there is little information about where their cultural bias might lie, or what risks might be seen as important. In seeking to examine this, Douglas (1992, p.110) describes isolates as 'eccentric' with 'no special respect' for any authoritative knowledge systems, but a belief in 'mysterious conspiracy beyond the human sphere'.

In Douglas' work, isolates are generally under-theorised, and this represents an uncharacteristic weakness within her account. In Douglas and Wildavsky's (1982) cultural theory text, the isolate group does not feature at all, because they were not considered to play an active part in the political system, however they are part of all the other iterations (e.g. Douglas 1982, 1992, 2006). The isolate group is retained in the version of cultural theory discussed here, because the presence of individuals in positions that resonate with the isolate or excluded culture is indicated in the literature on birth place choice. Although its use is potentially problematic given the absence of strong theoretical explanation, this constitutes an opportunity to explore whether the concept of being isolated or excluded has salience in contemporary policy research. There are several other recognised limitations to cultural theory, and the implications of these are addressed below.

Critiques and limitations of cultural theory

Critiques of the theoretical foundations of cultural theory

The post-modern critique of Douglas and Wildavsky's (1982) structuralist explanation of risk selection discussed above outlines an important but partial challenge of this account. Wilkinson (2001) also regards the core theoretical principles of cultural theory as untested, and argues that these are effectively polemical rather than being confirmed by existing anthropological data, as Douglas claims. Citing Adams (1995), Wilkinson (2001, p.10) alleges that the method 'founder[s] in tautology' because it begins by categorising respondents into groups, and then forms explanations on the basis of these. Wilkinson (2001) also summarises a set of commentaries on cultural theory, arguing that it is considered to be overly rigid and inflexible, and not capable of sensitivity to the fluid, interactive nature of individual responses to risk. These critiques are salient, and should inform the application of cultural theory to empirical questions, but at this stage it is relevant to note that these researchers have often attempted to objectively 'measure' either culture (Gross and Rayner 1985; Douglas Caulkins 1999; Douglas and Peters 2002) or risk perceptions (Wildavsky and Dake 1990), and few accounts of using cultural theory with longitudinal interpretative methodologies have been published.

Cultural theory and change

The critique of determinism leads to accusations that cultural theory fails to account for human agency or change (Douglas 1982, 2006; Douglas and Wildavsky 1982; Bellaby 1990; Wilkinson 2001). Yet Douglas (1982, p.186) argues that cultural theory arose *because of* the lack of a unifying theory of cultural change (or stability), which at the time was a problem facing both anthropology and sociology. Addressing this issue, she argued that cultural theory does not assume that individual's views are fixed, but rather argues that if people do adopt a particular world-view, their own explanations for 'subjective perception[s] of the scene' reveal how they see the universe and their part in it, and given that culture is demonstrably dynamic, she anticipated that both individual and environment can interact and that either can change (Douglas 1982, pp. 198, 200). Given that some aspects of cultural theory have become dated (such as the

conceptualisation of group discussed previously) it is probably also the case that the cultures, however interpreted, are limited to describing what options are available in a situated historical, national and political reality.

A separate critique which Douglas also acknowledged was that despite its interest in political competition and cultural change, cultural theory failed to account for the 'dimension of power' (Douglas 2006 p.8). Subsequent work by Douglas' colleagues did attempt to redress this balance, but these developments have not been broadly accepted, and the individual experience of power within the model is not clearly theorised beyond the concepts of grid and group constraint.

Different iterations of group-grid cultural theory

The group and grid dimensions that underpin cultural theory are linked to social integration and to the sense individuals have of the rules by which their universe operates. However, the meanings of these dimensions changed as Douglas revisited and revised her work, and this has lead to a further critique of group-grid theory. Spickard (1989) argues that the theory has been prone to misinterpretation, largely because there are various different iterations in print, and Douglas Caulkins (1999) makes a similar observation. Douglas herself acknowledged in her later writing that 'group and grid cultural theory' was a 'simple idea presented in a complicated way' (Douglas 2006, p.1), but reiterates that the dimensions of group and grid are valuable for understanding different aspects of risk selection.

Despite these limitations, cultural theory has potential application as a framework for exploring individual risk selections, and this socio-cultural theory of risk perception informs the second research question, which seeks to document the ways in which accounts of birth risk and safety are developed and negotiated between women, partners and health professionals. The key elements of value are the notion that worldview is instrumental in classification of risk perceptions, and that pollution metaphors reveal moral reasoning when risk selections are explained; these attributes contribute to the interpretation of micro-contextual factors. Despite its structuralist origins, cultural theory is purported to allow for changes in context and in viewpoints,

but the ability of the framework to permit change is contested and would benefit from further empirical research. Cultural theory has not previously been applied to studying risk perceptions in childbirth, but has valuable potential in this context. The main limitations are twofold. Firstly, there is theoretical reliance upon assumptions derived from somewhat dated group typologies, and secondly, despite the political application of this framework, the model does not clearly account for the extent of power which may have variable application to contemporary individuals' decisions. These limitations are addressed here by additionally drawing upon Bourdieu's (1984, 1990) theoretical conceptualisation of power exercised through various forms of 'capital', and the cultural reproduction of social 'distinction' and 'taste'.

Structural and cultural constraints upon agency and choice

Acquiring and reproducing cultural norms

Douglas and Wildavsky's (1982) cultural theory was informed by Bernstein's sociological insights into cultural reproduction though education and family life (Bernstein 1971). Bourdieu's (1984) theory of 'distinction' similarly places family and education at the centre of cultural reproduction of values and tastes. The application of these concepts to birth place decisions is evaluated here; this section outlines the perceived relevance of Bourdieu's work to birth place choice in the context of risk perceptions, and puts forward an argument that these perspectives are complementary, and together strengthen the conceptual basis for the research.

Hays (1994, p.57) reviewed the use of the terms 'structure' and 'culture' in social science literature, and was critical of the ambiguities that persist in the ways these terms are used. According to Hays, this is exacerbated by a 'tendency to imply the meaning of 'social structure' either by opposing it to agency or by contrasting it with culture, thus reducing 'structure' to pure constraint, and arguing that 'culture' is not structured'. Hays (1994, p.64) rejects such 'oppositional' definitions, and argues instead that culture has structural aspects and that agency can be understood as existing on a continuum, which is 'influenced by the depth and durability of the structural form in question, by the level of power held by those making the choices,

and by the larger cultural milieu in which the choices are made'. This conceptualisation posits culture as 'both the product of human interaction and the producer of certain forms of human interaction' so that 'culture is both constraining and enabling' (ibid, p.64).

Social taste and 'distinction'

Although Hays (1994) drew on Giddens' (1984) account of 'structuration' to illustrate her argument, Bourdieu's sociology of practice in everyday life similarly positions agency as dependent on social constraint and enablement in 'fields of practice' (Bourdieu 1990; Swartz 1997; Williams 1995). Bourdieu argued that power differentials account for variations in human agency, and that individuals exchange forms of capital in the quest for success and resource. Central to Bourdieu's argument is that although material wealth is an important source of power, exchange 'capital' is much broader than this, and includes 'cultural capital', or 'legitimate knowledge' which is acquired through education and family upbringing (Williams 1995, p.587; Lawler 2008). Through these traditions, approved values and tastes are also culturally replicated (Bourdieu 1984).

Central to Bourdieu's explanation of cultural reproduction is the concept of habitus (Bourdieu 1990, p.52), described by Webb et al (2002, p.36) as the 'partly unconscious 'taking in' of rules, values and dispositions...'. Habitus is therefore *acquired* knowledge; it is 'formed in the context of people's social locations and inculcates them into a "worldview" which is based upon and reconciled to their position, thus serving to produce existing social structures' (Williams 1995, p.585).

The argument that beliefs, attitudes and tastes are socially reproduced is important, and Bourdieu (1984, p.177) further contends that tastes can be separated into underlying class distinctions, revealing 'tastes for luxury (or freedom)' associated with the dominant or middle classes, or 'tastes of necessity', which are found amongst working classes or otherwise dominated groups. According to this thesis, dominant classes have more choice because their opportunities to purchase goods and services

are greater, and are also built upon stronger class investment in education and professional knowledge.

Bourdieu also argued that 'particular classes and class fractions compete to impose their own particular tastes as legitimate' (Swartz 1997, p.164), meaning that claims to taste are reproduced within different social classes, and then exerted as a form of dominance over others. Middle class tastes favour quality over quantity and luxury above economy; these are based on abstract, aesthetic values, and a love of 'art for art's sake', including the 'art of motherhood' (Bourdieu 1984, p.379). In contrast, working class tastes represent the practical or functional, with an aversion to 'frills' or 'fancy nonsense', embodying an ethical preference for 'conventionalism' and doing 'the done thing' (ibid, p.379). The insight here is that 'people develop tastes for what is available to them' (Williams 1995, p.590), and by this mechanism, working class tastes effectively transform 'constraints into preferences' (Bourdieu 1984, p.175, Swartz 1997, p.166). In the UK context, Lawler (2008, p.128) draws upon Bourdieu's sociology to argue that the term 'tasteful' is analogous with middle-class values, which encapsulate what is 'inherently right', and are used to distinguish what is approved or sanctioned from what is considered tasteless, common or 'vulgar'.

Evaluating the application of Bourdieu's sociological insights to contemporary UK context

Applying Bourdieu's theories of working and middle class tastes to the contemporary UK setting is of course problematic on a number of levels. As Swartz argues (1997, p.289), these ideas emerge from a distinctly French preoccupation with maintaining an 'imposing high-culture tradition' which may have less relevance in more culturally diverse environments, and Bourdieu's 'class culture distinctions' (ibid, p.289) between the aristocracy, bourgeoisie and working classes map poorly onto UK class differentiations, or at least require some careful conceptual thought. A separate, post-modern critique argues that class differences have diminished as individuals become 'liberated' from traditional roles in the home and workplace, and instead experience a 'new type of social commitment', to markets, institutions and agencies (Beck 1992, p.128), but despite increased labour market participation, there is scant evidence that

women's traditional home and childrearing responsibilities have decreased (Young 1997, p.4), and motherhood 'continues to be central to the ways in which women are defined' (Miller 2005, p.48). A further well established critique argues that systems of occupational classification are inappropriately applied to women (particularly during their childrearing years), because these are historically derived from male patterns of working and systematically exclude those who take care of others and may never have been employed outside the home (Arber 1991; Blaxter 2000).

Differentiations between working and middle class lifestyles are also considered to be losing traction as liberal democracies shift towards wider access to education and improved gender equality (Hays 1996; Lewis 2005), but this also leads to the problematisation of other categories of motherhood, particularly those associated with a socio-economic 'underclass' (Lawler 2008; Macvarish 2010). Lawler (2008, p.125) explicitly challenges the argument that class 'is a defunct social category' in the UK, and suggests that instead:

> ...class distinctions...become displaced onto individual persons (or families) who are approved or disapproved, considered as 'normal' or considered as faulty and pathological.
>
> (Lawler 2008, p.126)

The displacement of class identities is then one way of accounting for the 'absent presence' of class, which continues to 'circulate socially while being unnamed' (ibid, p.126). Lawler's analysis draws upon UK-based notions of class and taste to argue that the middle class is unable to differentiate itself through economic wealth, having relatively similar economic capital to a rapidly expanding working class; instead, middle classes sequester areas of symbolic and cultural capital and use this to achieve and maintain social dominance.

In the context of this research, an imposition of cultural power is theorised to occur in relation to childbirth and birth place choices. In view of the difficulties associated with occupational class divisions to denote social class, Bourdieu's theory of capital

differentiated into cultural, economic and social 'means' is adopted as a basis for demographic analysis, because this allows broader aspects of subjective and external identity conferral to be taken into account (see Chapter 5). Lawler's (2008) argument that class differences persist in the UK, but are exercised in a more subtle fashion than before is valuable, particularly if the idea that cultural capital reproduces middle class taste in the UK is accepted, a notion which requires further empirical investigation.

Bourdieu's theories of practice and of social distinction therefore provide added insight into mechanisms of social constraint and individual agency, and these conceptual theories underpin the research questions which seek to explore the acquisition of cultural norms about place of birth and also inform the question about how individuals make sense of birth in relation to the events which take place, and the discourses to which they are exposed. However, like Douglas and Wildavsky's work (1982), Bourdieu's theories have also subject to a critique of determinism on the basis that these ideas fail to account for individual agency and the possibility of social change (e.g. Williams 1995; Swartz 1997, p.290), and this difficulty is addressed next.

Choice: reproducing norms, or transformative change?

In a context where culture generates both constraint and agency, Hays (1994) argues that choices achieve one of two possible outcomes. The likelihood is that a given choice will serve to reproduce the existing status quo, and Hays argues that although this may appear determinist, it is also feasible that the 'way things are' serves other purposes. She illustrates this with an example of nineteenth-century middle class American women who achieved a new social position for mothers as moral guardians of future generations, thereby enhancing women's status and social stability (Hays 1994, 1996). By a conservative analysis, this contributes to social order, and because the search for order remains an organising principle of western democracies, change which reverses this could be resisted. In other (fewer) cases though, Hays argues that choice will be 'transformative'; that is, the deployment of cultural or social capital will effect a change. Zadoroznyj's (1999) finding that working class women's birth models changed following their first experience of labour could be considered an example of transformative change, and Behague et al (2008) discuss 'transformative agency'

amongst patients experiencing severe, life-threatening obstetric events in Benin, and suggest that despite a cultural norm of passivity, some women overcame deep structural inequalities to achieve agency, and this was often associated with having a *garde-malade*,[12] present and providing support. The *garde-malade* was often a female relative with experience of childbearing, whose presence added legitimacy to labouring women's accounts, and made it possible to confront staff and demand better care (ibid, p.502), hence some women benefitted from the added social capital accorded to the older, more experienced companion.

Despite acknowledging possibilities of agency and change, Bourdieu's analysis of taste as a mechanism of 'social distinction' has still been regarded as favouring a balance towards societal constraint rather than agency or enablement (e.g. Williams 1995; Swartz 1997; Calhoun et al 1993). Yet, as Lawler also notes, 'identity production' is never fully established, but rather continually contested within cultural discourses; this argument reconciles with Bourdieu's assertion that 'class is defined as much by its **being-perceived** as by its **being**',[13] and it is through these mechanisms that conferral of valued and devalued identities are theorised to occur. In the context of birth preferences, Nelson (1983), Martin (1987), Zadoroznyj (1999) and Liamputtong (2005) have all argued that working class women want different things from maternity care to middle class women, but that these wishes are overlooked by maternity care policy and providers (see Chapter 2) . Differences arising from nationality and ethnicity have also been identified (e.g. Martin 1987; Rudat et al 1993; Small et al 1999; Cheung 2002), and there is also some evidence that UK midwives stereotype women on the basis of class, education, nationality and language competence and make judgements about women's preferences on the basis of these (e.g. Green et al 1990; Bowler 1993), although this is not necessarily representative of contemporary practice.

Idealised norms in cultural narratives

The theoretical linkage between class dispositions and conferred identities may then be traced within Bourdieu's work, but other than a putative tendency towards choices

[12] Meaning 'guardian of the sick person'.
[13] Bourdieu (1984, p.483) emphasis in original text.

that reproduce the status quo and risks of identity conferral, it is not necessarily clear what impact cultural reproduction of taste might have upon women's choices about place of birth. However, cultural dispositions are articulated through cultural 'scripts' or 'narratives' (Miller 2005) and these are a source of received knowledge available to women, their partners and families during pregnancy, and although the reach and extent of these cultural narratives is not well understood, it is likely that they contribute to debates over what is normal, acceptable and approved in the contemporary cultural context. Examples of manifestations which might constrain or enable birth place choices include several potentially overlapping 'valued' identities, such as the 'ideal' mother, pregnant woman, partner/husband or patient. Conceptualisation of the ideal mother as white, native-born, educated, affluent, middle class and married (or in long-term relationship) is prevalent in recent socio-cultural accounts of familial roles (Hays 1996; Miller 2005; Lawler 2008) and builds on 'biologically determinist' perceptions that all women aspire to be mothers (Miller 2005, p.55; Letherby 1994). It is also situated within discourses of the morally and physically 'fit' pregnant body (e.g. Ruhl 1999, Nash 2011). It is unsurprising that this idealised concept of motherhood is not openly articulated, given the clear parallel with the eugenicist aims espoused by the NCT in its early days, when the organisation sought to promote 'a race of good quality men and women'[14] (Briance 1957, cited by Kitzinger 1990, p.99; see also Moscucci 2003), but if this is a genuine template for what is expected or socially privileged (a premise which remains uncertain), this would suggest the persistence of traditional and modernist values which originate in an earlier era.

In common with the medicalisation thesis, the notion of an ideal western mother conflates the cultural aspirations of Anglophone nations generally, but Miller (2005) and Lawler (2008) each report the same categories in their accounts of 'privileged' motherhood in the UK. Behague et al (2008) detailed the health professional approval afforded to women of low parity (those expecting their second, third or fourth babies)

[14] The NCT was called the Natural Childbirth Association (NCA) when it was founded in 1956, and the organisation was formed during the post-war era when there was widespread concern about the general health and fitness of the nation (Kitzinger 1990).

above first-time mothers or 'grand multiparous' women[15]. Women 'appropriately' aged for childbearing also attracted more approval (Behague et al 2008), and although this research took place in Benin, similar categorisations of older and younger mothers have been identified in the UK (e.g. Macvarish 2006, 2010). If these follow the class and cultural demarcations suggested by Bourdieu (1984), we might anticipate that women in these groups will have particular ideas about what is received, accepted and 'the done thing' in relation to place of birth, and also anticipate examples where these norms are challenged in current or future pregnancies though changes in social or cultural capital.

The notion of an ideal father

The issue of fatherhood and the changing role of fathers has also been addressed in recent social science and policy literature (Cabrera et al 2000; Draper 2000, 2002; Brannen and Nilsen 2006; Collier and Sheldon 2009; Coalition on Men and Boys [COMAB] 2009). Collier and Sheldon (2009, p.4) argue that the normative concept of a father as central to the family unit in legal, financial and moral terms has 'disintegrated' in response to rising rates of divorce and separation. Recent research into fatherhood and masculinities positions the ideal father as white, educated, affluent, heterosexual, masculine (Dolan and Coe 2011), also (emotionally) supportive and bread-winning (Miller 2011). The concept of normalisation also extends into transition to parenthood; in her discussion of place and belonging, Taylor (2010) describes the hetero-normative trajectory of couples meeting, making a home together and then having children. These narratives place men into a potentially conflicted position, where their needs and expectations during pregnancy should be suppressed in keeping with the precepts of masculinity and being supportive partners, yet they should also be presenting as embracing fatherhood and actively involved. Although little is known about partners' involvement in birth place decisions, it seems likely that their influence will be bounded by the expectations to which they are exposed.

[15] Women who have given birth to five or more children.

The ideal patient

The wider notion of the 'ideal patient' reaches a point of conceptual complexity, having worked through several iterations in recent history. Since Parsons' (1958) functionalist critique of the 'sick role' identified that patients were expected to be co-operative and deferential after seeking medical support, this role has changed. In the context of increasing US health care medico-legal claims, Annandale (1989) records the shift towards a requirement that patients be rational, educated, responsible, and respectful of clinical judgement *rather than* consumerist (consumerism being related to a preparedness to pursue legal action) whilst, as discussed previously, recent UK policy reforms idealise the 'informed, self-directed and autonomous' consumer-patient (Clarke et al 2007; Le Grand 2007; Robertson and Dixon 2009) and give scant regard to the more 'relational' model of autonomy adopted by pressure groups seeking to reform maternity care and health care generally. The concept of 'relational' autonomy is interpreted here using Mackenzie and Stoljar's (2000, p.22) argument that autonomy should be reconceived as 'intrinsically relational', because an individual's perceptions of freedom and capacity to act are necessarily influenced by the 'social context in which they are embedded'. This conceptualisation provides a useful basis for reflection on the social realities of individuals' lives when considering the freedom or constraints they may experience when planning where to give birth.

The positioning of pregnant women as patients has also been subject to critique by feminist authors and social scientists (e.g. Oakley 1984; Rothman 1982) through the reclamation of pregnancy and birth as normal events in women's lives, ideally conducted with the support and companionship of midwives (Annandale and Clark 1996; Annandale 2009). This serves as a reminder that the social idealisation of birth also continues, and is divided between 'safe, medical birth' on the one hand (e.g. Bryant et al 2007) and an empowering, women-centred 'natural' experience on the other. Neither of these ideals leaves conceptual space for hospital birth as safe and natural, although opportunity for this clearly exists in England, where approximately two-thirds of women have spontaneous vaginal births, and about a quarter give birth without any medical intervention at all (Downe et al 2001) and where, in practice, most natural births occur in hospital as opposed to out of hospital settings.

Through each of these iterations runs the thread of western citizenship conceptualised as autonomous, rational (where this means enlightened, forward-looking and oriented towards objective knowledge), fair, and liberal towards the individual, differentiated person (Hays 1994; Lupton 1997b; Miller 2005), and the associated ideation of the consumer as autonomous, rational, informed, educated (e.g. Fotaki 2010; Dixon et al 2010) and motivated by self-interest, efficiency, and virtue (Hirschman 1970). These powerful cultural discourses may be liberal by intention, but also place demands of responsibility, rationality and justice upon individuals.

Bourdieu's (1984) thesis of social distinction provides a means of bringing these disparate forms of idealised norms and identity conferral or 'othering' within a single analytic framework, and with potential application to understanding elements of constraint and agency experienced by women. The different kinds of capital available to individuals provides opportunity for a nuanced understanding of acquired beliefs, whilst at the same time generating an awareness of cultural discourses which serve as narratives of distinction. However, Bourdieu's work does not seek to account for perspectives of risk, and existing empirical literature situates perceptions of risk and safety at the core of birth place decisions at policy, practice and individual levels, so the need for a theoretical basis upon which to explore these is clear. The earlier discussion of socio-cultural perspectives of risk proposed that, despite some limitations, Douglas and Wildavsky's (1982) cultural theory of risk has a range of insights to offer, and is based on precepts that are sufficiently coherent with Bourdieu's sociology to permit an integrated theoretical approach. Both of these theoretical frameworks are therefore used in conjunction here, to underpin analysis of individuals exercising birth place choice in a social context of contested risk, and encountering the limits of agency.

Summary: choice, risk and agency in birth place decisions

This chapter has drawn together a range of conceptual debates, each of which has consequences for the individuals' lived experiences of deciding where to give birth. The first section focused upon the conceptual basis for choice in policy, expanding

upon the earlier policy analysis, and arguing that although English health policy seeks to democratise choice in health care through a consumerist model, demands for choice and empowerment in birth decisions arose in response to a feminist and liberal humanist agenda. Choice policy is then enabling by intention, but may conceptualise women and birth partners as autonomous rather than relational, and presupposes that choice is available to all when life contexts may restrict this.

The medicalisation of birth thesis contains many elements associated with constraint; knowledge is legitimated by particular and powerful groups and a vision of birth as potentially dangerous, and safe only in hindsight is super-imposed upon accounts of birth as a natural event occurring in a social or community context. Rooted in a techno-scientific paradigm, this conceptualisation of risk generates the morally imbued expectation that 'responsible women have safe births in hospital', which must be expected to serve as a constraint upon choice. A counter argument holds that women are empowered through medical birth, and many choose this not through false consciousness but because it meets their needs better than an alternative midwifery model. According to this view, if medical birth is constraining, then midwife-led birth is equally so; it claims to emancipate women from medical control, but neglects their socially orchestrated need for medical safety in the face of uncertainty, and for effective pharmacological pain relief. Although social scientists have explored birth from the perspectives of women, little is known about how women and partners in England make sense of these debates and what influences these impose upon birth place decisions, and these issues of choice in a particular socio-cultural context are explored within the first research question addressed by the study (see below).

Bourdieu's (1984) social distinction thesis proposes that that on balance, choice is likely to be constrained rather than enabled, although this is open to empirical enquiry. While Bourdieu's broader sociology of practice underpins existing socio-cultural research into birth and motherhood (e.g. Jordan 1997; Miller 2005; Behague et al 2008) and contemporary culture (Lawler 2008), the influences of social 'distinction' and taste upon individual agency and constraint have not been explored in relation to

birth choices in the UK or elsewhere, and these issues inform the first and second questions outlined below.

Birth safety and risk are morally politicised in England, and debates are conducted by powerful proponent groups with high levels of media exposure, but how individuals make sense of contested accounts of birth risk and safety, or the extent to which their accounts of birth risk are modified over time is rarely explored. Cultural theory provides a framework for analysing individual risk patterning in birth place decisions, and for identifying trajectories of change over time, in response to the events of pregnancy and birth. Despite broad application to other fields, cultural theory has rarely been used in interpretative studies and not yet been applied to the study of how individuals perceive birth *place* risk and safety; the final research question addressed by this study is underpinned by the cultural theory framework.

Based on the socio-cultural approach outlined here, this research aims to explore the experience of making decisions about place of birth in contemporary English NHS maternity services from the perspectives of women and their partners, and to identify factors that constrain and enable their decisions along with individual selections of risk. The research addresses the questions outlined below, and the methodological approach to the study is set out in Chapter 4.

Research questions

1. What is the *process* of choosing where to give birth, from the perspectives of women and their partners receiving English NHS maternity care, and how do socio-cultural contexts impact upon this?

    - What factors influence the choices that women and their partners make?

    - Are cultural norms acquired through exposure to familial, educational or peer perceptions of birth risk and safety?

- What factors serve to constrain or enable birth place decisions?

2. Do birth place preferences change in response to events during pregnancy, labour and birth?

    - Do women and their partners feel able to revise their decisions in response to events of pregnancy and birth?

    - What is the impact of being involved in decision making on how women make sense of birth experiences in the early postnatal period?

    - How might this influence decisions taken in future pregnancies?

3. What perceptions of risk and safety are held by women and their partners in relation to birth, and to different possible places of birth available through contemporary English NHS maternity care (OU, AMU, FMU, home)?

    - To what extent are perceptions of risk shared, disputed and negotiated between women, their partners, and their health professionals?

    - How are individuals risk perceptions patterned?

    - Is there evidence that individuals select some kinds of birth place risks over others, as cultural theory predicts?

Chapter 4: Research design and methodology

'Hearing voices': Exploring birth place decisions through longitudinal, narrative, interpretative research

> We cannot give voice, but we do hear voices that we record and interpret. (Riessman 1993, p.8)

Introduction

The preceding chapters outlined the policy context of birth place decisions in England, and reviewed empirical and conceptual literature, leading to a set of key research questions to be addressed. This chapter describes the research design for the study and explains the steps taken to answer these questions. As in previous chapters, the terms OU, FMU, AMU and home birth are used to describe the options available to women and pregnancy risk categories reflect advice contained in the NICE *Intrapartum Care Clinical Guideline* (NCCWCH 2007).

The overall aim of the study was to explore the experience of making decisions about place of birth in contemporary NHS maternity services, from the perspectives of women and their partners. A narrative, interpretative method was chosen because this approach seeks to elicit subjective accounts which arise from the socio-cultural context of participants' lives, and facilitates naturalistic enquiry. The narrative method described here draws upon the hermeneutic tradition associated with Ricoeur's (1984) work, which places the interpretative focus on the meanings intended by speakers and takes into account the historical and cultural context within which narratives are formed (Patton 2002, p.114).

The research questions for the study arose from the earlier chapters, which identified that much research into birth place decisions has been undertaken in countries with very different socio-political situations to those of the UK, and that despite a long history of GP and midwife-led units (both FMU and AMU) within NHS maternity care, few studies have explored service user perceptions of these particular alternatives. [1] Even fairly recent national surveys (Redshaw et al 2007; HCC 2008) have also not asked women to differentiate between AMUs and FMUs, because even if these are available where women live, the terms used to describe these are too varied to allow categorisation within a survey question.

The appropriateness of women's choice of place of birth has also been contested over several generations through professional and media debates about birth risk and safety. In order to better understand the impact of these factors on the process of deciding where to give birth in contemporary maternity care contexts, this study used an in-depth narrative interview method. Previous studies have usually studied birth place decisions retrospectively, so this research used a prospective design and followed the same group of participants throughout pregnancy and birth, to explore the impact of events during pregnancy and the influence of familial and partner relationships upon this decision. By recruiting women and partners from a range of NHS trusts, each of which offered different birth place alternatives, it was also possible to explore the impact of local service provision upon their decisions. Social class differences in birth preference have been identified in research from other countries, but much UK interpretative research has focused upon the views and experiences of relatively affluent, educated women. To address the lack of qualitative data pertaining to women and partners from a range of different backgrounds, this study was designed to recruit a socio-culturally diverse sample. The overall research design is then a longitudinal, narrative, interpretative enquiry, with a diverse sample of women and partners drawn from three NHS trusts in England, and the design and conduct of the research are outlined in the discussion which follows.

[1] English GPs are now rarely involved in intrapartum care (Smith et al 2010).

Research context

This study was undertaken at a time when women's awareness of birth place choice was growing and professional and media discourse variously championed birth safety and women's choice, and these debates influenced both the study and the fieldwork interviews. The research was funded by the National Institute of Health Research (NIHR), and is an adjunct study to the national Birthplace in England programme of research,[2] and was also adopted by the King's NIHR Patient Safety and Service Quality research centre.[3] As well as providing collegiate support and embedding the research within a multi-disciplinary academic infrastructure, these links informed the development of the research through providing continual exposure to debates about safety, quality and place of birth from a wealth of different perspectives.

This chapter first outlines the rationale for the research approach and discusses the epistemological position of the study. Then, the research design and method are described, and this is followed by an account of the conduct of the research. The chapter concludes with a summary of the data analyses.

Rationale and justification for the methodological approach

Epistemology

The earlier discussion of socio-cultural perspectives of risk (see Chapter 3) positioned this study within a weak constructionist approach, where risk is real but 'inevitably mediated through social and cultural processes and can never be known in isolation from these processes' (Lupton 1999b, p.35). Reflecting this position, the research is methodologically framed within a 'hermeneutic realism' paradigm (Liamputtong and Ezzy 2005, p.37) which proposes that 'there are independent knowable phenomena, but our knowledge of them is always shaped by culture and socially constructed'. The social world is considered to be present and subject to observation, but there is also an acknowledgement that 'events and narratives endlessly inform and influence one another' (Ezzy 1998, p.178). In the discussion below, the reasons for using a narrative

[2] https://www.npeu.ox.ac.uk/birthplace
[3] http://www.kingspssq.org.uk

approach are outlined, and the consistency between narrative epistemology and a hermeneutic realist approach are further explored.

The potential contribution of narrative enquiry to an exploration of birth place decisions

A narrative approach was used in this research for a number of reasons. It provides a means for analysing how accounts are ordered and structured, and for assessing the moral positioning of the self as a protagonist within the account. It also lends itself well to longitudinal research, through recording and documenting accounts that reveal change over time. The justification for the narrative method is discussed below, and the epistemological basis for claims to truth or trustworthiness arising from this method is also considered (Riessman 2009, p.184).

Epistemological congruence with longitudinal research

The term narrative is variously used to mean stories, accounts, oral traditions (Riessman 2008; Stainton Rogers 1991), and narrative study has roots in a range of disciplines, including literature, linguistics and, more recently, social sciences (Czarniawska 2004). Narrative method is valuable to interpretative, longitudinal research because, as Miller (2000, p.311) discusses, 'narratives are interpersonally constructed as people make sense of what is happening to them in relation to past events and future expectations and in relation to other actors'. According to this view, narratives contain more than a series of events to be recounted. They also contain information about how events are interpreted by the speaker, and further knowledge might be revealed through how events and their consequences come to be organised by speakers within dialogues. It is this process which links narrative epistemology to hermeneutic reasoning, as meaning is attached to accounts and becomes enfolded into the narrated story, which in turn contributes to the reasoning behind subsequent actions and intentionality.

Moral positioning of the self

Central to an understanding of the contribution of narrative is the argument that narratives contain both story and plot – they are a way of explaining 'what happened

and why it is worth telling' (Bruner 1991, p.12). In relation to the story, Riessman (2008, p.86) discusses the 'teller's problem', or the need to 'convince a listener who wasn't there' of the events and compelling nature of the account (Wolf 1988, in Riessman 2008, p.86). Similarly, Bruner (1990, p.113) argues that through telling a story, individuals construct or reconstruct events in a form that makes sense to them. This has been described as the performative nature of narrative, which arises because the existence of an audience introduces a dialogue between the account and the observer (Riessman 2008; Langellier 1999), and the telling of the story includes evaluation, political persuasion and moral positioning (Langellier 1999, Baruch 1981; Bury 2001; Ehrich 2003), processes which prove particularly valuable to addressing the questions posed by this research.

The way that a narrative is presented contains information about the values, beliefs and work undertaken to position the self in the story, and when there is moral work to do, some of the account may be hidden, unvoiced or suppressed. As Bury (2001, p.277) argues, narrative research is concerned both with 'what is explicit and what is hidden'. A narrative approach to this research is then valuable because it highlights the opportunity to hear an account from an individual (or, as is sometimes the case in this study, a couple) perspective, to listen to subjective experiences and links made by respondents to cultural referents, and to compare across accounts to determine which aspects are discussed readily, and which are kept from public view. The concept of performativity provides a way of observing how individuals make sense of their identity in relation to their social world; as Bruner argues, the unit of analysis then moves beyond the individual as an atomised, self-contained being and shifts to the individual within culture, where this may refer to family culture or positioning one's own or familial mores, rules and metaphors within a wider national context (Bruner 1990, 2001).[4] This final point is central to the justification of a narrative approach within this study because the focus of analysis then incorporates the content of the

[4] For example, Bruner (1990, p.127-138) discusses an American family's use of 'private' and 'public' to discriminate between our 'home' values (open, sharing) and their different versions of 'the real world' , which might be exciting in some ways, but also less safe and trustworthy than the family's shared space.

narrative, the way an account is constructed and presented, and the links made by the participant to wider cultural discourses and their subjective evaluation of these.

Narrative, time and truth

The second aspect of narrative enquiry with relevance to the study method is the concept of plot, meaning the temporally sequenced order of events, and the process of 'emplotment', which 'makes an account a narrative' (Lawler 2002, p.245). The centrality of time to narrative enquiry influences the methodological opportunities afforded by conducting longitudinal narrative research. It also has bearing on the epistemological truth claims arising from such research, and it is the latter issue which is considered here. Like other narrative theorists, both Lawler (2002) and Bruner explain emplotment with reference to Ricoeur's notion of 'human time' rather than abstract or 'clock' time (Bruner 1991, p.6). Ricoeur's analysis of narrative and time proposes that nature of memory and expectation leads individuals to organise narratives into timelines, but because memory of experience alters with the passage of time and events, the activity of narrative also generates retrospectively organised accounts and reconstructions, and hence the meaning of narrative truths should also be considered temporal, and subject to continual revision (Ricoeur 1984 pp.3–10).

Recognition that memory can be unreliable undoubtedly invokes questions of truth and validity within narrative research, and this represents a fundamental critique of the method. Yet the core premise of narrative enquiry, as Bruner (1991, p.4) argues, is that, 'Narratives ... are a version of reality, whose acceptability is governed by "narrative necessity" rather than by empirical verification ... so that narrative "truth" is judged by its verisimilitude rather than its verifiability' (ibid, p.13). Elsewhere, Bruner extends this argument through proposing that there is something to be learned by the way in which accounts are made, so that the enquirer looks beyond the content to the form of the narrative account, and draws on Polkinghorne to outline the crucial link between identity construction and narrative:

> We achieve our personal identities and self-concept through the use of the narrative configuration...we are constantly having to revise the plot as new

> events are added to our lives. Self then, is not a static thing or a substance, but a configuring of personal events into an historical unity, which includes not only what one has been but also anticipations of what one will be.
>
> (Polkinghorne 1988, from Bruner 1990 pp.115–6)

What these perspectives on the truth of narrative share is a sensitivity towards post-modern configurations of meaning and representation, and although the study adopts a realist approach towards interpretive research, the influences of post-modern thought are undeniably present and affect the study design and data analysis in a number of ways. After Frank (1995, p.4), the term 'post-modern' is used here to reflect the argument that 'over a period of time ... how people come to think about themselves and their worlds has changed'. The shift toward post-modernism is perceived to have altered the relationship between individuals and their accounts of their lives, as people use voice to engage with, and construct meaning through their narratives. This in turn contributes to conscious attempts to engender a more equal relationship between interviewer and participant in social research as interview data are thought of as co-constructed, emerging from collaboration between each party (Rapley 2001; Fontana 2002). In this study, the power relations resulting from health research which originates in policy concerns were carefully scrutinised, and ways of including 'unarticulated voices' were sought (Fontana 2002, p.162). Participants were also invited to discuss and negotiate where and when interviews would take place and how they would prefer to be interviewed. However, and again agreeing with Frank (1995, p.5), whilst the post-modern influence is acknowledged, this is not presumed to be a universally shared experience. Rather, the study aimed to illuminate the breadth of participants' accounts, which ranged from traditional, modernist experiences of health care to more reflexive positions akin to post-modern subjectivity, and to observe how these different stances informed individual expectations of maternity care.

Summary: Justification for the use of a narrative approach

The value of narrative to a prospective study of birth place decisions is summarised as follows. The narrative approach is epistemologically coherent with the study aims. It provides a means of conducting a longitudinal interpretative enquiry and eliciting accounts from the perspective of participants, whilst also acknowledging the objective realities of structured social lives and encounters with health professions and institutions.

Within the context of this study, narrative is understood as occurring when 'a speaker connects events into a sequence that is consequential for later action and for the meanings that the speaker wants listeners take away from the story' (Riessman 2008, p.3), so that story and plot, when analysed together, produce meaning and reveal sense-making. The beliefs expressed within narrative accounts provide a unique opportunity to explore prospectively and detail whether and how sense-making shifts through longitudinal interviews with the same participants. Within narrative qualitative enquiry, establishing the veracity or otherwise of events described is considered less central than the pursuit of an authentic rendition of subjective worldviews and of the effects these bring to bear on construction and evaluation within the speaker's account.

This conceptualisation of narrative method draws on both psychological and social science disciplines and applies these ways of knowing to an enquiry which in turn is contextualised by governmental policy of providing choice in maternity care. The next section describes the process of undertaking the research, and explains how the narrative method was implemented within the study.

'Birth place decisions': Research design and method

In this section, the research design is outlined. Briefly, the study involved longitudinal narrative interviews with a diverse group of 56 participants (41 pregnant women and 15 partners). Initial interviews with women and partners were conducted in early pregnancy, usually between 16–24 weeks, at participants' homes. Most interviews were individual, but some couples opted to be interviewed together. Short follow-up telephone interviews involving women only were carried out in the last four weeks of pregnancy, and the final, postnatal interview again took place in women's homes up to three months after birth. The study design is also outlined in the research protocol which accompanied the application for ethical approval (see Appendix A).

Access, ethical approvals and research governance

I visited the heads of midwifery and then midwifery managers at each site to gain in principle approval and all three sites agreed to participate. At this point, approval from an NHS Research Ethics Committee was sought along with separate research governance approval from each individual trust (see Appendix B for approval documents). Because the study was funded by the NIHR, it was also admitted onto the NHS Clinical Research Network portfolio database,[5] which means it could be identified in an online search by other investigators interested in the same field, and that NHS trusts involved were reimbursed for supporting recruitment to the study.

Ethical issues

The application for ethical review addressed a range of issues raised by the study; key amongst these were the potential time-burden of participating in a qualitative interview study with two follow-ups, and the possibility of invoking emotional distress during the course of interviews. This might not necessarily arise from the study questions, but could occur if participants had previous experiences of pregnancy loss, or developed complications during the current pregnancy. The possibility of instilling anxiety by anticipating the events of birth were also considered, along with the

[5] http://www.crncc.nihr.ac.uk/about_us/processes/portfolio

likelihood of causing dispute or disagreement between women, their partners and their health professionals.

The application described plans to balance the burden upon participants by ensuring as far as possible that interviews would be held at times and venues most convenient to respondents, and willingness to take part in follow up interviews was sought at each stage. The application also outlined a detailed strategy for responding to distress, which involved allowing participants time to talk and to stop the interview at any time if they wished, and providing an opportunity to all participants to debrief after the interview, either with myself or with a counsellor if that seemed more appropriate. In practice, none of the participants stopped the interviews or sought post-interview debriefing, although one participant did recognise that his level of distress was greater than he had previously realised, and as we debriefed at the end of the interview, he planned to talk about how he felt with a friend. The debriefing information was included in a leaflet which also contained details of local trust Maternity Services Liaison Committees (MSLCs), web resources relevant to pregnancy choices, support organisations and a note entitled 'what happens now', which reminded participants when I would contact them next, and how they could get in touch with me (or my supervisors) between interviews. This leaflet was given to participants at the end of the interviews.[6]

Although some respondents did describe emotional distress during antenatal interviews, more powerful emotional experiences occurred during postnatal interviews, when respondents discussed their relatively recent birth experiences. As Ribbens (1989, p.586) discusses, whilst a research interview is not a therapeutic or counselling situation, by 'listen[ing] empathetically and creating rapport, the researcher intentionally invites emotional engagement', which implies reciprocity. The distinction between eliciting information and a therapeutic exchange may become unclear, or difficult for both parties to navigate. Several participants reflected that the opportunity to speak uninterrupted (as the narrative method encourages) about their

[6] These were modified to provide local contacts within each NHS trust, and partner leaflets had slightly different web resources and support organisations.

experiences was beneficial, and helped them to make sense of the events that had taken place. Riessman (2008, p.40) also acknowledges the emotional content of narratives and discusses the way that emotions expressed and experienced during interviews, by both participants and interviewers, become part of the narrative account, requiring the interviewer to 'bear witness' to the respondent's feelings (ibid, p.41). Recognising emotional experiences is then part of the method, but the means of responding appropriately and proportionately to distress was carefully considered beforehand, and a supervisory protocol for responding to emotional distress, or other issues raised by participants during the research, was prepared in advance.

Site selection and access

The fieldwork began in early 2009, when potential NHS trust sites were selected and initial approaches made. Despite the *Maternity Matters* policy guarantee to provide choice of place of birth by the end of that year, marked differences amongst trusts in their provision of birth place choices persisted (Dodwell and Gibson 2009; NCT 2009) and although many had started to establish AMUs, these were still not widespread. This meant that women were encountering different choice scenarios, depending on where they lived, and reliance upon local rather than national criteria for admission to home birth, AMU or FMU further complicated this picture (Rowe 2010). Because the research intended to describe making a decision in the context of what was available, and to be relevant to trusts with different provider models, it was important to include NHS trusts which offered different options. As previous research shows that distance and travel times contribute to women's decisions (Green et al 1998; Combier et al 2004; Pitchforth et al 2008; Dodwell and Gibson 2009; NCT 2009), the inclusion of trusts with diverse geographical settings was also indicated. The sites were therefore selected firstly on the basis of varied service provision and secondly, on the basis of variation in distances travelled to access care. The site which provided the broadest range of options also covered a large geographical area; women had to consider both the time travelling to different settings, *and* time for transfer to more acute settings.

The research was undertaken at three NHS trust sites (Southcity, Eastcity and Westfield trusts) each of which are pseudonyms; further contextual details of these

are provided in Chapter 5. At the time fieldwork was undertaken (October 2009–November 2010), the sites varied in their provision of birth place options as follows:

- Eastcity NHS trust offered either consultant OU *or* home birth, with no AMU.
- Southcity NHS trust offered either consultant OU, an AMU or home birth.
- Westfield NHS trust offered two consultant OUs, one AMU, two FMUs or home birth

Sample and sample size: addressing the implications of diversity for qualitative enquiry

As the empirical literature review demonstrated, qualitative enquiries into birth place decisions have often relied on small, homogenous samples usually of white, affluent participants (e.g. Abel and Kearns 1991; Davis-Floyd 1994; Jomeen 2006; Dagustan 2009; Viisainen 2000) and few researchers have sought to include the views of men, or women from a range of socio-economic backgrounds (exceptions include Zadoroznyj 1999; Houghton et al 2008; Viisainen 2000). It follows that what is known about birth place decisions has its origins in very specific social milieux.

The study therefore aimed to recruit a diverse sample, and to include participants from a range of socio-economic, cultural and ethnicity backgrounds. The sampling approach used within the study was maximum variation sampling, which Patton (2002, p.234-5) defines as 'a strategy for ... capturing and describing the central themes that cut across a great deal of variation'. Indeed, an implicit aim was to determine whether a preoccupation with birth risk would be found consistently amongst a range of respondents. This marks a divergence between this study and a grounded theory approach which had implications for analysis, because a maximum variation sample is unlikely to reach a point of data saturation that theoretical sampling within grounded theory aims to achieve (Sandelowski 1995; Coyne 1997). The sample variation was not stratified or intended to be representative in quantitative terms, but instead attempted to achieve both detailed and in-depth accounts and evidence of 'shared patterns that cut across cases and derive their significance from having emerged out of heterogeneity' (Patton 2002, p.235).

There are few guidelines on sample sizes in narrative research, but as Sandelowksi (1995, p. 183) argues, the sample size should ideally be appropriate to the aims of the enterprise for which the research is undertaken, which she suggests is:

> ... one that permits – by virtue of not being too large – the deep, case-oriented analysis that is a hallmark of all qualitative inquiry, and that results in – by virtue of not being too small – a new and richly textured understanding of experience.

It was also important to recruit women who both did and did not feel they had a choice of place of birth to participate, as well as men (or other birth partners) whose views about planned place of birth were relatively unknown. The justification for this was that the benefits of choice within the public sector are argued to extend to all service users,[7] regardless of whether their personal characteristics or clinical situations might ultimately limit the choices available to them.

Finally, the study aimed to recruit participants with diverse socio-economic, cultural, national, and relationship backgrounds, and used Bourdieu's (1984, 1990) theories as a basis for incorporating notions of capital beyond economic means. Although Bourdieu's concept of class is in many ways problematic (see Chapter 3), the research questions sought to explore whether it is indeed the case that affluent class discourses constrain decisions made by women from less dominant groups, and this analysis required inclusion of single and younger women, those who do not work or hold graduate qualifications, and to women from different ethnic and cultural groups, including those who do not speak English as a first language. Such groups have sometimes been excluded from qualitative research on the basis that they are unable to provide information-rich or reflexive data (e.g. Sandelowski 1995; Coyne 1997, p.624; Miller 2000; Dagustan 2009), and have also proved more difficult to recruit.[8] However the narrative approach means that the different ways in which people

[7] 'Properly designed, such systems will deliver services that are of higher quality, more responsive and more efficient ... Moreover, they will also be more equitable or more socially just' (Le Grand 2007, p.2)
[8] Miller (2000) recounts her intention to include 'working class' participants in her study of transition to motherhood, but almost all who were willing to be interviewed were middle-class women.

divulge their experiences and order their stories can be compared within the analysis, rendering accounts by less talkative respondents just as valuable to the study as those who articulate thoughts in greater depth. The study had also secured resource for interpreter and translations services, so information sheets could be translated into other languages, and interviews could be conducted with interpreters present, meaning that women and partners without fluent English could participate. The inclusion and exclusion criteria were therefore designed to be broad, and are summarised below.

Inclusion and exclusion criteria

Study inclusion criteria:

- Pregnant women referred for antenatal care at the identified NHS trusts.
- Partners identified by the pregnant women respondents.

Exclusion criteria:

- Women over 20 weeks pregnant at time of accessing antenatal care (because these women will not have had the early pregnancy opportunity to think about where to give birth).
- Women under 16 years of age, because this younger age group are likely to be more dependent on their families for support and less in a position to make an autonomous decision about where to give birth. It would also be more complex to obtain informed consent from respondents below the age of 16.
- Women over 8 months (36 weeks) pregnant at first encounter, because it would be difficult to track any changes in their decisions from so late in pregnancy, and much of their account would be retrospective.

Recruiting at each site

After obtaining approval from each of the trust R&D departments, I began recruiting at midwives' antenatal and booking clinics (see glossary), where I sat in waiting rooms and introduced myself to women and explained the purpose of my research and what

it entailed. If women were accompanied by interpreters, I asked the interpreter to help explain the study to them and provided translated information sheets. If women were interested in participating, I gave them study information sheets, and contacted them within a week to make the necessary arrangements. Overall, about a third of women I approached fulfilled the criteria *and* were willing to consider being interviewed, and a third of these ultimately took part.

Some challenges of recruiting a diverse sample

Initial recruitment took place between October and December 2009. I attended 12 clinics and provided information to 67 women, of whom 22 agreed to participate (33%). Although the participation rates for the study seemed low, this was anticipated in view of the longitudinal interview design. However it was also apparent that although almost half of the women approached were from black or ethnic minorities (reflecting the local population), only one black woman agreed to be interviewed, and the participant group was not proving to be ethnically diverse. Whilst the concept of diversity within this study always intended to encompass educational, social and relationship backgrounds, non-graduate women, and women from more deprived localities also proved harder to recruit. It was noticeable that women who showed interest in participating were similar to me; they were comfortable with the concepts of research and choice, and were usually (but not always) white women whose accents, manner and engagement often suggested a graduate education. Riessman (1987), in relation to US research, proposes that mutual recognition of cultural similarity facilitates research relationships between women, and argues that women with shared language and national identity can relate to each other *across* socio-economic class differences, although this is not necessarily the case in the UK, where social class differences remain more pronounced and are evident through dialect (Kerswill 2007, p.51). Women from less advantaged backgrounds often said they had no choice about where to give birth and were baffled by the suggestion that this was something we might discuss in an interview. This meant that I was particularly interested to involve them but needed to think of ways to overcome their understandable resistance.

The barriers to diverse participation hence went beyond the difficulties of fluency in English that the design had anticipated. It seemed that many women associated my self-presentation as a white, postgraduate researcher as too markedly different from them for there to be common ground or interests. Although the study leaflets and information sheets deliberately used the phrase *decisions*, women's responses showed that they perceived the study to be about choice. Whilst there is good evidence that choice is valued across socio-economic groups (e.g. Dixon et al 2010; Fotaki 2010), in relation to birth experience, the existence of an historical, class differentiation between middle class women's investment in the personal experience of birth and working class women's greater ambivalence and apprehension about birth has been recognised in the literature (Nelson 1983; Martin 1987). Being willing to discuss choice of place of birth would mean some women self-identifying with the former category, which they were naturally reluctant to do. Like Miller (2011, p.31), I sometimes felt 'that the fine line between persistence and coercion was trampled' (or at least blurred), as I engaged extra effort in trying to engage women through explaining that I was particularly interested to find out why they felt they had no choice about place of birth.

Although mindful of debates within feminist and other literatures about recruitment of others and attempts to give voice to for those from different ethnic or socio-economic groups (e.g. Oakley 1981, 1998; Reid 1983; Clarke and Olesen 1999; Epstein 2008; Lawler 2008),[9] I remained keen to broaden the socio-economic and ethnic diversity of the respondent group. In response to similar challenges, US researchers have developed methods for engaging individuals from different ethnic minority groups, but are often less reflexive about socio-economic inclusion. Epstein (2008, pp.807, 815) discusses extensive trust building work undertaken with ethnic minority communities to encourage inclusion in intervention studies. These approaches are designed to respond to distrust in clinical research within these communities due to previous unethical practices in scientific research. Riessman (1990) used same-ethnicity

[9] Lawler (2008, p.23) cites Bell hooks' discomfiting allegation: 'No need to heed your voice when I can talk about you better than you can speak about yourself. No need to heed your voice … Rewriting you, I write myself anew. I am still author, authority. I am still coloniser…'

researchers to facilitate recruitment and interviews with participants in a US study about divorce, but this was not feasible in the context of a single investigator study. After taking advice from women with different ethnic backgrounds and from colleagues, I decided to apply for a substantial amendment to my ethics application in January 2010, so that I could provide £20 vouchers to participants in recognition of the time they contributed to the study.[10] The substantial amendment was approved by the research ethics committee on 15 March 2010, and after this date I provided revised information sheets to all potential participants, which explained that they would receive £20 vouchers at each interview.

How recruitment altered following the introduction of vouchers

Overall, 30% of women participated in the study after information was provided, but recruitment increased from 25% to 59% when £20 vouchers were offered in all three sites. This was a marked increase, and due partly to the vouchers, but providing these also unexpectedly increased targeted recruitment by indivduals known to the respondents; that is, their midwife or interpreter. The vouchers meant that these individuals felt that they had something to offer their clients (as well as asking for something) so they became much more comfortable about inviting women to participate on my behalf, and recruitment of women who required interpreters followed. The vouchers also increased recruitment of women (but not men) from black and minority ethnic groups, and also encouraged single women, less affluent women and some who had not entered higher education to participate.

Recruitment at Westfield NHS trust

In Westfield trust, recruitment took place at an FMU (which provided antenatal clinics for all local women, not just those planning to use the FMU), at a newly built polyclinic, and also via interpreters in February and March 2010. During this time, I received notification that the substantial amendment to the study ethical approval had been approved so I was able to use the new information sheets (see Appendix C). However, and counter-intuitively, it proved easier to recruit a more diverse sample in Westfield

[10] The funds for this were drawn from the research budget, as I had requested funding to widen participation.

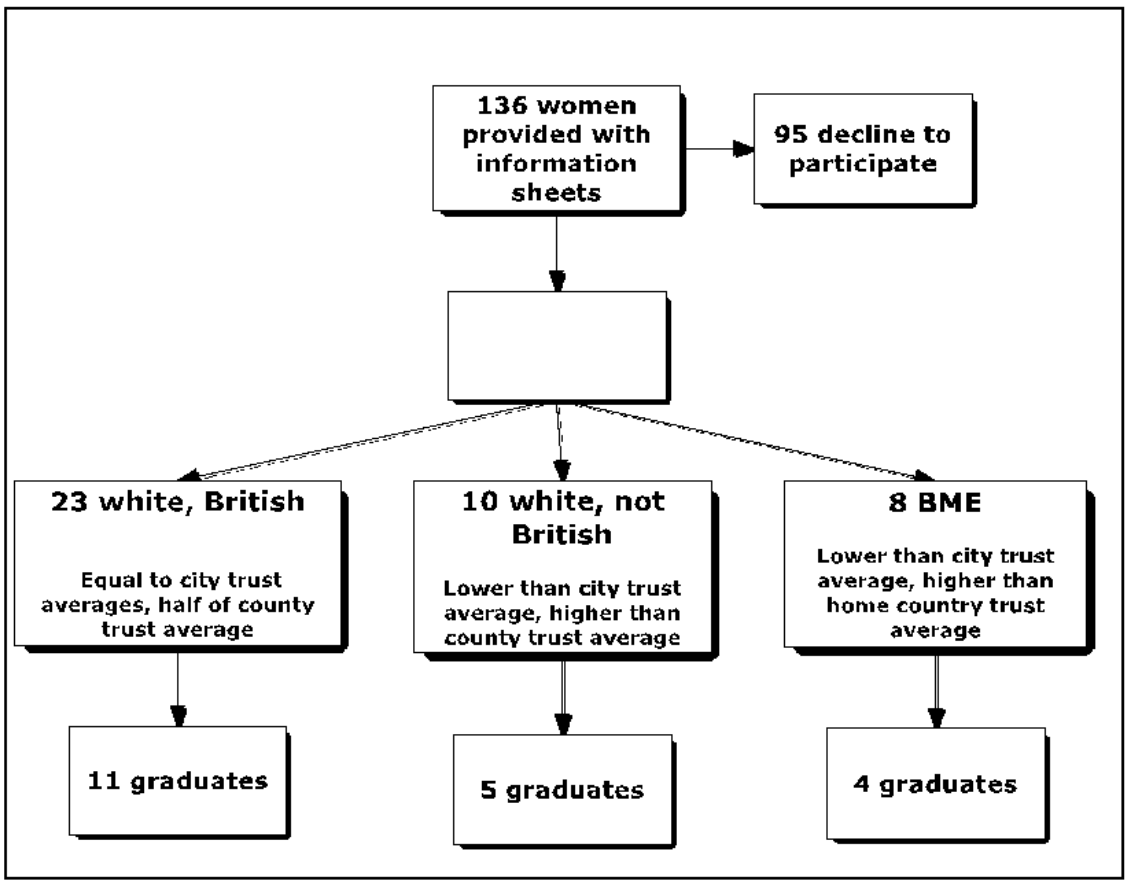
both before *and* after the amendment was agreed. This was unexpected, because the population is much less ethnically diverse; in the three localities within Westfield where I recruited, the proportion of the general population which is white and British ranged from 93%–96%. The population is also considered to be relatively affluent, although the polyclinic was based in a locality which was in the most deprived 20% for the area (IMD 2007) and its Index of Multiple Deprivation score was equivalent to those in the localities served by the Eastcity and Southcity trusts.

In Westfield NHS trust, I was able to recruit younger women, single mothers and women without graduate education. It was particularly noticeable that the ethics amendment helped me to recruit women with diverse educational attainment, because using the earlier information sheets (with no vouchers offered), 30% of women who participated were graduates, which is about average for these localities, but using the new information sheets, this dropped to 20%. The reasons for more diverse recruitment in this NHS trust are unclear, but women in the inner city trusts are routinely asked to participate in many studies, whereas an invitation of this nature is unusual in Westfield, which is served by District General Hospitals rather than large research and teaching hospitals. The clinics in Westfield were also much quieter, so it was often possible to talk to women in greater depth, which essentially meant that a relationship beyond basic provision of information had already been established during the initial contact. The vouchers also provided an additional incentive, which seemed to give those who did not feel having choice was a priority (and who therefore had little to gain from the research), a reason to take part in the interviews.

Combined recruitment at the three NHS trusts

Around a third of women (41/136) who took information about the study later agreed to take part, and in about a third of these cases (15/41), their partners also agreed to be interviewed.

Figure 6 Recruitment of women to study, with ethnicity and graduate status



Overall, fewer women from black and minority ethnic (BME) groups and more white, non-UK born[11] respondents took part than would be anticipated given the regional demographics.[12] Just over half of the women participants were graduates, compared to 40% national average for this age group, indicating that even though there was some ethnic diversity, respondents were *still* more likely to be graduates.

[11] This category includes Europeans, Australians, South Africans, Canadians and Americans, and most but not all speak English as a first language. Others were multilingual, with English in addition to their other languages.

[12] Figure 6 describes the ethnicity and graduate status of women participants only; further information, including male participants' ethnicity, and numbers recruited at each site, is included in Chapter 5.

I had anticipated that it would be easiest to recruit non-English speaking women in the inner city trusts, where many use interpreters for appointments, but in these trusts, interpreters were booked via a large organisation for each appointment, and an ongoing relationship between women and interpreters did not exist. In Westfield trust, the same interpreter usually attended all appointments and in some cases accompanied women during labour to interpret. In Westfield, with help from interpreters, I was able to recruit five women who did not speak English and to conduct antenatal and postnatal interviews with the interpreters present; the interpreters themselves did the end of pregnancy follow-up phone calls. On reflection, it seems likely that the idea of having an unknown interpreter present during an interview in the city trusts would have been off-putting to women, and this may also explain why it was easier to recruit non-English speaking women in the home county trust, where interpreters had a continuous relationship with their clients. It is also important to acknowledge that translation of information sheets into another language did not address whether the potential respondent has literacy in their first language, or freedom to take part in research when this requires additional conduit via husbands or family members, or indeed a shared repertoire of cultural beliefs about whether choice of place of birth is beneficial rather than potentially unsafe.

Overall recruitment and sample diversity

The final participant group does not achieve representativeness in the sense used to generate validity in a quantitative study, but this was not the intention of the sampling strategy. Rather, the research aimed to include a maximum variation sample and this was achieved, at least in terms of variation between experiences and backgrounds. Nevertheless, certain groups (including South Asian women[13] and BME men) were conspicuous by their absence. Where male partners agreed to take part, these were usually in white, relatively affluent couples having their first baby, so that although there is a degree of socio-economic diversity amongst the couples participating, this is more limited than for the respondent group overall. The participant group is described

[13] One Asian woman participated, but a disproportionate number declined. Here, the UK interpretation of South Asian is used, which refers to women whose families originate in India or Pakistan.

in greater detail in Chapter 5, where the link between various forms of capital and birth place choice is proposed more clearly.

Narrative interviewing

As Riessman (2008, p.23) observed, 'narrative interviewing has more in common with ethnographic practice than with mainstream … interviewing practice', because sequential interviews conducted over long time frames lead to detailed, contextualised and sometimes shifting accounts. The main practical difference in the context of this study was that the method aimed to elicit initial, uninterrupted narrative accounts, during which the respondents' responses were unguided. A key reason for using this narrative approach was to avoid framing the interview topics in a way that would predispose respondents to talk *to* particular discourses. The problems of framing have been discussed by Henwood et al (2008) following their methodological reflections on researching perceptions of risk. In their words:

> The reification of risk … exists as a methodological problem when researchers define research situations from the outset in terms of universal notions of risk, and unreflexively import constructions of what that term might mean to participants, rather than treating this as part of the research.
>
> (Henwood et al 2010, p.2)

Given the intention to explore the impact of birth place risk debates upon individuals without importing the assumption that a shared view of birth risk exists, risk framing was a potential problem, so it was important to focus on the experience of making a decision of this nature without inferring that such a decision *ought to* emerge from evaluation of clinical risks. At the beginning of each interview, the following 'narrative eliciting' question was used (Wengraf 2001), and was designed to encourage discussion of birth place decisions without introducing risk as an issue:

> As you know, I'm researching how people decide where to give birth, and in a minute, I'm going to ask you to tell me the story of your pregnancy, and where you think you may give birth at this point in time. Please include all

those events and experiences that were important for you, personally. I'll listen, I won't interrupt. I'll just take some notes in case I have any questions for after you've finished. Please take your time and begin wherever you like...

This narrative question was posed following a brief orientation discussion, during which the information sheet for the study was revisited, and opportunity given for questions to be asked before the participant signed the consent form. Initial narrative accounts ranged from just a few sentences, to around 20 minutes of uninterrupted speech. The narrative section ended when the interviewee indicated that they had arrived at the end of their account.

Home-based interviews

Home-based interviews were proposed for a number of reasons. Firstly, the study involved three interviews, and asking individuals to attend clinical settings would introduce practical difficulties and place quite a time and travel burden upon participants. Secondly, and in keeping with the interpretative nature of the study, I was keen to follow a naturalistic approach by 'studying real-world situations as they unfold' and conducting interviews in a way that was, as far as possible, 'non-manipulative and non-controlling' (Guba 1978, from Patton 2002, p.39–40). This approach sought to acknowledge the normality of home as a place where women and partners might discuss pregnancy and birth together. Thirdly, the use of a clinical setting would be likely to alter the ambiance of the discussion. Home-based interviews allowed participants to relax in their own environment, to dictate the time of day they preferred (including evenings or weekends) and to moderate the intrusion into their personal or private lives.

Of course, none of these justifications is entirely straightforward. Feminist scholarship challenges the notion of domestic home as either safe or normal for women (Abel and Kearns 1991; Taylor 2010), and whilst the burden of travelling to appointments shifted to me as a researcher, participants instead acquired potentially burdensome positions of hosts. Some had tidied up before my arrival, or rearranged their meal plans, others needed to cajole young children or pets to behave in a manner that allowed an audio-

recorded interview to take place. All participants offered me drinks and tried to ensure I was comfortable, so to some extent, there was always a degree of intrusion. However, the majority of interviewees did opt for home-based interviews, and where this was not acceptable, alternative arrangements were made.[14]

Six participants preferred not to have face-to-face interviews, opting for phone interviews instead. This preference was accommodated partly to widen participation, and also to follow the naturalistic principle of sharing control with participants. In practice, phone interviews were shorter, and allowed fewer opportunities to take situational contexts, facial expression and body language cues into consideration. One respondent agreed to take part, but contacted me by email to say she was very busy with work and would prefer a phone interview. We arranged a date and time, and when I phoned the mobile number she had provided, she was out walking her dog. The interview went ahead on this basis, and was very valuable for a number of reasons, but the mode of participation meant that she had made a conscious decision *not* to allow me access to her private, home life. Three interviewees also agreed to participate but did not want the interviews to be recorded; they were willing for me to take field notes and to quote from these, but felt self-conscious with a recording device running.

These experiences alerted me to the issue that home-based interviews required that participants allow me to enter their private homes on the basis of often very brief conversations. The idea that I should be trusted to enter the home emerges from an inequality within the researcher-researched relationship because it stems from the notion of my being appropriately qualified and vetted (by the university as the research sponsor and by NHS ethics and governance processes). Part of the rationale for these processes is to generate assurance that a researcher, even as a student, is legitimated through an external authority. Clearly, some participants were able to make a decision not to allow me access to their homes, but it was noticeably those with high professional standing or postgraduate qualifications who were able to do

[14] All participants were offered a choice between interviews at home or 'another place of their choosing', clinical settings and university-based settings were possible alternatives. In practice, only one participant requested a clinic-based antenatal interview.

this, suggesting that others might possibly have preferred to do so, but felt less able to negotiate the terms of study inclusion. As Ribbens (1989) argues, the metaphor of an interview as a natural situation has its own limitations. To some extent, all interactions are socially constructed and endowed with existing power relations, yet those with less power are unlikely to be able to 'assert power over the research process' (ibid, p.590). This issue was not one that I had anticipated, but as the recruitment progressed, I became increasingly careful to highlight the alternatives available to women and to follow up any cues which intimated that home interviews might be problematic with direct offers of telephone interviews.[15] On balance it seemed more important to access accounts from women or partners who for whatever reason might otherwise not participate, even though some opportunity to gain a rich, contextualised sense of individual experiences might be lost.

Follow up and postnatal interviews

Initial follow up interviews with women only were conducted by phone at the end of pregnancy (weeks 36–40). These were included in the research design in response to reviewer comments that early antenatal interviews might not capture the influence of antenatal classes and hospital tours provided in the latter stages of pregnancy (see Appendix D, Schedule B). These interviews lasted between 5 and 15 minutes and sought mainly to establish whether the planned place of birth had altered since the first interview, and if so, whether this was the woman's preference, or arose for other reasons.

Postnatal interviews took place between 6 and 12 weeks after the birth, and all the participants agreed to these. This time frame was chosen to allow respondents time to recover from the birth, but also to ensure that the events of birth were sufficiently recent to provide good recall. At this stage most women preferred daytime interviews because their newborn babies were more restful than during the evening. Several partners had returned to work and elected to have separate telephone interviews. These did not have the same drawbacks as the antenatal phone interviews, because I had previously conducted face-to-face interviews with them, and the existing

[15] I also made clear that I would make calls and bear the cost of these.

relationship meant the phone interviews were more relaxed. The postnatal interviews were similar in format to the initial antenatal interviews. Each lasted about an hour, and elicited a narrative account of the events leading to giving birth, and also used a semi-structured question schedule to ensure that key questions were addressed during the interview (see Appendix D, Schedule C).

Conducting individual or joint interviews

Although the study aimed to include birth partners whenever possible, it was always likely that some may not wish to participate. When considering this issue, it seemed appropriate to invite women to participate first, and then ask whether they had a partner or birth partner who might also agree to be interviewed. The information sheets made clear that for the purposes of the study, a partner could be anyone that the woman considered to be her key supporter, including friends and family birth partners as well as husband or partners. This meant that single women were explicitly invited to take part, and to nominate their birth partners, and that partnered women could elect to involve a mother, sister or friend if they saw them as their birth partners. The justification for this approach was that it was important to identify the relational influences upon women's decisions, and the social and familial contexts of their deliberations.

The study information sheets requested that couples consider having separate interviews, but also stated that if participants were at all uncomfortable with this, joint interviews could be conducted instead (see Appendix C). This represented a balance between the narrative method, which is usually discussed in relation to individual accounts of self, and a realisation that some couples might find it strange to be interviewed separately about a topic which they viewed as important to them both. There are a number of precedents for narrative interviews with couples, including Ehrich's (2003) research with parents and Baruch's study of parents' 'moral tales' (1981). Page (2002, p.101) argues that interviewing couples separately is important because of the gendered nature of storytelling, where women tell personal tales whilst men recount heroic anecdotes, but also concludes that context of narrative is ultimately more important than gendered features of talk (ibid, p.113). Page's rather

essentialist interpretation of gender in narrative did not prove to be the case in this study, because men sometimes divulged personal emotional accounts, and women also varied in their narrative positions, with some preferring brief stories with mainly factual details. In relation to household research, Valentine (1999, p.71) discusses benefits of both individual and joint interviews: separate interviews allow participants more freedom to express their own individual views, which is important given that birth place decisions might be contentious and cause conflict between partners. On the other hand, Valentine (ibid, p.69) argues, 'one of the most valuable aspects of a joint interview is that participants frequently challenge or modify each other's account', and again this was pertinent to a study which intended to explore negotiation and moral positioning.

Guided by a naturalistic approach, when I encountered resistance to separate interviews early in the fieldwork, I assumed the respondents to be the best judge of their preferred interview context and modified the design accordingly. Altogether, 15 partners took part, one of whom was a female birth partner. For antenatal interviews, 8 couples elected to have joint interviews, but only 4 couples had joint postnatal interviews, due to partners being at work during the day. The initial preference for joint interviews may have been rooted in what Taylor (2010, p.15) describes as the 'couple narrative', alluding to a normative social expectation that couples do things together and so perform their couple identity. Couples' discussions prior to interviews also showed that they suspected I might be trying to test the unity of their views about birth, although the information sheets had emphasised that this was not the case. Joint interviews actually proved valuable to the research. As Valentine (1999) had observed in her study, couples disagreed openly and *did* challenge each other's views, and the balance of turn-taking and deferral to each other within couple narratives also provided rich information about couple negotiation of birth place decisions.

Working with interpreters

The importance of addressing language difference in health research is tackled by Murray and Buller (2007, p.206), who argue that individuals who do not speak English are effectively barred from participation in health research, but also recognise that

multilingual research can be difficult and expensive to conduct. Recruitment of non-English speaking participants is rarely attempted in qualitative or narrative research, due to the perceived difficulties of conducting in-depth interviews through an interpreter. There are exceptions to this, including Riessman's (2000) study of infertility in South India. However, and as Riessman (2000), Miller (2005) and Langellier (2001) also argue, language is only one of many potential barriers to consider. If participants from different countries and cultures are included, then it is also likely that the research will occur across barriers of culture, national identity, ethnicity and socio-economic class, and any of these factors may disrupt mutual understanding within a research encounter, or render analysis more difficult.

As Riessman (2000, p.116) discusses, the presence of an interpreter shifts the dynamic of interviews. It is also the case that eliciting narrative becomes more challenging, because the women's accounts are being continually relayed by the interpreter, which manifests as a breaks in the narrative form. Interpretation also occurred on several levels as the initial translation of speech often required a second translation to explain *why* a woman might have a particular view. For example, during a postnatal interview with Jia,[16] it became clear that although she felt she had benefited from a water birth, she also blamed the birth pool for her swollen feet and ankles after the birth. The interpreter explained to me that women from Jia's country are encouraged to keep away from water during pregnancy and to avoid immersion, so Jia felt she had been ill-advised to stay in water for so long. The multi-level translation work undertaken by interpreters during research interviews is therefore intensive, and the interpreters spent further time outside interviews explaining women's different cultural expectations of maternity care to me.

[16] All respondent names are pseudonyms.

Data analysis and measures of authenticity

Data analysis

Data analysis took place throughout the study, partly to ensure that the antenatal data analysis for each participant was conducted before they gave birth. The staged prospective analysis was intentionally 'future blind', meaning that it was not informed by where each individual actually gave birth, or their experience of this, and instead preserved their perceptions of how they envisioned their dilemmas at the time of the interview. Further details of how the narrative approach was maintained throughout the analytic process are provided below. The analytic approaches are outlined in turn, and the measures taken to enhance the quality and validity of the research are also discussed.

Narrative data analysis

In this study, two forms of narrative analysis were used: thematic narrative analysis and structural analysis. The first of these draws on principles of grounded theory analysis, but was modified to include deductive as well as inductive codes. The second approach is markedly different because it addresses narrative text as a whole, and analyses the development of plot within the story. Structural analysis pays close attention to the construction of narratives, and is not feasible with a large corpus of data, but valuable for micro-analysis of selected cases.

Identifying data and preparing texts

As Riessman (2008, p.53) argues, probably the most intrinsic difference between narrative and grounded theory approaches is that in narrative research, the intention in all types of analysis is to maintain the integrity of accounts and keep text and context together, rather than deconstructing data into themes and rebuilding these into inductively derived syntheses. This requires that the data are treated differently, from transcription through to analysis, and these processes are described below.

The final participant group numbered 56 participants, and the study design meant that each individual, or couple, took part in at least two narrative interviews averaging an

hour in length as well as the shorter end of pregnancy follow-up interviews (with women only). Altogether, 141 interviews took place. The recorded interviews were all transcribed verbatim by a professional transcriber who was familiar with qualitative research and health terminology.[17] Pauses (and timed lengths of these), vocal utterances (such as 'mm', 'OK' or 'ah') and turn-taking between myself and interviewees were noted at my request, in order to record how the interview narratives were co-constructed between 'teller and listener' (Riessman 2008, p.40). I developed familiarity with the interview texts having conducted the interviews and written contemporaneous field notes. I also read the transcripts fully before conducting each follow-up interview, and again during the coding and analysis stages, when I often listened to sections of the MP3 recordings as well, so that tone, inflexion and pace of speech were included in the analyses.

Field notes were written before and after the main antenatal and postnatal interviews; some of these were transcribed, but others were handwritten and kept in field note journals. The full data set was therefore large, and to help manage the analysis, all transcribed interviews and field notes were imported into N-Vivo (version 8). This software helped to manage the extent of the data set, and supported a systematic approach to analysis. Because N-Vivo was developed to support coding and theory generation using a grounded theory approach, the software was useful for the initial thematic analysis. However, it had less functionality for the subsequent structural narrative analyses, because this requires whole transcripts to be kept in one document, reduced and compared. The structural analysis was conducted using Microsoft Word, and supported by N-Vivo memos.

Demographic analysis

The demographic data were gathered at the end of the initial interviews using an attribute sheet (see Appendix D, schedule A) and entered into an N Vivo 8 'casebook'. As discussed earlier, socio-economic class has limited explanatory value in relation to childbearing women (e.g. Blaxter 2000, see also Chapter 3). The theoretical arguments generated by Bourdieu's (1984) work also propose that aspects of capital beyond

[17] Funding for this was available in the fellowship grant.

economic means needed to be considered, to explore the conferral of class-based identities and of different values and tastes. In this research, women's socio-economic class has been included in the group level analysis, based on their current (or pre-pregnancy) occupation, using the NS-SEC[18] scale, which considers both occupational categories and position in the labour market. For individual analysis of agency and constraint, and structural narrative analyses, more extensive attributes relating to Bourdieu's concepts of economic, social and cultural capital have been collected for each individual; these are presented in Chapter 5, and included in Appendix E.

Dimensions of narrative

The research questions also anticipate that cultural narratives impact upon decisions, based on the presence of idealised narratives identified in the conceptual literature. According to Somers (1994, p.606) 'it is through narrativity that we come to know, and understand, and make sense of the social world, and it is through narratives and narrativity that we constitute our social identities'. This reasoning places individuals into a social web of relations, signals and discourses all of which constitute a rich array of 'cultural resources' (Taylor 2010, p. 17). Although this point is frequently made by narrative theorists, the terms 'cultural narrative', 'cultural script', and 'cultural discourse' tend to be used interchangeably without clear definition. During this analysis, examples of prevalent cultural narratives and reference to these were sought, and a separate N Vivo memo kept for each identified narrative. In order to distinguish between different types of cultural narrative, Somers' (1994, p. 617) 'dimensions of narrativity' were used; these discriminate between individual accounts ('ontological narratives'), which contain subjective reflections on the 'way things are', institutional accounts, ('public narratives'), which convey societal accounts of the way that things ought to be (the 'idealised' norms discussed in Chapter 3), and 'metanarratives' or 'masternarratives' which comprise the grand narratives of history and time (such as the western 'enlightenment' narrative).

[18] National Statistics Socio-economic Classification (Rose et al 2005).

Thematic narrative analysis

As well as exploring the effects of structural factors and discourse on agency and constraint, the research questions focused on understanding choice in the context of risk perceptions, and adopted Douglas and Wildavsky's (1982) cultural theory as a theoretical framework. To address these questions, antenatal and postnatal interviews were analysed using an approach informed by Riessman's (2008) thematic analysis of narrative data, which involved analysis of multiple cases whilst keeping the data contextualised. Each narrative transcript was coded using free nodes and tree nodes. The codes included selected segments of narrative text, including the question that had led to the speech and any clarifications by the respondent, rather than a grounded theory in vivo, line-by-line coding process. The initial coding framework was developed from the literature, and pre-defined themes included risk and safety, choice and agency, and the experience and meaning of different birth places. These themes were expanded inductively to include the breadth of accounts and new themes were also added to the initial framework. Ultimately, about a quarter of the themes were added to the pre-defined framework during initial data analysis, usually to account for different aspects of experience (such as trust, or relationships with staff).[19] The most significant category added to the initial framework arose through accounts of multiple dimensions of quality and trustworthiness perceived through exposure to NHS maternity care services, which were present in almost every narrative account, however brief.

Narrative induction

The transcriptions of initial unguided narrative responses were also preserved in a separate Word document, so that I could move between thematic analysis and the temporal sequencing of individual accounts, and explore how respondents prioritised particular aspects of their experiences within their narratives, and rendered others as less central to their story. To record these analyses, I developed a memo for each

[19] The literature does of course recognise the importance of trusting relationships between women and midwives (e.g. Flint et al 1989; Hatem et al 2009), but the analysis showed how fragmented many women's relationships with midwives were (in contrast to the 'official' accounts). In the absence of a consistent relationship with a midwife women instead needed to evaluate whether they trusted 'this NHS trust' or 'that hospital/birth centre'.

participant within N Vivo, which detailed the context of their narrative, along with their subjective positions on birth risk and place safety as they emerged over time. During analysis of the antenatal data, different hierarchies of risk selection developed iteratively. I examined each case to find out which risks were prioritised, and how this was explained by the participant, including use of pollution metaphors. The grounded theory constant comparison method was used to compare accounts of birth risk and safety, and experiences of agency, between participants.

I also considered the extent to which the individual's narrative suggested any similarity to Douglas and Wildavsky's (1982) political cultures. Each participant was assigned to a quadrant using a theoretical rationale based upon their revealed risk selection and bias (a fuller account of this is provided in Chapter 7). Complex or disconfirming cases were discussed with colleagues. Eventually, all cases were accommodated within the model, although many shifted between quadrants during the course of the study and some spanned more than one quadrant.

Douglas and Wildavsky's (1982) cultural theory framework emerges from a realist paradigm and takes for granted that political worldviews expressed are an accurate representation of an individual (or group) position. This failure to discriminate between culturally imposed narratives and subjective expression of these runs the risk of drawing assumptions without a nuanced understanding of individual positions. Such subjectivities proved difficult to discern without a more detailed structural analysis of narrative data, and this was undertaken using two approaches. Firstly, each individual account was analysed for changes that occurred over time, and secondly, structural analysis of selected accounts was undertaken to explore apparent anomalies amongst women's experiences and sense-making. These are described further below.

Structural narrative analyses

Following analysis of antenatal data, postnatal interview transcripts were examined for evidence of consistency (with pre-birth worldview) or change. The longitudinal data analysis therefore considered sequential interviews together as a single data set for

each case, and explored these for narrative turning points where a shift in thinking was revealed.

To address the research question about women's sense-making following birth, a structural comparison of episodes within narratives was undertaken, based upon the approach outlined by Gee (in Riessman 2008, pp.94–103). For the purposes of this analysis, an individual's antenatal, follow up and postnatal interviews were considered together as a single longitudinal data set. This more detailed narrative analysis involved re-reading transcripts whilst listening to recordings so that changes in tone, pace and inflection were evident. Transcripts were parsed (reduced), so that essential segments (episodes) were identified and then compared between cases to pick out different ways of explaining similar experiences (see Appendix F, part B). Structural analyses depend on close readings of the data, and also introduce further opportunities for researcher subjectivity to influence the eventual account. Hence these analyses were shared with colleagues for further authenticity checks, and samples of comparisons are reproduced in Chapter 8 to convey detail of the analytic approach.

Theoretical rigour and validity

The justification for using narrative methodology noted Bruner's argument that narrative accounts do not constitute objective truths, but rather a version of the truth for the speaker at that time, and that narrative analyses are better judged by their 'verisimilitude' than by 'verifiability' (Bruner 1991 p.13). In a similar vein, Lincoln and Guba (1986, in Patton 2002, p. 546) propose that interpretative research should be judged on the basis of 'dependability … and authenticity'. In pragmatic terms, Riessman (2009, p. 193) recommends that researchers 'ground their claims for validity by carefully documenting the process they use to collect and interpret data', and use 'detailed transcripts … attention to … [the] contexts of production, and … structural features of discourse and a comparative approach'. This research has followed Riessman's principles closely. The research method and interviewing approach is

described in detail here, and the analysis included careful attention to the formation of narrative within interviews and compared structures between accounts. The theoretical frameworks underpinning the analysis have also been presented to colleagues and at conferences,[20] so the premises for these were subject to peer review and modified over time. The use of a structuralist model which has been associated with modernist rather than post-modern thinking provoked the most consistent critique, yet despite recognised drawbacks, cultural theory did seem to have valuable insights to offer to the study of birth place risk, and the narrative method usefully helped to avoid framing the research in terms of clinical risk.

Reflexivity

The need for both transparency and reflexivity during research and analysis is well established, particularly in relation to interpretative methods (e.g. Van Maanen 1988, p.125; Denzin 1994, pp.500–15; Liamputtong and Ezzy 2005), and during the course of this discussion, I have reflected on the ways in which I situated and presented myself whilst doing the research. As Riessman (1993) suggests, a particular issue arises in narrative research because participants' voices are sought as data sources, but these personal accounts are then interpreted in the context of competing discourses of media and professional debate. The decisions which are later reached about how data is used and which particular accounts are privileged are beyond the control of the participant. For this reason, it was important to be aware of professional and cultural discourses, but also to retain a firm commitment towards documenting these from the perspectives of interviewees.

Segal (1999) argued that 'our own most cherished conceits, stubborn evasions or persistent illusions are all fashioned by a growing stock of cultural narratives … This … is what we need to study, not seek to evade' (Segal 1999, quoted in Lawler 2002, p.242). On this basis, immersion in multiple viewpoints was deliberate in this study, and was undertaken to inform analysis through reflecting on the lived experience of

[20] The cultural theory model and use of hygiene and pollution metaphors was presented at the Normal Labour and Birth conference at Grange-over-Sands (UK) in 2009, and a more developed iteration presented at the BSA Medical Sociology Conference in 2010.

making decisions whilst being exposed to broader cultural debate. A store of articles from national and local print and web media was built up during the course of the study, and this informed the subsequent analysis of cultural narratives and maintained the analytic focus on the cyclical construction of narratives in response to broader discourses.

It is also relevant to record my own personal experiences of maternity care both as a mother and as a midwife.[21] I had my children before I became a midwife, and they were each born in hospital. During my early childbearing years, I was influenced by the NCT classes I attended and pursued a natural birth philosophy. This was in the late 1980s and I did not consider home birth at the time when advice against home birth was much more explicit than it is now. On the basis of two normal hospital births, I planned a home birth during my third pregnancy in the mid 1990s (post-*Changing Childbirth*), but the pregnancy went post-term, and I agreed to a transfer to hospital care.

As a midwife, I attended births in hospital and at home, but I did not have opportunity to work in an AMU or FMU, although I did visit birth centres in the course of my training. Exposure to medical perspectives during my years as a nurse and a midwife meant that I gradually became more sceptical about the natural birth ideology, and reconceptualised home birth as safe and appropriate only for some, in line with received professional wisdom at the time. However I also observed that women were selectively provided with home birth support, and that this could depend on the views of the midwife, as well as the organisational complexities of providing sufficient cover for community on-call rotas. These personal and professional experiences sensitised me to separate lay and professional discourses before embarking on this study, and potentiated my interest in birth in contemporary UK cultural contexts. During the course of my postgraduate studies and research, my position has shifted once again. As a consequence of becoming immersed in women's and partners' narratives, I have

[21] I am no longer registered to practice as a midwife, and to avoid creating an expectation that I could provide advice on the decisions people were making, I introduced myself to potential participants as a PhD student.

become more detached from the professional perspective. However, the same detachment has also extended to the natural birth philosophies I once espoused (and continued to nurture as a midwife), as I increasingly saw these as sometimes beneficial for women but also potentially exclusive. The overall perspective adopted during the analytic process was increasingly one that sought to communicate to others the social and cultural sense-making that women and partners undertook during pregnancy and birth, and to convey the constraints women experienced alongside the efforts they and others made to achieve agency.

Summary

This chapter has outlined the epistemological approach of the study, and argued that a narrative interpretative enquiry is appropriate to address the research questions raised. This approach is coherent with the theoretical premise of the research, which privileges a socio-cultural understanding of risk on the basis that individual actions and intentions occur within social and cultural contexts. The longitudinal narrative method was described and a case made for the additional contribution of narrative enquiry to the research, although the burdens of time-demand on participants, and the analytic challenges that arise with such a large data set have also been acknowledged.

The chapter discussed the rationales for recruiting at three different sites, and seeking to include women and men from diverse backgrounds using maximum variation sampling. The complexities of achieving this became clear as the study progressed. Chapter 5 briefly contextualises the research findings through presenting further information about the three study sites, and describing the sample in greater depth.

Chapter 5: Research context

Sample demography and the provision of choice in the three NHS trusts

Introduction

Chapter 4 outlined and justified the narrative, longitudinal methodology. In order to set the scene for the findings chapters which follow, the first part of this chapter provides further contextual information about the three NHS trust sites, and more detailed description of the sample demography. In this section, contextual and demographic data are summarised in tables, and percentages are used to describe the sample, and where appropriate, compare the sample with published national data so that clear differences between the sample and the wider maternity care population are made apparent. The second part of the chapter provides additional contextual data about the birth place alternatives that were available to women locally, and the extent to which women reported being offered these options. Data is again summarised in tables, but here the numbers and percentages relate only to the study sample and are provided to show patterns amongst the participants; the sample is purposive rather than representative and there is no intention to suggest that the same patterns would be found in the wider population. As in other chapters, the NICE *Intrapartum Care Clinical Guideline* recommendations are used to identify when women's pregnancies are complicated by factors which indicate that planned birth in OU is advised (NCCWCH 2007, pp. 64-66).

The NHS trust recruiting sites: Southcity, Eastcity and Westfield trusts

Three NHS trusts in South England took part in the study. Two are large teaching hospitals serving inner city areas (Eastcity and Southcity NHS trusts), and the third is a county NHS trust[1] which encompasses a far larger geographical area than either of the

[1] This NHS trust serves part of a large county; in the UK, large geographical regions are divided into counties.

inner city trusts, and serves a mixture of urban and semi-rural populations (Westfield NHS trust).

Both Southcity and Eastcity trusts serve an ethnically diverse population with areas that have high indices of deprivation. Both are also international centres of excellence for specialist services. Southcity NHS was described as 'better performing' by the Health Care Commission in 2008 (HCC 2008). Eastcity NHS is a slightly smaller trust, and was 'fair performing' in the same review, which included women's reports of being offered choices in each trust. Table 5.1 (below) outlines the birth place options available at these sites during the year 2009-2010.

Table 5.1 Birth rates and birth place options at the three participating NHS trusts 2009-2010

	Birth rate 2009-2010	**OU (% of total births)**	**AMU (% of total births)**	**FMU (% of total births)**	**Home (% of total births)**	**Total births in settings *other than* consultant OU (%)**
Southcity NHS Trust	6698	✓ 81.5%	✓ 16.2%	No FMU	✓ 2.3%	18.5% (n=1239)
Eastcity NHS Trust	5804	✓ 93.3%	No AMU	No FMU	✓ 6.7%	6.7% (n=389)
Westfield NHS Trust	7323	✓ 83%	✓ 6%[2]	✓ 7%	✓ 4%	17% (n=1253)

Source: These data are drawn from Local Supervising Authority (LSA) reports for the year 2009-2010, except the Southcity AMU birth rate (NHS trust data for 2009–2010), and Westfield AMU and FMU rates (NHS trust data for 2009–2010)

Key differences between these NHS trusts are that women in Southcity were able to give birth in the AMU (assuming they meet the admission criteria), but the home birth rate was marginally lower than the 2.7% average for England.[3] In contrast, women at Eastcity NHS trust were more likely to have a home birth; at 6.7%, the trust home birth rate is well above the England average, but there is no AMU available. In relation to

[2] Westfield AMU opened in July 2009, so this figure represents 9 rather than 12 months.
[3] 2009 UK home birth rate is 2.6% but England rate is 2.7% (Source Birthchoice UK) http://www.birthchoiceuk.com/BirthChoiceUKFrame.htm?http://www.birthchoiceuk.com/England.htm derived from data supplied to Birthchoice UK by ONS

the *Maternity Matters* choice guarantee, Southcity trust fulfilled the promised options for place of birth (which should include home birth *and* 'birth supported by a midwife in a local midwifery facility' (DH 2007a, p.12), but Eastcity did not. Yet from a different perspective, neither trust provides genuine choice for all women since the Southcity home birth rate is low and women in Eastcity trust do not have the option of an AMU *or* OU (NCT 2009). An added complexity is that women can self-refer to these trusts should they choose, but they may still not be eligible for homebirth by the trust midwives, because they live outside the catchment area for home birth provision. Women in each of these trusts *could* opt to go to birth centres in other neighbouring trusts, but this 'choice' is constrained by issues of transport and travel time, referral systems and limited provision of information. Part of the inner city context is that services may be geographically close, yet remain inaccessible.

Westfield NHS trust

Westfield trust covers a larger geographical area (293 square miles, compared to an average of 11 square miles for the city trusts), and includes two OUs sited in district general hospitals, two FMUs based in non-acute community hospitals and one AMU. At 4%, the home birth rate is higher than the England average. The population is less diverse than the inner city sites in terms of ethnicity; around 5% is made up from ethnic groups other that 'white British', compared to 45%[4] in the city trusts, but there are areas of high deprivation amidst relative affluence, and the region is also home to migrant populations. This is one of the few trusts in England that can fulfil the *Maternity Matters* choice guarantee (DH 2007a), but with transfer times of up to an hour, women do not always feel that these choices are genuinely available to them (Dodwell and Gibson 2009; NCT 2009).

Participants' economic, cultural and social capital

In this section, the attributes of individual participants are described, and observations made regarding how they resemble (and depart from) national population statistics for the following reasons. Firstly, it is useful to make explicit key attributes (such as parity, age and risk status) that are used in clinical and policy texts to determine

[4] Source: Office of National Statistics [ONS] (2001).

appropriateness of particular birth places for individuals, because some of the theoretical analyses draw upon disjuncture between these official discourses and women's own experiences. Secondly, the characteristics of the sample can be used to undertake analyses that draw on Bourdieu's notions of economic, cultural and symbolic capital within the 'field' of maternity care (Bourdieu 1990, p.66), and explore the implications of these for birth place choices.

Privileged identity

As discussed in Chapter 3, sociological literature identifies notions of idealised motherhood (e.g. Walkerdine and Lucey 1989; Hays 1996; Lawler 2008) as central to accounts of class dominance, and the extent to which individuals appeared to resemble or depart from these descriptions is outlined here, as a basis for later discussions. Lawler (2008, pp.122-142) specifically argues that 'middle class identities are identities of privilege' (p.125), and proposes that such identities 'are constituted through a rejection and repulsion of those identities with which they could be compared' (ibid, p. 142). Informed by the work of Lawler (2008), Hays (1996) and Behague et al (2008), the culturally sanctioned notion of a mother with a privileged identity in the UK context appears to be one who is white, native born and speaks 'received' English (Kerswill 2007, p.51), graduate, relatively affluent (for example, the couple is home owning, and one or more partners is employed in a high status role), married or in a long-term relationship and of an appropriate age to have children, and with a moderate-sized family. This combined set of attributes is used here to denote 'privileged' identity, however, this is not intended to infer that such attributes are, or should be, considered in any way ideal, or indeed that this idealised notion is universally accepted. Rather, it represents a theoretical basis formed of interwoven cultural discourses which appear to obliquely reinforce notions of what has historically been considered right or acceptable, for example, through media debate about non-UK born mothers having larger family sizes, or younger mothers having children who become socially disadvantaged. It proposes a possible template of ideas which may influence perceptions of others, or be internalised as part of individual subjectivity. As Lawler (2008) pointed out, ideological notions of class dominance are generally unspoken, which means they are difficult to account for analytically, and hence the

notion of an idealised norm is at most a starting point for exploring conferral of privileged (or non-privileged) identity, rather than an explicit expectation within the population.

These attributes are described here in order to support analysis of these issues in the later chapters. Providing group level data also supports transparency of method by making it possible for the research audience to determine the extent to which findings have relevance to maternity services locally, nationally, or to their own personal experiences as maternity service users or representatives. Individual 'attribute' data is also provided (See Appendix E) because this informs the interpretation of narratives, and provides details of participants' life contexts which are difficult to discern from sample demography.

Economic capital

Although Bourdieu (1984) argued for the co-existence of several forms of capital, he also acknowledged that economic capital was a predominant source of power (Swartz 1997). Because of the difficulties of linking women's income with their class position, especially during childbearing years, income data for participants was not sought (see Chapter 3). However, women and their partners' current or pre-pregnancy occupation was gathered. This information is summarised below (Table 5.2), using the National Statistics Socio-Economic Classifications (NS-SEC) (Rose, Pevalin and O'Reilly 2005), which classifies occupations by both income and position in the labour market, and includes a range of categories that reflect the contemporary diversification of labour skills, overcoming some of the difficulties of earlier classification systems.

Table 5.2 Participant occupational categories using NS-SEC

NS-SEC categories	Women	Partners	Totals
Managerial	20	11	31
Intermediate	4	0	4
Lower technical	0	1	1
Routine	3	1	4
Full time student	4	1	5
Not working	10	0	10
Retired	0	1	1

The majority of the sample were employed in managerial positions, and almost all partners were in this category, but women's occupational situations were also relatively diverse. A sizeable group had not worked before the current pregnancy, although they had often worked before having children.

Cultural capital

Bourdieu's (1984, p.114) concept of cultural capital encompassed education and qualifications, and in this context extends to ethnicity and spoken English. Bodily capital (or 'physical' capital) was also an element of cultural capital in Bourdieu's account (1984, p.193), and so parity (number of births) and pregnancy related 'risk' are included here.

Educational qualifications

Table 5.3 Highest qualification held by participants

	Female	Male	Total	(% of sample)
No qualifications	4	0	4	7%
O Levels/CSE/GCSE	2	0	2	4%
A Level/AS level	7	0	7	13%
NVQ Level 1,2,3	2	1	3	5%
City and Guilds, BTEC, HND, NVQ4	6	1	7	13%
Graduate/Postgraduate	21	12	33	61%
Total	**42**[5]	**14**	**56**	**100%**

The majority of interviewees were graduates, but fewer female than male participants had a degree (50% compared to 86%). Currently, around 40% of women of childbearing age have first degrees (ONS 2005: Table 20a) so the proportion of women graduate participants is a little higher than would be anticipated. Although most partners were graduates, only about a third of partners participated in the study, so this may simply indicate that partners who were graduates were more willing to be interviewed. Women interviewees were more likely to have no qualifications, or to have finished their education at leaving secondary school (31%), although some were studying for further qualifications, or had suspended their studies whilst they looked after others at home.

Participants' country of birth, ethnicity and spoken English

Table 5. 4 below reports participants' ethnicity. Most interviewees were white and UK born (62%), and 56% of women participants were in this category, which is lower than the national figure (76% for 2008),[6] indicating a degree of ethnic diversity within the sample. The ethnicity categories on the data collection form were imported from the 2001 population census, and as others have detailed (e.g. Bradby 1995; Aspinall 2001), self-identification of ethnicity is, to say the least, problematic. Most participants gave extended accounts of their background and family origins, and the lack of a category

[5] One birth partner was female, and she is included in this table. So although the number of pregnant women included is 41, the total number of female participants is 42.
[6] ONS (2008a) FM1 table 9.1 p.47

reflecting 'Arabic' ethnicity (since included in the 2011 census form) led one participant to reflect on the choices that were left to him:

> I've never really known how to describe [my ethnicity] in terms of British forms or the way they're … I mean if you're asking about my actual ethnicity … my father is Arabic, my mother is English, so dual nationality. I don't know if it fits into any category. I've always had to tick 'Other'.

(Salah, AN1)

Table 5.4 Respondents' ethnicity

	Women	Partners	Total (%)
White British	24	8	32 (56%)
White, other	10	5	15 (26%)
Black or mixed white and black	5	0	5 (9%)
Asian or mixed white and Asian	2	0	2 (4%)
Chinese or mixed white and Chinese	2	0	2 (4%)
Any other ethnic group	0	1	1 (2%)
Total	**43**	**14**	**57**

As discussed earlier, although women with BME ethnicity made up around 40% of the local population profiles at two trusts, they rarely accepted an invitation to participate in the study. Some did take part, but effectively renegotiated the relational basis of the study through requesting shorter and less discursive interviews or telephone interviews rather than home-based discussions, or by putting some areas of enquiry 'off bounds'. However, not all BME participants 'renegotiated' in this way, and sometimes women from white backgrounds who were marginalised in other ways (e.g. young or single women) engaged in similar negotiations. The challenges of recruiting individuals from different ethnic groups meant that this aspect of diversity was only partially realised, and as Campbell and Maclean (2002) discuss, ethnicity and socio-economic deprivation constitute different axes of exclusion, which may be experienced

separately or together, each of which predisposes individuals towards avoiding participative activities. It seems likely that the sample included BME women with relatively strong feelings of acceptance or inclusion due to their graduate education and inclusion in the workforce, and also white, UK born women who were socio-economically marginalised as a consequence of non-graduate qualifications and reduced participation in paid employment.

English as a first language

English was the first language for 8 of the 21 non-UK born respondents; some were born in English-speaking countries (e.g. Australia or Canada), and others were born to English-speaking parents who were living in other countries. The remaining 13 participants included some who were multilingual (including English), and 6 respondents who required an interpreter to participate, including Polish and Chinese women and partners. One other participant spoke English but had a sensory impairment, and a BSL interpreter facilitated the postnatal interview; her antenatal interview was based on a series of emails, which was her preference.

Having English as a first language is a good example of an aspect of cultural capital which has a range of socio-cultural implications and which may potentially either enhance or detract from the individual's experience of maternity care. 'Spoken English' may also refer to the level of convention used amongst 'native' English speakers (including 'received pronunciation' versus non-standard English or dialects) which may be a means of differentiation for either party, when client and health professional originate in different localities or class milieux. English 'speakers' also differ broadly, and include those who are fluent in many languages (effectively an elite group with a valuable cache of cultural capital). This is relevant for the later analysis, because 'not speaking English' did seem to be a barrier to choice for some, but speaking even fluent English as an *acquired* language could also be problematic, perhaps because accent and altered communication patterns revealed a 'difference', and that the first language might be acquired in a culture with different 'cultural norms' including stronger association of birth with medical risk.

Parity

Table 5.5 Parity (number of children) amongst women participants

	Number in sample (%)	**National average (ONS) %**	**Difference**
First baby	**18 (44)**	**43**	**+1%**
Second or subsequent baby (multiparous) of which:	**23 (55)**	**56**	**-1%**
… second baby	15 (36)	33	+3%
… third or subsequent baby	8 (8)	23	-4%
Total	**41**	**99**	

Amongst respondents, 44% of women were expecting their first baby and 55% expecting their second or subsequent baby, which is very close to the national averages of 43% and 55% respectively. Those expecting their second or subsequent babies had given birth to between 2 and 4 babies, but most were expecting their second or third baby, again close to national averages. This provides a rather partial summary though, because some women had also experienced miscarriages and pregnancy losses which mean that they were experiencing their fifth or subsequent pregnancies, and these factors may contribute to risk conferral by health professionals, or by women.

Clinical risk: Respondents with straightforward or complex pregnancies

Table 5.6 Proportion of women with complex pregnancies by parity

	Straightforward pregnancies *'low risk'*	**Requires 'individual assessment'**	**Complex pregnancies *'higher risk'***
Expecting first baby (n=18)	17 (95%)	0 (0%)	1 (5%)
Expecting second or subsequent baby (n=23)	11 (48%)	5 (22%)	7 (30%)
Total (n=41)	**28 (68%)**	**5 (12%)**	**8 (20%)**

The assessment of pregnancy complexity is categorised here according to the current NCCWCH (2007) guidelines for planning place of birth. These indicate conditions or

situations that suggest increased risk to women or babies is present, and advise that in these circumstances birth in a consultant led obstetric unit 'would be expected to reduce this risk' (NCCWCH 2007, p.64). The list covers medical conditions in the mother or baby as well as complications in the current or previous pregnancies. It is difficult to estimate the proportion of pregnant women in the population that have one of these factors as this data is not part of routinely published national data sets.

The NCCWCH (2007) assessments also differed from women's own perceptions of pregnancy related risks. Some of the women who were assessed as having complex pregnancies took issue with the reasoning behind this and did not agree that they would benefit from giving birth in an OU. More commonly, women with straightforward pregnancies felt that their risk status had been underestimated by health professionals. The latter included some women who had IVF or assisted conception, older mothers and those expecting their first babies, but not all women with these factors present considered their pregnancies to be more risky.

'Social capital': Relationship status and age of women participants

Social capital denotes 'a capital of social connections, honorability and respectability' (Bourdieu 1984, p.122), and it is the last concept of 'respectability' which has most relevance in this context, because of the value which is continues to be placed upon having children within partnered or married relationships.

Relationships

Amongst the participants, 67% of births took place to married couples. According to the Office of National Statistics (ONS 2009), 55% of births occur 'within marriage' and so respondents were more likely to be married than would be expected in the wider population. The ONS also report that about 30% of births are to cohabiting couples (ibid, p.3), based on birth registration information, and in my sample 21% described themselves this way. In England and Wales, 15% of births are registered to single women, or parents who live apart, a description that encompasses 12% of study respondents. So although married relationships are over-represented, the participants

do include women from a variety of relationship arrangements including 2 who described themselves as being in a relationship, but living apart.

Linked to relationship status is the age of pregnant women. Although youth is widely regarded as valued within UK culture, young parenthood continues to be regarded as a 'social problem' (Macvarish 2010), and whilst the average age at which women have children has risen, older mothers may also be stigmatised. Table 5.7 below summarises the ages of women participants.

Table 5.7 Ages of women participants

Age (women participants)	**Number in sample (%)**[7]	**ONS National average (%)**	**Difference between national average and sample**
up to 24	3 (7)	25	-18%
25-34	27 (64)	54	+10%
35+	12 (29)	20	+ 9%
Total	**42 (100)**	**99**	

Source of national average ages for pregnant women ONS (2008b)

Fewer younger women (aged up to 24) than would be expected are in the respondent group, whilst women of 25 or more are over-represented. As discussed earlier, it was more difficult to recruit younger women; many were reluctant to take part, or did not feel that they had a 'choice' that they could discuss in an interview. Although I approached services which provide specialist care for teenagers, 'gatekeepers' for these argued that their service users were experiencing 'research fatigue' and hence they preferred not to put 'their' teenagers forward as potential research subjects. The final group included women aged 19-42, and the mean age is 31.67, which is a little higher than the national average for giving birth (29.3).[8]

[7] Percentages have been rounded to the nearest decimal point.
[8] According to ONS (2009) data, the average age for giving birth is 29.3, but 27.5 for first births.

Birth partners were slightly older, as would be expected; their mean age was 36.4 (national average 32.4) and the median was 34,[9] but this difference probably arose as a consequence of including higher numbers of older mothers.

Privileged identities

So far, this section has considered individual attributes at group level, but 'identity' theory, underpinned by Bourdieu's work on forms of capital (1984, 1990), proposes that different aspects of identity interact with each other, and these may either potentiate an individuals' 'capital' (for example when wealth provides access to private education which in turn teaches children to appreciate classical 'tastes'), or impoverish it, such as when poor spoken English interferes with school education, and limits access to culturally endorsed skills, education, and attitudes (Lawler 2008, p.131). Identity theory proposes that the points at which several negatively viewed attributes overlap are those where forms of hegemonic control might be anticipated; a very similar thesis is also advanced within feminist intersectionality theory (e.g. Browne and Misra 2003; Young 1997). Table 5.8 below describes the range of 'privileged' identities within the sample (using the definition provided on p.133), and the numbers of individuals who had differences from the idealised template suggested by Lawler (2008), Hays (1996) and Behague et al (2008).

[9] ONS (2009).

Table 5.8 Privileged identities

		Number	Total (sample %)
Privileged identity (all attributes present) White, native-born, speaks 'received' English, graduate, affluent (home owning, both partners employed), married/LTR, appropriate child-bearing age and family size	women men/partners	10/41 5/15	15/56 (27%)
One 'difference' from privileged identity	women	11/41	15/56 (27%)
	men/partners	4/14	
Two or more differences from privileged identity	women	20/41	26/51 46%
	men/partners	6/15	

In practice, the first two groups (that is, those with privileged identities or one different attribute) appear very similar and account for about half of the sample, but the last group contains individuals whose difference starts to become evident mainly through speech or disposition ('habitus' in Bourdieu's terms). There are a number of further possible categories that could be added. The table is not a comprehensive account of the possible identities that might be visible to others, or manifest as part of self-presentation, but it begins to outline a basis for analysing differential experiences of choice in birth place decisions based on the theoretical construct of culturally endorsed identities.

Although commitments to provide more sensitive, pluralistic services abound, an intersection between less privileged identities and inequalities of pregnancy outcome is already substantiated in the public health literature (e.g. DH 2007b; Marmot et al 2010). Also, findings that individual attributes including being single, or in the highest quintile of socio-economic deprivation, or non-UK born or non-English speaking are associated with reduced choice of place of birth have been published in a national survey (Redshaw and Heikkila 2010), and this provides the basis for considering aspects of identity in relation to birth place choices within this study. Appendix E contains individual level data combining economic, cultural and social capital for individual participants, and also indicates couple relationships.

Birth place alternatives offered to women at the trust sites

During the course of antenatal interviews, it became clear that although each trust had a different range of options available, few women were offered the full range of birth place options available to them *in any of the three trust areas,* and non-hospital alternatives were discussed less routinely than hospital OUs. This observation is detailed here, because it provides context for the thematic analysis of women's and partner's experiences which is presented in Chapter 6.

Thinking about parity and risk

A core recommendation of *Maternity Matters* is that 'depending on their circumstances, all women and their partners' will be able to choose where to give birth (DH 2007a, p.5). The requirement to take circumstances into consideration may qualify the extent of choice provided to women, but the meaning of the term 'circumstances' is not elaborated upon within this policy document. Fuller clinical guidance is found in the NICE *Intrapartum Care Clinical Guideline* (NCCWCH 2007) and *Antenatal Care Clinical Guidelines* (NICE 2008, p.12), which recommend that 'women's decisions should be respected, even when this is contrary to the views of the health professional'. Here, this guidance was interpreted to mean that each pregnant woman (and partner) should as a minimum be provided with information about different birth settings, even if they are then advised to give birth in an OU, on the basis that this then becomes an informed decision rather than one made on their behalf by others.

Assessments of clinical risk

Each of the women participants had sought antenatal care by 12 completed weeks of pregnancy. The NICE *Intrapartum Care Clinical Guideline* (NCCWCH 2007, pp. 10-12) are expected to inform clinical decisions about birth place planning, and because this has implications for women and partners' perceptions of risk, the advice offered by these guidelines is summarised here.

Women are described as having more complex or higher risk pregnancies when 'there is increased risk for the woman or baby' and 'care in an obstetric unit would be

expected to reduce this risk' (NCCWCH 2007, pp. 64-66). Examples of conditions in this category include women with serious medical conditions (such as heart disease or diabetes) or a history of caesarean section in a previous pregnancy. A different category of less serious medical or pregnancy-related conditions are considered to carry some risk and include stable conditions not affected by pregnancy or a past history of a large baby (over 4.5 kg). The guidance advises that factors requiring individual assessment do *not* mean that birth in an OU is necessarily indicated, but rather that: 'These risks and the additional care that can be provided in the obstetric unit should be discussed with the woman so that she can make an informed choice about place of birth' (ibid, p.64).

Within this guidance, in the absence of clinical risk indicators or history of these, birth in non-hospital settings is argued to be 'generally safe' with the caveat that:

> The [guideline development group] was unable to determine whether planning birth in a non-obstetric setting is **as safe** as birth in an obstetric unit. This was because the data from the included studies consistently showed a non-significant increase in perinatal mortality (including perinatal mortality that is directly related to intrapartum events) in non-obstetric settings.
>
> (NCCWCH 2007, p. 62, emphasis added)

The guidance also recognises that women are more likely to have a normal birth, and less likely to experience medical interventions in non-hospital settings. But it does not offer practitioners advice about how to help women balance pregnancy and birth risks against the potential risks of medical intervention, and also fails to discriminate between the risks attached to women of different parity. As other authors have shown, first labours are much more likely to involve intervention and assisted or surgical deliveries than subsequent labours and births (Downe et al 2001; Bragg et al 2010; Davis et al 2011). The ways in which this guidance was interpreted by clinicians could have implications for women's birth place options, and these are discussed as they arise. The tables that follow summarise information about the choices women

were provided with, but as mentioned above, the numbers and percentages these contain are purely descriptive, and refer only to the study participants.

Options offered to women with different levels of clinical risk

Table 5.9 below summarises the extent to which women were offered OU and non-OU options in relation to their level of clinical risk.[10]

Table 5.9 Options discussed with respondents by 36th week of pregnancy

	n	Option discussed with women by 36 weeks (where available)			
		Home	FMU	AMU	OU
Women with higher risk factors present	10	3	3	4	10
Women requiring individual assessment[11]	3	1	0	0	3
Women with straightforward pregnancies	28	13	10	13	27
Overall	**41**	**17/41**	**13/19**	**17/33**	**40/41**

Almost all women were offered hospital OU whether their pregnancies were complex or straightforward, and sometimes women with complex pregnancies were offered non-hospital options, whilst those with straightforward pregnancies were not. Of the non-hospital alternatives, women were least likely to be told about home birth, and information about AMU and FMU was also variable. Across the sample, only 13 out of 41 women received information about all the options available in their areas.

As the options available to women depended on which area they were living, the tables below are arranged by the three sites, starting with Eastcity (where women had fewest options) and then moving on to Southcity and Westfield trusts. To be clear, these tables reflect whether or not women were given information about a birth place option that was provided in their area, but this does not necessarily mean they were

[10] AMU and FMU were not available at all trusts, so the denominator in the 'overall' row varies.
[11] Individual risk assessment is required for women who have a risk factor present which may not affect planned place of birth, but which should be taken into consideration. Examples include extensive perineal trauma in a previous birth, and age over 40 at booking (NCCWCH 2007, p.66).

offered the choice to birth there or encouraged to do so. Where women were aware that the options of home birth, AMU or FMU existed, they are only described as being denied this choice if they stated during interview that nobody had discussed this option with them in relation to their own pregnancies. For each area, the options provided are summarised in a table and then discussed.

Birth place options discussed with Eastcity trust respondents

Eastcity trust has an OU and also has a higher than average home birth rate, but no AMU (see Table 5.10). Eight women from Eastcity NHS trust took part in the study, one of whom required individual risk assessment in relation to place of birth. The other participants had straightforward pregnancies; 5 of them were offered a choice of both home and hospital birth, and of these, 3 planned to give birth at home

Table 5.10 Birth place options discussed with Eastcity participants by 36 weeks of pregnancy

Eastcity participants: clinical risk and parity	**n**	**Provided with information about:** **Home**	**OU**
Individual risk assessment required Second+ baby[12]	1	0	1
Low risk first baby	5	4	5
Low risk second+ baby	2	1	2
Overall number provided with information (%)	**8**	**5**	**8**

Although Eastcity provides a home birth service, all three women who wanted a home birth lived outside the defined geographical area for home birth support by Eastcity trust midwives, despite living within the trust's target locality. As a result, two homebirth women were referred back to their own GPs for antenatal care and home birth support. The third decided to transfer to a local district general hospital for the remainder of her antenatal care. None of the women knew when they chose Eastcity that they could not get home birth support from the trust, and this highlights the lack of clear information about the scope of services available when couples choose a

[12] The term 'second+ baby' is used here to describe women who were expecting their second or subsequent baby at the time of inclusion into the study, without identifying the actual number of children they have had.

hospital in early antenatal appointments. Eastcity interviewees could also have opted for three other nearby city hospitals which have AMUs, but they were either unaware of this possibility, or mistakenly believed that they could not use these units. The framing of options at the start of pregnancy is discussed in more detail in Chapter 6, and this data helps explain the process by which women become partially informed and sometimes reach erroneous conclusions.

Birth place options discussed with Southcity trust respondents

Southcity NHS trust has a hospital OU, and an alongside AMU; the trust also provides a home birth service, but home birth rates are slightly below the England average (see Table 5.11). Although all of the women were told about the hospital OU, only 5 women at Southcity NHS trust received information about all the options available at that trust. Six women did *not* receive information about home birth, of whom 4 had straightforward pregnancies, and 2 women with higher risk pregnancies received information about home birth, one of whom (Vita) instigated this by requesting a home birth. At the initial antenatal interview, half of the women with low risk pregnancies had not been told about the AMU, and most found out about it during antenatal classes.

Table 5.11 Birth place options offered to Southcity participants by 36 weeks of pregnancy

Southcity participants: clinical risk and parity		**Provided with information about:**		
	n	**Home**	**AMU**	**OU**
Higher risk first baby	1	1	0	1
Higher risk second+ baby	3	1	3	3
Individual risk assessment required Second+ baby	1	1	0	1
Low risk first baby	5	3	4	5
Low risk second+ baby	4	2	4	4
Overall number provided with information (%)	**14**	**8 (57%)**	**11 (79%)**	**14 (100%)**

Birth place options offered to Westfield trust respondents

The situation is even more complex in Westfield NHS trust, which has two district general hospitals with OUs, one of which has an AMU (where 6% of births take place),

and two separate FMUs, both based in community hospitals (amounting to a further 7% of births), and where 4% of births occur at home. In theory then, women with uncomplicated pregnancies have the option of giving birth in any of these settings, although geographical constraints may mean that they do not consider these options as realistic for them.

Table 5.12 Birth place options discussed with Westfield participants by week 36 of pregnancy

Westfield participants: clinical risk and parity	**n**	**Provided with information about:**			
		Home	**FMU**	**AMU**	**OU**
Higher risk second+ baby	6	1	3	1	6
Individual risk assessment required Second+ baby	1	0	0	0	1
Low risk first baby	7	2	6	3	6
Low risk second+ baby	5	1	4	2	5
Overall number provided with information (%)		**4 (21%)**	**13 (68%)**	**6 (32%)**	**18 (95%)**

In fact, participants at Westfield were *least* likely (within the three participating trusts) to receive information about all the options available to them within the trust, and this was partly because there were so many alternatives available, some of which were competing with each other. Only 3 of 19 participants heard about the full range of alternatives, but most women with straightforward pregnancies were told about at least one non-hospital option. Again, home birth was the option least likely to be discussed; of the 12 women with straightforward pregnancies, 9 had not been assessed for home birth and 7 of these were also not told about the AMU. Most were told about the FMU and one woman (Jia) was not offered the choice of giving birth in an OU.

Overall birth place options offered to women participants during antenatal care

Across all the trusts, women with straightforward pregnancies were not always told about both home birth, AMUs or FMUs where these were provided. Other authors have identified that the choices presented to women are restricted, but suggest that this is normally attributed by health professionals to pregnancy risk factors (Barber et al 2007; Jomeen 2006, 2007; Pitchforth et al 2009). If pregnancy risk were indeed the

main concern, then only women with straightforward pregnancies would be offered choices, but in practice, these women received restricted choice, and some said they had 'no choice' or 'no decision to make'. On the other hand, women with complex pregnancies were sometimes given information about non-hospital settings, which might appear to be in keeping with the spirit of *Maternity Matters*, but because it was relatively unusual, and often instigated by women rather than midwives, this is unlikely to explain this phenomenon. Although there are occasions when increased pregnancy risk does contribute towards women not being offered a particular choice of place of birth, these women's mixed experiences suggest that this explanation alone is insufficient. Other factors contribute to this, including geography and pressure to increase uptake of less well known birth place alternatives, and these issues are discussed further in Chapter 6.

Summary

This chapter sets the scene for the chapters which follow, by describing the participating trusts, the sample demography and the local contexts within which women were offered birth place alternatives. The intention has been to describe the composition of the 'maximum variation sample' in relation to the national population, and also to establish the variable options which might be offered to women, along with some of the clinical restrictions that may be placed upon women through routine risk assessments in early pregnancy.

Aspects of 'capital' including education, employment, ethnicity and language acquisition were presented. Although there is evidence of ethnic diversity amongst the sample, this was challenging to achieve and is partial, with several major ethnic groups not included. However, the study was never intended to statistically reflect UK 'multiculturalism', which would require a different design and method, but rather to include a broad range of interviewees, with both socio-economic and cultural differences. The opportunity to include women and partners who did not speak English as a first language was valuable, but the variations in language even amongst those with fluency in English pointed to the importance of social class differences in language

and education. The inclusion of participants from a broad range of socio-economic classes, ethnicities and (national or religious) cultures affords an opportunity to explore variations of experience in relation to aspects of structural and cultural constraint.

The observation that options which were available to women in their localities were not always discussed with them, and that women were less likely to be told about alternatives to OU birth, provides a basis for the thematic analysis of women and partner's experiences of birth place decisions during pregnancy. The following three chapters contain findings from the study, and these follow a chronological pattern. Chapter 6 documents women and partners' experiences of the *process* of deciding where to give birth, and explores influences acting upon them and the exercise of agency. Chapter 7 contains an account of the risk selection analysis, with new observations about the birth risk 'safety' hierarchies observed within participants' accounts, and Chapter 8 employs thematic and structural narrative analysis to explore how narrative accounts changed over time, exploring how individuals made sense of the events surrounding their births and the influence of socio-cultural norms upon this process.

Chapter 6: Structure, culture and agency in birth place decisions

Introduction

This chapter explores the experience of deciding where to give birth from the perspectives of women and their partners. The discussion expands upon the contextual information presented in Chapter 5 and uses this as a basis for further analysis, and also lays the foundations for a more in-depth discussion of how individuals' risk sensitivities led them to attenuate their perceptions and choices about planned place of birth in Chapter 7. The particular focus is on the events of pregnancy and engagement with antenatal care, and the various effects which arise from the processes which occur within contemporary English NHS maternity services, and the effect of these upon the exercise of agency and choice.

Unpacking these issues a little, the chapter presents findings about individual participant's perspectives of birth place decisions within the context of influences that were brought to bear upon these. Chapter 3 examined some definitional issues of structure, culture and agency and acknowledged Hays' argument that culture is 'both the product of human interaction and the producer of certain forms of human interaction' (Hays 1994, p.65). Culture is then manufactured within structural 'systems of social relations' such as social, familial or gender roles, and 'systems of meaning', which include beliefs, knowledge and 'common sense' (1994, pp.64-65), whilst agency is 'influenced by the depth and durability of the structural form in question, by the level of power held by those making the choices, and by the larger cultural milieu in which the choices are made' (ibid, p.64). Within the course of this chapter, the 'structural form' of antenatal care, its social processes and accompanying discourses, are viewed from the perspective of participants, and evidence of constraint and enablement within birth place decision-making is sought.

Chapter 5 showed that women who participated in the study were not consistently offered all of the birth place alternatives available to them in their localities and

argued that clinical risk criteria could only partially explain this phenomenon. This chapter discusses how birth place options were framed in early antenatal appointments, and how this influenced women's perspectives of the choices available to them. Women and partners' views about place of birth were often rooted in previous experiences of pregnancy and health care, events in their own upbringing or their family's history, or in acquired cultural beliefs or about birth and appropriate places for birth, and the influence of these 'systems of meaning' (Hays 1994, p.64) are explored here.

For many participants, the decision about where to give birth was not a clear cut event, but rather occurred gradually during the course of pregnancy. Considering this from the perspectives of the respondents begins to open out maternity care as a varied landscape where decisions are reached through the vista of objective realities and process rationalities (appointments, scans, referrals, risk assessments). The experience of reaching or negotiating a birth place decision was therefore complex, and took place within a matrix of expectations and obligations, during the course of which women and partners adopted various agentic positions, and the extent and implications of these are discussed here.

Conventions applied during presentation of findings

In keeping with the narrative approach to the study, contextual information about the women and their pregnancies is provided, and further individual data is available (see Appendix E). My speech is included where appropriate (KC), to demonstrate the context of the question, and to render transparent elements of co-construction within the dialogue. The thematic quotes used here are not edited, except to remove identifying details, and where the notation '[...]' is used, this represents a brief pause in speech (of less than three seconds), rather than indicating that sections of text have been omitted.

Participant pseudonyms are used throughout. All interviewees were invited to suggest these, so that their contributions and the ways in which their responses were incorporated into the findings could be visible to them in any reports or other outputs arising from the research. About half chose to do so, and most participants were

aware of their pseudonyms by the time of the last interview. Some requested that their real names be used. This presented an ethical dilemma, because, as Langellier (2001) discusses, providing anonymity to participants is a conventional requirement of research ethics which leaves little room for interviewees to reclaim their authentic names and personhood from the research identity that is created for them. Langellier argues that researcher insistence on participant anonymity reproduces 'dominant power structures' (ibid, p.176) and inverts attempts to balance the power relationship more equably. In practice, it would not have been evident to the research audience whether a participant chose their real name or an alternative, and recent UK work in this field argues that cultural preference for recognition over anonymity is increasing (Wiles et al 2006). However, as the study was already bound by NHS research ethical and research governance approvals and by university sponsorship, each of which requires participant anonymity as well as confidentiality to be maintained, I asked these respondents to accept a pseudonym for the purposes of this study. The names of any other people referred to within the texts have also been changed.

Exploring complexity in birth place decisions

During the course of the fieldwork, it became evident that there was no single pattern of birth place decision making. These differed by parity, and there was variation in both when decisions were made and what those decisions were. The influences which gave rise to this variability are explored here. An overview of the decisions participants had reached by the final month of pregnancy is presented first, followed by a discussion of broad social influences, and the particular influence of maternity service practices.

Timing of birth place decisions

Women and their partners reported making birth place decisions throughout pregnancy, ranging from prior to the booking appointment to deciding during labour. Amongst women expecting their second or subsequent baby, almost half had made their decision before they saw a midwife for the first time. These decisions were also the most enduring, because these participants only rarely reconsidered their birth place preference, which was most often for hospital OU birth. Around a third of

women expecting their first babies decided where to give birth before the booking appointment (see glossary), another third decided (or found the decision was made for them) at the time of booking, and a further third made their decisions in the last few weeks, after attending classes or tours, or having investigations to ensure they fitted criteria for low risk birth settings. In the final month of pregnancy, women planning non-hospital births had regular blood tests for haemoglobin (iron) levels, scans to estimate fetal size and glucose tolerance tests (see glossary), so uncertainty about whether they would be able to give birth in these settings was maintained throughout labour and birth. These issues are explored further below.

Variation in planned place of birth in the final month of pregnancy

Just under half of women expecting their first babies opted for hospital OU birth, and the remainder were considering giving birth in non-hospital settings in the last month of pregnancy. Sometimes, women expecting their first baby knew they preferred a non-OU birth, but their decisions were delayed as health professionals debated the appropriateness of non-OU births. Samantha found herself in this position, and the following extract is from an email interview.[1]

> I was little annoyed with the length of time it took them to come to a decision but I understand that the consultant just had my best interests [at heart]. I have been seen numerous times by the consultants, a consultant midwife and a community midwife were all involved in the decision. There were lots of discussions and checking of my notes etc., so I do think that I was carefully assessed. Now I know I am getting the place I want I am much more relaxed about the labour so definitely a good decision.
>
> (Samantha, first baby, Southcity)

Iona found herself in a similar position towards the end of her pregnancy:

> **Iona** And I had a blood test last week, so the results will come through … well, this week [the midwife] will call and say whether [...] because

[1] Samantha is deaf and opted to have an email antenatal interview; her postnatal interview was conducted at home with a BSL interpreter present.

then it means that by the time I next see her the week after I'll know the result and therefore what decisions are to be made or not to be made. But yes.

KC So when did they say that there might be a question over you going to [the FMU]?

Iona They rang and told me after I had my first blood tests that showed low iron levels. And said, you know [...] 'We'll check again in so many weeks,' or whatever it was at the time, 'And then at that point we'll have to make a decision, or you'll,' [...] you know [...] 'We'll help you make a decision on where you're going to be having the baby because it may affect it.' But er [...] she may have actually said [...] No, yes, she said that all. Yes.

(Iona, first baby, Westfield)

Others expecting their first baby had often not made a decision until the last month because they did not receive information about the alternatives available until this time. This was particularly evident if an AMU was available; at the start of pregnancy, most women and partners only heard about the hospital OU option:

> So [...] yeah, so we'd need to do more research, I need to build up some more positives against the lack of [laughs] information that we've got. We really have a, you know, very, very little information on what a hospital birth involves.
>
> (Annette, first baby, Southcity)

On the other hand, Laura had reached a clear decision about where to have her first baby at the start of pregnancy, and she linked this to her families' experiences of birth:

> Um [...] in deciding where to have the baby I guess I was pretty determined I'd have it in hospital, both my sister and my mother had some problems during birth, I was born by emergency caesarean and my sister had an emergency caesarean with her first child, and then an elective caesarean for her second, so it made sense given all of that and the experiences of people

close to me that I'd like to be somewhere with good medical care on hand, if something goes wrong.

(Laura, first baby, Southcity)

Many women expecting their second or subsequent baby preferred OU birth to the alternatives available. Whilst it is the case that there were more women with pre-existing risk factors amongst those expecting their second or subsequent babies, if all women with clinical risk factors are excluded then the finding remained consistent; fewer women with straightforward pregnancies chose OU. An example is provided by Homer and Ella, for whom an 'ideal birth' was not a 'real life' proposition:

Homer like Ella said, in your [...] if you want an ideal birth you want to think that you can do it without any intervention and you want everything goes quick and no problems, that's what you maybe imagined as an ideal birth, but it's not real life you know, there are always complications and always things, and [...] when there are stuff it's better that you have a hospital on hand.

(Homer, partner of Ella, second+ baby,[2] Southcity)

Arabella was clear from the outset that she wanted to give birth in hospital, and was also aware that her determination meant that health professionals were not invited to discuss alternatives with her:

I'm quite, I mean I've already got in my mind, obviously I know I want to be in a hospital and I'm pretty sure I want an epidural, and you know, so [...] Yeah, I wasn't [...] I obviously took on board what [my GP] was saying about the different options but I knew, I know that they're not for me. It's not something that I plan to do.

[A little later in the first antenatal interview]

So [the midwife] didn't really go into it then because I also said to her I know what I want to do, I know that I want to be in hospital, I want just, you know,

[2] As in Chapter 5, 'second+' is used to refer to women expecting their second or subsequent babies.

> I want to go up to the normal delivery suite and just basically be anywhere where the anaesthetist is and [...]

Arabella's strong preference for an OU birth arose as a result of a difficult previous delivery, and in the course of our interview, she tried to envisage how she could cope with the pain she experienced if an epidural was not available:

> I just remember the unbearable pain and then I remember getting the epidural and it all just went away. Then after [...] when [baby] was delivered I ripped pretty badly, and then again I didn't feel it because I'd had the epidural, and all I was thinking was, **imagine if I hadn't had that** and I got that, because it was quite a bad tear, I had to have a lot of stitches and [...] yeah.
>
> (Arabella, second+ baby, Southcity, emphasis added)

For many participants, hospital birth was a taken for granted fact of social life; women who had previously given birth did not consider their preference for OU to be exceptional. For some women, receiving medical help during previous births had persuaded them that birth was risky. This finding has been reported previously; Houghton et al (2008, p.61) acknowledged that women's previous experiences were an important influence, and argued that women's risk perceptions were 'negatively distorted' by their own (and others') accounts of birth events. The experience of a hospital birth often led women to reappraise their pre-birth assessments of pregnancy risk, and because this was a key theme during the postnatal interviews, it is discussed in further depth in Chapter 8. Other women opted for hospitals for reasons of practicality or familiarity, and because they believed hospitals had good facilities and well-trained staff who could cope with all eventualities. Although the availability of both drugs for pain relief, and active birth equipment were sometimes perceived as important, hospitals were above all perceived as being safe, and this theme is also examined more extensively in Chapter 7. The observation that women expecting their second or subsequent babies consistently prefer OU challenges the suggestion that women will opt for lower risk settings after their first birth, but has resonance with some of the studies discussed earlier which also identified preference for OU, even

amongst women with poor experiences during their first births (Zadoroznyj 1999; Longworth et al 2001; Pitchforth et al 2008; Dagustan 2009).

Influences upon birth place decisions

Previous research has already proposed several influences on birth place decisions, including structural factors such as age, parity, social class and education (Nelson 1983; Davis-Floyd 1994; Zadoroznyj 1999), and features integral to birth places, including proximity, reputation, and quality (Combier et al 2004; Pitchforth et al 2008). Other researchers have argued that expressed preference for home-like environments may obscure real preference for a safe, clinical environment (Hundley et al 2001), and Houghton et al (2008) and Barber et al (2006) identified that UK women believe hospital to be a safer and more secure environment for birth. Participants in my study conformed to this overall picture, but family upbringing and friends or colleagues' views also proved important.

The experiences of friends and families became interwoven with advice or information from midwives or doctors. Almost every participant cited conversations they had with friends, colleagues and family members about aspects of maternity care advice or services. As Lowe et al (2009, p.1476) observed (in relation to pregnancy screening tests), information about aspects of pregnancy may initially be acquired through formal sources such as NHS leaflets and books, but is then compared against the lived experiences of others. The extracts below are from Kath's antenatal interview, and show how professional and peer accounts became intertwined:

> **Kath** But yeah, it was internet, a lot of internet research, and also talking to my cousin, then my GP's experience of [NHS trust], and then I've got a friend whose wife has given birth twice at Eastcity, and they've just kind of, yeah [...] they've had absolutely, probably your average experience, you know, painful but, you know, it was good and they would go back there if they got pregnant again.
>
> [A little later in the same discussion]

> [...] And then what actually swerved me towards Eastcity was my friend [name]'s experience there, after having gone private and then rushed to Eastcity, with complications [...]
>
> (Kath, first baby, Eastcity)

Family beliefs about birthing were also influential, as were internet resources (including NHS websites, Mumsnet and other internet discussion websites) and TV programmes. The Channel 4 documentary 'One born every minute', was cited most frequently; this programme filmed women in labour and was being screened weekly whilst the antenatal interviews took place. Previous hospital experiences were important, as was exposure to private health care; the latter is also discussed further in Chapter 7, because sensitivity to an idealised notion of private care, against which NHS maternity care was often compared unfavourably, proved to be an important aspect of risk perception for some interviewees.

Family and friends as cultural influences on birth place decisions

Whilst familial norms of birth are recognised influences on birth place decisions in other countries and cultures (e.g. Davis-Floyd and Sargent 1997; Chamberlain and Barclay 2000; Donner 2003), little is written about family influence in the UK context. Within this respondent group, family influence was a marked feature of some accounts, although the extent of the influence varied, apparently depending on levels of socio-economic affluence. Although the numbers involved are of course small, it seemed that women from both less privileged and very privileged families were constrained by family mores, and whilst middle-class women still discussed birth with their families, they were less likely to be guided by pre-determined familial views. Patsy and her birth partner Jan were both from working-class family backgrounds,[3] and during their antenatal interview they expressed strong aversion to home birth. When we discussed this further, they revealed that each of their families had experienced stillbirths at home within the previous and current generation:

[3] The terms 'working class' and 'middle class' are used here to differentiate between the *historical* class position of these families and their 'current' levels of class capital.

Patsy My brother had [...] well his wife had a baby at home and the baby died.

KC OK.

Patsy And I think I must have been about fourteen, something like that, and it was just a horrific family experience to [...] because the baby was fine, it went full term, it was just a cord round its neck and a mistake by the midwife, and I think that affects [...] that sort of affects the family for a long time, you know, like anyone in the family who was involved with that or remembers that, you can't, it's just a no-no for us.

KC No, understandably. That's quite a major event in any family's history. Do you think that plays on your mind when you think about [...]

Patsy Well also my mum had one baby at home, and my [...] my [sibling]'s got [a serious medical condition]. Now I'm not saying that that was caused by the home birth but it all [...] adds to it. So her only home birth wasn't [...]

Jan My mum had a baby at home and it died.

Patsy Yes, it's just [...]

Jan And it was 9lb something the baby, it was perfectly normal. But she was left too long in labour, and the baby stressed and [...] you know. But it was perfectly [...] I mean I've got a [sibling] and the baby was just like [my sibling], my mum said. But that was a home birth so [...]

Patsy So I just know too many horrible stories and [...]

KC Sure.

Patsy So it wouldn't be an option.

[A little later]

Jan No. It never [...] I don't think it ever entered my head.

Patsy I think I'd feel so vulnerable.

Jan I don't think my mum would have let me, to be honest!

Patsy No. No. Nor would my mum.

Jan No.

Patsy She'd do everything in her power not to [...]

Jan To stop me doing that. Because of what had happened.

(Patsy, second+ baby, and birth partner Jan, Westfield)

Each was clear that, even if they had wanted a home birth, neither of their mothers would have allowed this. The recent infant deaths have a powerful effect on the current childbearing generation, and this is a reminder that stillbirth was, and remains, more prevalent in socio-economically disadvantaged families (Marmot et al 2010).

Sarah's upper middle class family background was very different, but she also said 'my mother would never forgive me if I had a home birth!' Although Sarah's mother had straightforward births, she was vehemently opposed to home birth, ('not on your life'), and awareness of her mother's strong views impacted on Sarah's perception of birth place risk:

> [...] the whole thing's rather scary, [my sister would] probably be better, as I think I am better somewhere where there's just intervention or people around, with medical background.
>
> (Sarah, first baby, Southcity)

The notion that working and upper middle class families share structures of control was theorised by Bernstein (1964, from Douglas 2003, pp.26–27), who considered that each of these groups learns to recognise and recreate a firm hierarchal family structure based upon family roles, so that younger members defer to older generations, even during adulthood, whilst middle classes value individual liberty above family norms.

Whilst it might be anticipated that Bernstein's theory has less purchase in contemporary times, it was supported by the study data, although the numbers of participants who had such different backgrounds was small, and the attributes of speech and bearing which reveal differentiation within class strata prove difficult to record or evidence.

Kath's account perhaps demonstrates how middle-class families can discuss birth plans without introducing the same level of sanction. Like Patsy and Jan, Kath's mother had also experienced a pregnancy loss, although in this case the baby's death took place following a hospital birth. During her initial antenatal interview, Kath outlined the importance of talking to her mother about her decision:

> One Sunday in [...] must have been late October, when we just had all the facts in front of us, and we were just like, aah! Mum was sitting there with a glass of wine, which was really helpful, and I was sitting there with a glass of water. But that was, no, it was fine. But that was when it all kind of came down, we kind of correlated everything [...] [identifying data removed] [...] and then it was just like, no, it's easier if I just stay in situ here, because I've got the house and everything like that, I'm close to Eastcity, it was just so much easier in the end.
>
> (Kath, first baby, Eastcity)

Kath's mother did not appear to direct Kath's birth place choice, despite her own experience and the impact of this on the family. This does not mean that her mother's pregnancy loss was not an important factor in Kath's decision to give birth in hospital, only that it was not part of this birth place conversation; if the influence is felt, it is historical and concealed, rather than being presented as an explicit sanction.

Previous experiences of hospital

Previous experience of maternity care is a known influence on women's decisions, but previous general experiences of hospital was also influential, although the direction of influence was variable. Some participants wanted to avoid hospital birth because of prior hospital experiences, whereas others drew upon these to explain why hospital was a site of safety, comfort or reassurance. Ella's childhood experience made hospital seem safe and normal, and she elected to give birth in the OU:

> And I think anyway, because my mum is a paediatric nurse, so I spent a lot of time as a child in hospital, also being a patient and I also worked in a hospital later on, so I basically don't have this fear of hospitals, I feel quite comfortable being in a hospital.
>
> (Ella, second+ baby, Southcity)

Ella was born in an EU country which has a higher caesarean section rate than the UK and where hospital birth is usual, so for her, hospital was both culturally normal and personally comfortable. She later recalled the following anecdote:

> **Ella** And what I remember once when I was six, they tried to put me [...] I don't know how to call it in English [...]
>
> **Homer** (Ella's partner) [...] An IV?
>
> **Ella** An IV, yes, and they tried like six or eight times, and I was so proud because I didn't cry, and they thought, oh gosh, she's so good. And this is what I felt, that I'm really brave. So I think I was probably that kind of child, and felt this was important, you know, to not cry! So yes.

Repeated attempts to gain IV access during a childhood stay in hospital could easily have been traumatising, but instead Ella remembers how 'they' (perhaps hospital staff, or her parents) made her feel proud of herself. As an adult, she might revisit this and see it differently, but instead these experiences seem to have anchored the sense of safety she acquired in childhood. The feeling of being safe is associated with her experiences in her originating country, where hospital birth is positioned as normative, and where, compared with the UK, there is less consumer debate about the appropriateness of this for all pregnancies. Here, the (national) cultural 'system of meanings' can be seen as the resource on which Ella draws, and reproduces through her own decisions; as Hays (1994, p.69) argues, 'culture is surely social and transcendent at the same time as it is *experienced* as individual and subjective'. For Ella, a difficult first birth which ended in an instrumental delivery did not shift her perceptions; rather, she said 'I just feel secure in hospital'.

Samantha had also been hospitalised as a child, but in her case this led to a strong preference to give birth in what she described as the more relaxing and homelike environment of the AMU:

> I have been in and out of hospital since I was six years old so they are not really a pleasant thing and there are not pleasant associations really with hospital, they are all surgery, pain and being poked and prodded really.
>
> (Samantha, first baby, Southcity)

Experiences of hospital during adulthood could also carry influence, and partners were also adversely affected; some partners had childhood experiences of hospitalisation, or had experiences of visiting dying parents or friends. This was a hidden influence not usually evident to those not socially close to the individual, but remained capable of instrumentally reshaping expectations of hospital and in-patient care.

The contribution of early pregnancy appointments to birth place decisions

Almost 20 years ago, *Changing Childbirth* recommended that women should not have to decide where to give birth at their first antenatal appointment (DH 1993, p.24), yet NICE antenatal care guidelines still encourage health professionals to provide information on place of birth in early pregnancy, ideally by the tenth week (NICE 2008, p.11). The early presentation place of birth options impacted strongly upon couples' birth place decision, and these experiences are discussed in relation to the variations achieved when GPs and midwives were the primary point of access.

Early pregnancy: differences between city and county trusts

Women in the city NHS trusts invariably saw their GP in early pregnancy and were then referred to midwives for a full booking appointment. For the remainder of their pregnancy, they were seen by midwives or GPs. They often saw many different midwives, unless they were with a caseload practice, where continuity of care was maintained by one or two midwives. In comparison, women in Westfield NHS trust almost always saw their midwives first, and usually saw the same midwife or pair of midwives throughout pregnancy.

Early pregnancy appointments with GPs

The impact of having initial appointments with GPs was that women learned that the choice of place of birth was between different hospital OUs, and also that there was some urgency about making their decision. Although some of the hospitals in question also offered AMUs, GPs did not provide information about these 'within hospital' alternatives to women, and it was usually the case that women only found out about AMUs during antenatal classes later in pregnancy; until that point, they believed that only hospital OUs were available to them. In Westfield trust, which provided FMUs, most women saw a midwife rather than GP for booking, but one participant who sought medical care from a GP in early pregnancy described his advice to her about the FMU as follows:

> He said, um … he was very, he said [the FMU's] fine, but he told me that, as you know, there's no doctors, and he used to work in [district hospital], so he told me, um … that he can only say [OU] is good, 'And if something happens to the baby, if something happens, you're 40 minutes away, 40 minutes away, you just think about that!' He was very strong on that.
>
> (Donna, first baby, Westfield)

Donna was receptive to her GPs views:

> I said, 'Look, don't worry, I'm not going anywhere there's no doctors.' And he's like, 'Yep, I'm just saying, you know, because you know the chances are … It's a 40 minute journey. Do you want to risk that?' No! [Laughs] But yeah, that's all he really said, but he was all right.

The GP's advice chimed with her existing belief that birth was risky and that it was best to be in hospital to ensure safety:

> I'm not risking that [giving birth at home or in an FMU], I'm not risking the baby's life or my life. So … you know, it's just eliminating all the risks as much as you possibly can.

Florence's experience with her GP in Southcity NHS trust was not unusual:

> Yes, and it's probably worth mentioning what happened in my first pregnancy, which is the doctor did say, you know, these sort of hospitals are your choices. I was ten weeks pregnant at that point, but she did very much say, 'You need to make a decision quickly, you need to register with them very quickly, and you know [...] there's no hanging around.' So I very much was of the impression that a decision had to be made very early on in the pregnancy, and I think her reasons for that were with regards to being booked in etc.
>
> (Florence, second+ baby, Southcity)

Sarah, who was pregnant for the first time, had a similar experience:

> As soon as I told my GP I was [...] pregnant, which was at about eight weeks, um, she said, 'Which hospital are you having it?'
>
> (Sarah, first baby, Southcity)

A while after this, Sarah reflected on whether she felt able to change her mind later:

> So by that, I don't know [...] when one can change your mind or when you have to make the decision, but it seems to me if you start down a process [...] you start down a process with a hospital and they've got your records and you've done your scans there, it's probably quite difficult to change.

Although most women who saw GPs first were only offered choices between hospitals, there were two notable exceptions to this pattern. Arabella's GP discussed the *Maternity Matters* (DH 2007a) choice guarantees in full with her, mentioning GP-based antenatal care, hospital based antenatal care and also 'things like home births'. Hilary's GP was also unusual:

> I mean just today going to see, well, even when I first went to see the doctor at (surgery name) she said, 'Oh well we're really supportive here of home births,'

and I said, 'Even for first births?' and she said, 'Oh yes, they definitely are, you should speak to the Eastcity midwives and speak to the midwife that operates from that surgery.'

(Hilary, first baby, Eastcity)

In these unusual cases, GPs did provide full information about the options available to women, and Hilary's experience was particularly enhanced by the unanticipated support for home birth she received from both her GP and her midwives.

Midwives' booking appointments

Booking appointments can last up to an hour, during which time midwives gather information about women's medical and obstetric histories, acquire baseline physiological data and provide pregnancy information. But surprisingly, these were curiously absent from women's initial narrative accounts of birth place decisions. Women often talked at length about their birth place decision without mentioning a midwife, and follow-up questions were often required to discern what role (if any) midwife appointments had played. Participants sometimes had difficulty recalling these appointments, or described repetitive history taking and over-abundant information being provided en masse. Holly's experience provides an example of this.

KC And if you bring that back to mind do you remember anything particular about [the booking appointment], about the midwife or about the room or [...]

Holly [5-second pause] No not really. I mean I [...] I was [...] you know, I was satisfied that everything that needed to have been done had been done. Er [...] I do remember potentially [...] [3-second pause] I'm just trying to think if anything sort of stood out really. No, as I say, it was mainly going through the usual [...] the usual questions about lifestyle and what have you.

(Holly, second+ baby, Eastcity)

Donna (whose experience with a GP in early pregnancy was discussed above) had a particularly unsettling experience of a booking appointment. She had been worried by

some slight bleeding in early pregnancy and revealed her fears to the midwife, who suggested she might have had a miscarriage and advised her to have a scan later that week, but continued nonetheless with the booking appointment. The midwife's advice meant that Donna then felt deeply anxious that the pregnancy was no longer viable, and so after the midwife left, she '[...] threw [all the sheets and leaflets] in the cupboard and closed the door, and I wouldn't look at it again until [...] you know [...]. Actually I didn't look at it for a while'. Donna's painful experience was quite extreme, but other women also reported similar anxieties at the time of the booking appointment. For example, Margaret said she ' hadn't really thought of it as viable until the 12-week scan, so it was kind of a bit early to really think about [where to give birth]'. The reassurance many women experience when early ultrasound scans confirm their pregnancy as real and visible is recognised in the literature (Draper 2002; Garcia et al 2002) but booking appointments almost always occur before this, and the uncertainty many women and partners felt about the pregnancy, and whether the baby was healthy meant that they were not yet ready to engage in decisions about birth.

A presumption towards hospital OU birth was a feature of booking appointments; in this sense, midwife bookings mirrored women's experiences with GPs in early pregnancy. The following excerpt from an interview with James shows how the midwife funnelled their decision towards hospital, apparently for organisational reasons:

KC I guess what I'm getting at is, was it raised in the booking interview, did the midwife talk about where you might give birth?

James No, um [...] well she did ask. She asked and said, 'How are you thinking about the birth?' and we said, 'Well we're still open-minded,' and she said, 'Well do you mind if I put you down as Eastcity, have you got any strong objection to Eastcity?' and of course we didn't.

(James, partner of Alison, first baby, Eastcity)

'Putting you down as Eastcity' was a means of ensuring that the referral process for scans, appointments and other antenatal tests went smoothly, and although the midwife also reassured James and Alison that they could later change their minds, their immediate experience was that a decision had to be made then and there, and their role as patients was to acquiesce. In this example, the organisational logic also reinforced that hospital birth is normal and the participants' roles as novice first time parents became subordinated to the demands of routine care.

Early pregnancy experiences of choice provision and choice exclusion

Antenatal care services are guided by policy to offer women choice of place of birth, but as Chapter 5 shows, the extent to which midwives and GPs provided information to women about birth place alternatives varied between occupational groups, localities and even individual practitioners/practices within a given area. Participants' engagement with maternity care might be thought of as encounters with the ways that these services are socially structured. Although women are positioned within policy and consumer debates as beneficiaries of the right to choose where to give birth, the reality, as discussed in Chapter 3, is that these choices (and to some extent, the options their health professionals can advise and support) are circumscribed both by clinical appraisal of risk, and by professional and cultural discourses. Although most participants were provided with some choice of place of birth, some women with complex pregnancies secured access to settings which appeared contra-indicated, and a substantial number reported that they had, or were given 'no choice'. The experiences of women at each end of this spectrum are briefly reported here, as a basis for a more substantive examination of choice experiences in Chapter 7.

Jia was a young, single Asian woman, who did not speak English, and her early antenatal experience was unusual. She was assessed by a consultant obstetrician as being suitable for an FMU (meaning that her pregnancy was medically uncomplicated), and told that there was no need for her to give birth in an OU. During our first antenatal interview, which was conducted with an interpreter present, it became clear that she would in fact have preferred to plan a hospital birth at this stage of her pregnancy:

KC So, um, looking back at what Jia said about the way that she could go either to hospital, or to the FMU, does she feel that she could choose between those? If she wanted to go to hospital, could she go there? [Translator and Jia talk]

Translator, to KC If she **could** choose, she would like to go to the hospital

KC OK, so she would rather go to hospital?

Translator Yeah, (then paraphrasing Jia) 'because a hospital has doctors [...] it makes me feel safer'

(Jia, first baby, Westfield, emphasis in recording)

Many women would have been in a position to make a case that they should be free to choose birth in an OU, especially given that this was a first baby, but at this point, Jia's situation was complex. She did not drive, and neither speaking nor reading English meant she would find it hard to navigate public transport. She was quite dependent on interpreters and did not feel she had any way of getting to a hospital. Her involvement in the study was helpful in this regard, because when her translator realised how anxious Jia was, she ensured that arrangements were made to show Jia round the FMU and acclimatise her to this birth setting.

Rhian was also young and single, and although she was pregnant with her second baby after an uncomplicated first pregnancy and labour, her options seemed equally limited

KC: And do you remember if, when she came and did your booking, did she [midwife] talk to you about where you wanted to have the baby?

Rhian: No. No.

KC: OK.

Rhian: You don't really have an option except (OU1) and (OU2).

KC: So she didn't talk to you about going to (the FMU)?

Rhian: No.

(Rhian, first baby, Westfield)

Both of these women had straightforward pregnancies and preferred OU. Although they lived in the same area and OU, AMU, FMU and home birth were all available, Rhian was only provided with the option of going to the OU, and Jia was (exceptionally) not given the option of an OU birth.

Vita's experience was very different; she wanted a home birth after a previous caesarean, and although women are often encouraged to have vaginal birth after caesarean, they are currently advised to do so in hospital OUs.

> And so when this baby came along I started thinking about it again, I did quite a bit of research into trying to have vaginal birth after C section, which is what the hospital sort of recommend now anyway, and the issue then became do I [...] for me, do I have it at home, try to, do I go to hospital? **And my very first experience with the midwife at the doctor's office was quite negative, and she was sort of [...] I mean she was very polite but she was basically saying, 'No chance, you'll never find anybody** [...] you can contact the consultant if you like but you'll be out of luck.' And I was like, oh! And quite [...] so that, I got quite upset and was emailing everybody saying, 'Oh no, oh no!' and looking into private midwives and all the rest. **But since then the consultants and other people I've spoken to have been much more positive about it.**
>
> (Vita, second+ baby, Southcity, emphases added)

Vita managed to secure the support of health professionals during her pregnancy, and was able to exercise choice, and her experience is revisited in Chapters 7 and 8, but mentioned here to illustrate the variation between women's clinical risk status and the extent to which they were able to negotiate access to different birth place settings.

'Selling the unit': Service sustainability

A separate influence upon birth place decisions arose as a consequence of NHS trusts' strategies to encourage the use of non-OU services. Of the three included trusts, Westfield had the broadest range of birth place alternatives available to women, and

as discussed in Chapter 5, this paradoxically lead to women's options being narrowed by health professionals. Pressure upon midwives to ensure that the FMUs and AMU were used and remained sustainable led to these services being promoted.[4] Andy and Iona described this experience:

Andy I got the feeling that they were trying to save the (FMU), I did get that impression. I don't know why.

KC Trying to save the FMU?

Andy Well almost, by trying to get more people there

[A little later in the same interview]

KC Do you know what made you think that, what made you recall that?

Andy Um, well [the midwife] made comments that said, you know, 'There are these other options but of course we hope you come here.' Comments like that.

(Andy, partner of Iona, first baby, Westfield)

Other women reported similar experiences, and where this 'sales' agenda was suspected, it led them to distrust their midwives' advice. Melody, also from Westfield, described being shown around the AMU during a 'tour' of the hospital:

Mel Yes, I had a look round, I think they call it [the AMU]. I didn't like it. I didn't like [...] the fact that they tried to push sort of a water birth on me, and [...] um [...] I suppose I don't really like, it's not that I don't really like, I mean I wouldn't want a water birth anyway but like some of the, she was trying to show me other positions [for giving birth] and things that, and I suppose I don't really like change, I've [given birth before] and I've been quite happy with the result, so I just sort of wanted the same. So I suppose she tried to influence me into doing something I didn't want to do.

[4] Midwives at this trust acknowledged that they 'champion' the FMUs or AMUs in their areas when these findings were presented to them.

KC OK. So on that visit, that idea of being pushed into having your birth in a different way, can you remember what gave you that feeling? Was it something that was said, or [...]

Mel I'd said that I didn't want to and she still kept going on and, 'Oh you might change your mind when you get here,' and [...] And I just [...] I just didn't like the way she was speaking to me really, and sort of going on about it.

(Mel, second+ baby, Westfield)

Bloor and Bloor (2007, pp.139-41) argue that aspects of selling often have negative connotations because they are linked to practices of marketing and persuasion which may be considered ethically ambiguous. Midwives were enacting dual and possibly conflicting roles when, as health professionals, they provided consumer information, and the pressure to fill beds was perceived by participants as a potential compromise to objective assessment of pregnancy risks. Sometimes, participants felt that they were not being told the full picture. Ronnie changed her preference from FMU after a friend gave birth there and was transferred by ambulance because she needed repair of a perineal wound (see glossary). The FMU midwife was not able to do this, so she had to go to an OU by ambulance after she gave birth, and Ronnie recounted that 'for insurance reasons', the baby was not allowed to accompany her. Other issues were raised by her friend's birth, and these were recorded in the field notes from her second antenatal interview:

> Ronnie's friend gave birth at the weekend, and there was no paediatrician available to check the baby. She was only able to have gas and air – Ronnie previously believed that pethidine was available at the FMU (although she preferred to avoid it if possible, it had helped her in her first labour). Ronnie said 'the midwives didn't inform me of these downsides!'
>
> (Ronnie, second+ baby, Westfield)

Ronnie opted to transfer to the AMU for her own birth, and said her midwife had been 'disappointed' by her decision. We discussed her change of heart in the postnatal follow up interview:

KC And did you have to do anything to make the change? Did you have to talk to your midwife in [the FMU] and say, 'I'm going to go to [the AMU] now'?

Ronnie Oh I did tell her. She was like, 'Oh no! Why?' And I told her, and she was like, 'Oh, it's not all like that, [KC: Mmm] it varies in different people to your needs.' But, and I was like, 'Yeah, but I don't want that *maybe*, I want a *definite*.' [KC: Yeah] And she was like, 'OK, that's fair enough,' and she said, 'Would you like the number?' and I was like, 'Oh, I've already sorted it.' [Laughs] And she was like, 'That's OK then.' So [...] yeah.

These experiences demonstrate how midwives and women were affected by the pressures to keep units open, but presents new knowledge about the deleterious effect this could have on women's confidence that trust staff would place their birth safety ahead of these strategic goals. Although this situation was limited to one participating NHS trust, the NCT (2009) report that a key factor limiting choice in England is that staff shortages and financial imperatives lead to closure of AMU, FMU and home birth services. It is therefore likely that this problem affects women across other trusts in England, and Redshaw (2011, p.51) reports that 35% of AMUs and 32% of FMUs did report closures of between 4 and 30 days during 2007, 'largely as a function of capacity and staffing issues'.

Summary: the weight and direction of influences upon birth place decisions

Participants' accounts demonstrated that a broad range of socio-cultural influences were brought to bear on their birth place decisions. These drew upon family upbringing, hospital experiences during childhood and adulthood as well as previous birth experiences, cultural discourses in media accounts of birth, and contemporary peer group exchanges of experiences and knowledge. Although the direction and bearing of these influences was difficult to predict, cultural beliefs perpetuated within families were deeply integrated for some, and previous encounters with health care other than hospital care were also important to the ways opinions were formed. A key finding was that the expectation of hospital birth was reproduced by both doctors and, in many cases, by midwives too, either through failure to mention non-OU

alternatives, through accentuating risk assessment in early pregnancy and by signalling that OU birth was tacitly assumed to be a default option. The presumption towards hospital birth was introduced by health professionals in early pregnancy appointments through focus upon clinical risk assessment and monitoring, and these came to constitute a strong 'public narrative' (Somers 1994) which normalised hospital birth and positioned pregnancy and birth as risky.

For these participants, seeing a GP at the outset of antenatal care meant that they only heard about hospital OU options. Although midwives have longer to spend with women, their booking appointments proved hard to recall, and were remembered as occasions of clinical tests and history-taking. For some Westfield women, divided booking appointments did mean that non-hospital options were discussed, but for many, this was still too early in the pregnancy to be valuable. Exceptions occurred where GPs highlighted home birth, and caseload midwives also spent time with women in later pregnancy to discuss these options more fully, but the overall experience was that a biomedical orthodoxy was reproduced through GP and midwives' antenatal care practices.

Differential agency in birth place decisions

In Chapter 3, an argument was made that individual agency is mediated by social structures. In his theories of social practice, Bourdieu (1990, p.54) argued that an individual's worldview, or 'disposition', frames and limits their expectations. This position has been subject to critique on the basis that it '[strips] agency of its critical reflexive character' (Williams 1995, p.588).[5] Hays (1994) draws upon both Bourdieu (1984) and Giddens (1984) to formulate a similar argument, suggesting that 'people are agents on a daily basis' but that 'the choices that agents make' (and therefore the opportunities to behave reflexively), 'are always within the realm of structurally provided possibilities' (ibid, p.64).

[5] 'Habitus is 'formed in the context of people's social locations and inculcates them into a worldview which is reconciled to their position, thus serving to reproduce existing social structures' (Williams 1995, p.577).

The 'problem' of agency is of central relevance to birth place decisions as women are variously encouraged to choose, seek guidance, and feel and be responsible for a safe outcome for both themselves and their infants. It seems unsurprising that some reported having 'no choice' (Jomeen 2007, p.488; Houghton et al 2008, p.63; Pitchforth et al 2009, p.45). Pitchforth et al (2009, p.44) drew on qualitative research to argue that women fall into two categories of either 'acceptors' who prefer to 'go with the flow' or 'active choosers' who were prepared to 'put [their] foot down', although these authors also reflect that acceptance does not necessarily indicate an *absence* of personal agency, but rather a preference for (actively) delegating the decision to health professionals.

During antenatal interviews, women and partners presented different aspects of agency within decisions, and in the ways they reported that choices were presented to them. Altogether, five categories of agency were observed, two of which ('active choosers' and 'acceptors') have been previously described in the literature. In this discussion, 'acceptors' are described as 'deferential' agents, because these individuals preferred to accept medical or midwifery advice without demur. Three further categories of agency were identified within the sample; these were 'candidacy' (claiming eligibility for a particular service or model of care), and two linked concepts of 'relational agency', where women took decisions but in concert with others' views, and 'delegated agency', by which partners (or occasionally, women) accepted their significant others' decisions, at least temporarily.

Active agency was a feature of many interviews with women with privileged identities and backgrounds. These respondents used active speech and clearly describe their decision-making position, and therefore resemble the *active choosers* that Pitchforth et al (2009) identified. When I asked Florence whether place of birth had been discussed with her, she replied:

> I had my first child at Southcity and opted to have the second there, **so I very much informed my doctor that that's where I wanted to go to.**
>
> (Florence, second+ baby, Southcity, emphasis added)

This proactive stance was very different to that of interviewees whose agency was deferential. Like Pitchforth et al's 'acceptors', they expected a health professional to advise them or even decide for them, saying: 'it was all arranged by the midwife', 'it's out of our hands', or 'I have to do it at hospital'. These evaluations positioned health professionals as being active agents, whilst the speaker's voice is passive, as in the extract below from Cecile's antenatal interview:

KC So really you've just been offered [the OU], that is your [...] is it fair to say that's the choice you've been offered?

Cecile Well they [midwives] say, 'I presume you're going to have your child in [Southcity OU]' I think, I suppose so. So that was the conversation.

(Cecile, second+ baby, Southcity)

When participants talked in these terms, the final decision was usually made by the health professional, but this was not always the case. Iona was an exception; she said her birth place decision was dependent on having *good* blood tests and scans, and at the time of our first interview, felt resigned to being told where to give birth, but a few weeks later, her tests were all normal and she eventually chose where to give birth after the onset of labour.

Iona Well I was unsure of where [...] a. where I wanted to go, but b. there was potentially not a choice for me because of my [iron levels] and, um [...] but in the end that didn't come into the equation so it didn't matter.

KC So when was it really a definite decision, we're going to go to [the FMU]?

Iona Um, probably the day I went into labour. [Laughs]

KC OK. Really?

Iona Um, no, because neither of us [Iona or her partner, Andy] could really decide what to do, and I think in the end I just said, 'Oh let's just play it by ear, if I'm feeling fine and [...] as fine as I'm going to

> feel, then let's just go to [the FMU].' My notes were all at [the FMU] so, like, we both said, look, we'll go there initially anyway, and if need be we can drive ourselves to [an OU] and take the notes with us. So [...] yeah.
>
> (Iona, first baby, Westfield)

Although some women were in agreement with a health professional taking these decision, it was often the case that there was some regret, or a sense of exclusion, as in Rosa's response:

Rosa: [Midwife's name]'s told me that I've got to go to hospital

KC: OK

Rosa: She said they won't let me in anywhere else.

Deferential agency might in itself constitute a constraint upon decision making. In Bourdieu's (1990) terms, individual worldviews sometimes limited the horizons of possibility, because some women did not feel in a position to challenge choice restrictions, whereas others who were more proactive could envision alternatives and found the confidence to negotiate with health professionals (Florence, mentioned earlier, and Vita (p.172) provide example of this more active stance). Yet, as in Iona's case, the practice of deferential agency could sometimes become a route to more active involvement. During the time of uncertainty, whilst her blood test results were awaited, Iona deferred to the midwives' views and felt that 'there was potentially not a choice for me'. Once the results suggested that Iona could safely choose to give birth at the FMU if she wanted to, she decided to wait until she knew how she felt on the day, making the decision with her partner as events unfolded. However, Iona was unusual in this respect; it was more often the case that women with straightforward pregnancies who were deferential throughout pregnancy gave birth in hospital OUs.

Candidacy is a concept drawn from Dixon-Woods et al's research into access to health care (2006, p.8), and is described by these authors as 'the ways in which people's eligibility for medical attention and intervention is jointly negotiated between individuals and health services'. Dixon-Woods et al (2006, p.8) argue that affluent

individuals are 'more adept' at accessing health care, but those less advantaged are at risk of being excluded or judged unsuitable, even undeserving, of services. This was borne out in my data, as affluent, educated women managed to negotiate access to services for which they did not fulfil admission criteria. On the other hand, some women without graduate education, or from less affluent backgrounds, also expressed their case for a medical birth setting assertively to secure access to OU care during labour, and this was another iteration of candidacy amongst less affluent, but nevertheless assertive women. Mel provides an example of this; she had straightforward labours but was adamant that she wanted to deliver in the OU each time, because her first child was born with a problem that required unanticipated transfer to a neonatal unit.

> [...] because of [baby's name]'s problem in birth that's a factor for them, because although I have had scans with this [pregnancy] that it's still a factor for them, because obviously there's no doctors or anyone on the [AMU]unit. And also my BMI was sort of at the cut-off point. So [...] but they said I could give birth there if I wanted to but I've decided not to, just to go to the labour ward.
>
> (Mel, second+ baby, Westfield)

Mel recognised that her baby's problem was not something that would be expected to happen again, but the fact that it had happened to her once meant that she did not want to contemplate a birth in a unit without paediatric doctors. This represents agency through enhanced cultural (rather than socio-economic) capital, acquired through being an experienced mother, and a confident sense of self as authoritative. For some women, an additional supporting voice was still required, and this was the case for Vita, Samantha, Nia and Jia, all of whom were helped by an advocate (midwife or interpreter) to secure their eventual preference.

The final two categories described here, relational and delegated agency, are linked. The concept of relational agency is drawn from Mackenzie and Stoljar's (2000, p.4) feminist argument that 'persons are socially embedded and that agents' identities are formed within the context of social relationships'. This category of agency arose where

women reported that they had made their decision with their partners (or families) rather than independently, and has previously been reported in relation to home birth (Edwards 2005), but not in relation to birth place decisions more generally. For example, during Serena's antenatal interview, she explained that although she would have quite liked a home birth, her partner preferred hospital. In these circumstances, women did not necessarily feel that their autonomy had been stifled by their partner; rather, as Serena explained:

> No, I understood his reasons for it, and I would have [...] I wasn't prepared to put my foot down when I didn't know medically how I was going to be, and also risking something. Even though I know risks can happen at [...] in hospital, I'm not saying it's risk free, but I just thought maybe it is a safer option and we have waited this long, so [...] so yes
>
> (Serena, first baby, Southcity)

When women's decisions were relational, it was usually the case that pregnancy was considered to be a joint venture, where each had a vested interest in a safe outcome. Relational agency may also be thought of as performing couple-hood, in view of the social expectation that couples do things together (see Taylor 2010), or as a safeguard against family fragmentation in response to contemporary cultural anxieties about the longevity of couple relationships (Beck and Beck-Gernsheim 1995).

For some men however, the decision rested firmly with their partners, and I have described these men as experiencing delegated agency. Male partners sometimes had reservations about women's preferences, but felt that they could not voice these, saying: 'she's calling all the shots' or 'I'll support her', whilst explaining that the decision was beyond their control for the time being. This was therefore different from relational agency, and usually reflected a period of uncertainty, whilst men worked towards understanding and more wholeheartedly supporting their partners.

The categories of agency then varied, and were more profuse than other researchers have described. For some, agency altered during pregnancy as those with deferential

agency became more actively involved in decisions, or men who had initially delegated agency became more aligned with their partners as birth approached. Some respondents used more than one kind of agency, suggesting that agency was not fixed and could be either nurtured or negated. Those least likely to alter their position were women whose approach was deferential, and who agreed with the decisions made on their behalf, and as Bourdieu's theory predicts, their agency was restricted by the 'doxic' or 'taken for granted' notion that hospital is the safest place for birth (Bourdieu 1990, p.68).

When couple's birth place preferences differ

Amongst the participating couples, differences were most apparent in the initial antenatal interviews and male partners were generally more conservative at this stage, and wished the birth to take place in hospital. It follows that when the women wanted to give birth in OU, their partners were mostly in agreement, although in two instances, male partners privately considered a non-hospital OU birth to be safe and appropriate, but did not wish to impose this view on the women, who had reservations about these options.

When women wanted to give birth at home, their birth partners often experienced at least a stage when they felt either that OU was either more likely or simply safer. Michael's wife, Vita, planned a home birth in her first pregnancy, but needed an emergency caesarean. He told me:

> For the second pregnancy, the current one, she has wanted to have a home birth again, and I have been far more [...] cautious, I suppose. I'm worried and scared. Um [...] So [...] at the moment the plan [...] I feel very torn because I see my role as being one of supporting her, but I find myself torn between wanting to support her in her decision but also wanting to do the safest thing[...]
>
> (Michael, partner of Vita, second+ baby, Southcity)

Michael continued by saying that they had received advice that 'hospital birth is recommended'. His conflict between supporting Vita *and* being responsible for hers

and their baby's safety was shared by James, who described his fears about home birth as follows:

> I guess I'm envisaging a kind of darkened Victorian kitchen, you know, kind of like [...] with people coming and going and [...] pretty much ignoring the screaming lady who's having a baby in the background because it's pretty typical, and everyone knows that there's a pretty high risk of the baby dying and, that kind of image came into my head [...]
>
> (James, partner of Alison, first baby, Eastcity)

The deeply felt reservations these men shared showed that their concerns were not based on an unexamined notion that hospital was safest, but rather reflected their belief that in the absence of medical personnel, they would become responsible for knowing what to do and how to manage in any eventuality, and they and their partners would need to live with the consequences of this, should they fail. Locock and Alexander (2006, p.1354) also found that men assume the role of 'protectors/supporters'. Their research explored men's experiences of pregnancy screening, and also identified that men sometimes took on a role of 'decision maker' or 'enforcer', although this was not apparent in the different context of birth place decisions. On those occasions when participants rather than health professionals decided where birth should take place, only women seemed to reach decisions alone.

Several men expressed a perception that home birth must somehow involve a deficit of expertise, based on a belief that doctors, rather than midwives, normally attended hospital births. Others knew that midwives attended births at home and in hospital but argued that it was unreasonable to demand a home birth service, because this would leave women in hospital without sufficient staff to care for them. Midwives are sensitive to these beliefs and it is now usual for them to conduct a birth talk in the final month of pregnancy (Kemp and Sandall 2010), but these vivid anxieties featured much earlier than this, and men often struggled alone because their views were contentious and they did not want to appear to be withdrawing support from their pregnant partners. This finding would not have been apparent without the opportunity to

interview some male partners separately, and their narratives suggest that partner influence goes beyond the conservatism which is initially apparent, especially where couples are working towards a relational model of agency and the pregnancy is experienced as a shared transition to parenthood.

Agency in birth place decisions was then variable and nuanced; the agentic positions adopted by women and partners were constructed in relation to the views they held about appropriate engagement in decision-making, and refined during pregnancy and also throughout the childbearing 'career' (Thomas 2003). Women were able to take autonomous decisions, presumably on the basis of their right to choose the birth they want (Shaw and Kitzinger 2005), and men were in a more tentative position, and sometimes suppressed inner conflict whilst they came to terms with their partners' preferences.

Summary

New insights into birth place decisions in the contemporary context of English maternity care

This chapter addressed research questions related to women's and partners experiences making birth place decisions in the context of NHS maternity care, and presented new knowledge about how the processes of maternity care are experienced and interpreted, about the complexity of women and partner's decisions and the extent to which individuals adopted different agentic approaches practice within the social structures of constraint and enablement. Hays (1994, p.64) argued that ability to choose is mediated by the chooser's 'level of power', but in this context there are at least two and possibly more potential decision-makers (women, health professionals), partners), and distributions of power may vary on a number of axes. Lay professional relationships, gendered relations and intimate relationships may each contain separate structures of power (see also Sandall 1995, Annandale and Clark 1996, Annandale 2009). These might present constraints upon women's decisions, but could also feasibly enable these through advocacy, support and encouragement.

Variations in available alternatives

Choice depended on what was available locally, an issue which is already recognised as affecting maternity care nationally (Dodwell and Gibson 2009; NCT 2009). This study adds that women's experiences of being provided with choice of place of birth also varied. Most women did receive some choice, although this occurred in a context where the full alternatives available to them were narrowed by the health professional they saw first in pregnancy, by the social structures that positioned hospital birth as normal and created a presumption towards this, and again by the strategic championing of services to which midwives were attached. It is unlikely that this finding is limited to the three participating trusts, because national studies of maternity care also find women lack information upon which to base their decisions (HCC 2008; NCT 2009; Redshaw 2011). A few women received additional choices beyond what would be anticipated given their clinical histories, but a larger group reported having 'no choice' of place of birth.

Complexity in birth place decisions

Conducting interviews over the course of pregnancy brought into relief some of the complexities of birth place decisions. The study found variations in how and when women reached their preferences based upon parity. About half of those expecting their second or subsequent baby had decided before their booking appointment, but about two-thirds of women expecting their first babies had not done so. Women and partners expecting their first baby were also more open to birth place alternatives, and were more willing to alter their planned place of birth. Given the purposive nature of the sample, the proportions reported here may not hold true in the wider maternity population, but this could be tested in future research.

The study also adds new information about the breadth of influences acting upon women and partner's decisions, and contributes evidence that family beliefs about birth are transmitted through upbringing, and sometimes originate in oral histories of family births, or in the recent birth experiences of close relatives. Women and their partners revealed that the cultural norms they grew up with (particularly that hospital is the safest place to give birth) are often retained into adulthood, and these were even more pronounced amongst non-UK born respondents, for whom hospital is

emblematic of contemporary, safe birth and alternative models appear reminiscent of sub-standard care from earlier times. Women also accessed official NHS sources of information, although these were subject to reinterpretation in the light of media debate, and through the integration of friend, colleague and family perspectives into individual or couple subjective worldviews.

A further important influence was found to be women and partner's experiences of antenatal care in early pregnancy. Different models of care mattered; GPs only provided choices between hospitals and usually (but not always) omitted to mention AMU, FMU or home birth. Women were more likely to hear about these options if their first antenatal appointment was with a midwife. However, encounters with both midwives and GPs were oriented towards clinical risk assessments, and both frequently presented hospital OU as the default choice of birth place, by presuming that women would choose hospital, by focusing discussion on hospital OU care, or by omitting to mention alternatives which were locally available. Through the public narratives articulated by health professionals, hospital birth was positioned as normative during early engagement with antenatal care. Women and partners' narratives, and their accounts of health professional's framing of alternatives generally support Hays' contention that, 'most of the time, in most places, most people simply "habitually" reproduce the prevailing pattern of social life' (1994, p.63), suggesting that their choices *were* limited by social structures, but there were also exceptions where women renegotiated the options available to them, or gained extra advocacy from others and these were suggestive of enablement within the same confines.

Individual and couple agency

The practice of agency within structural and cultural constraints was analysed through women and partners' accounts of their individual and couple agency during birth place decisions and negotiations. Previous research has recognised that agency differs amongst pregnant women (Pitchforth et al 2009). This study contributes several new iterations of women and partners' agency within birth place decisions, which were described as candidacy, deferential agency, relational and delegated agency. In the context of birth place decisions, it seemed that although most couples shared decisions, only women were in a position to reach their own decision, and this differed

from Locock and Alexander's (2006) finding that during pregnancy screening men could in some cases assume a decision-making role. These findings, along with the observation that male partners experienced anxiety about the safety of birth in alternative settings, arose as a consequence of including birth partners in the study, but because men formed a relatively homogenous and privileged socio-economic sub-group within the sample, this may not hold true amongst a more diverse population of fathers-to-be.

Agency emerges as a diffracted and shifting capacity with various guises and roles, as an expression of individual autonomy or part of a couple's self-presentation during transition to parenthood, and with keen relevance to birth place decisions. Yet exploring the process of making birth place decisions in terms of structural constraint, agency and socio-cultural influences has in many ways provoked more questions than it answered. Chapter 7 explores participants' experiences within the context of a cultural theory framework, and this moves the discussion towards a more nuanced explanatory account of birth place decisions in the socio-cultural context of English maternity care.

Chapter 7: Cultural theory, risk and birth place preference

Introduction: Risk 'selection', choice and birth place decisions

This chapter presents findings about individual perspectives of risk and safety, and the influence of these upon birth place decisions. The way that Douglas and Wildavsky's (1982) cultural theory framework was used to explore this issue is explained, and findings arising from the analysis are outlined and discussed in relation to evidence from narrative interviews.

Chapter 6 explored the experience of making birth place decisions from the perspectives of women and partners, and found the opportunity to make such decisions to be variable and contested; some were able to actively choose where to give birth, whilst others were denied a choice. This was further complicated by a range of influences, particularly a normative discourse that reinforced hospital OU as the most appropriate setting for birth; women's own views of risk seemed to vary from broad acceptance of birth as medically risky to a reflexive rejection of clinical risks. This chapter begins to unpack some of these differences, and proposes an explanation based on three separate worldviews of birth place risk and safety. The issue of choice exclusion is revisited, and through integrating cultural theory with Bourdieu's (1984, 1990) theories of social class, a case is made that exclusion from birth place choice is part of a wider experience of exclusion which originates in women's historical relationship with health care. Women's experience of exclusion is also considered in more depth, and the ways in which some women collaborate with this, and their reasons for doing so, are explored. The discussion in this chapter relates mainly to antenatal interviews, and subsequent changes in response to the events of pregnancy and birth are explored in Chapter 8.

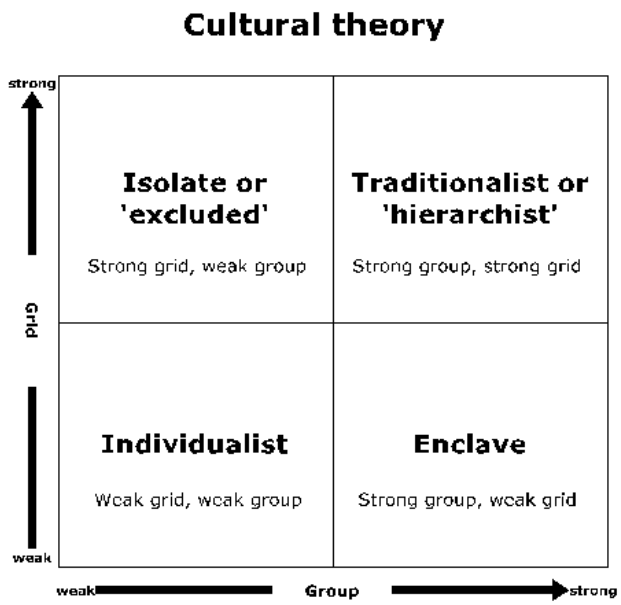
The basis for using cultural theory to inform the analysis was examined in Chapter 3, but the core components of the theory are briefly rehearsed below. The discussion

then explores notions of secular hygiene, and presents the different typologies of birth risk that these helped identify. The following section then combines these concepts to explain how different risk hierarchies were constructed within participants' accounts, and the implications these held for birth place decisions. The chapter ends with a summary and evaluation of the main findings.

Cultural theory and metaphors of hygiene and pollution

Figure 7 (overleaf) summarises Douglas and Wildavsky's (1982) cultural theory. The basis of the framework is that individual views relate to four 'political cultures'. The term 'culture' is used elsewhere in this thesis to refer to cultures associated with nationality or ethnicity, or cultures that exist within families. However, in Douglas and Wildavsky's (1982) theory, 'political cultures' refer to the particular worldview and biases inherent within each cultural group (or quadrant). If individuals are associated with a particular cultural group, they would be expected to share that group's worldview. According to Douglas and Wildavsky (1982, p. 14) 'risks are socially selected'. Each of the four cultures has a bias, which predisposes towards the awareness of particular risks as dangerous and demanding action, whilst other risks are considered less deserving of attention or may even be denied. Douglas and Wildavsky described the political cultures in terms of the strength of *group* (or belonging, to family, work, or other organisations), and *grid*, which is the extent to which individuals are subject to the external imposition of rules.

Figure 7 Cultural theory framework



Source: based on Douglas' (1982) descriptions of group, grid and the four political cultures

The significance of hygiene within this framework is derived from Douglas' (2002) argument that metaphors of hygiene and pollution are invariably used by cultural groups to help members distinguish between social practices that are approved and acceptable, and those which attract opprobrium or a sense of wrong-doing. Metaphors of pollution therefore 'function to keep some categories of people apart so that others can be together' (Douglas and Wildavsky 1982, p.37).

Secular hygiene and birth place settings

In *Risk and Culture*, Douglas and Wildavsky (1982) argued that groups distinguish between themselves and others through employing a 'non-technical' notion of pollution ('a contagious state, harmful, caused by outside intervention') which 'carries the idea of a moral defect' (1982, pp. 36–7). Pollution metaphors are identified by 'unwind[ing] the causal theories until they reveal who is being kept out and who is kept in' (ibid, p.37). Douglas and Wildavsky (1982, p.37) proposed the following four questions to accompany analyses of pollution, and these provided the basis for analysing aspects of hygiene, cleanliness or appropriateness within participant's accounts of birth place settings and practices:

> ...what is being judged impure; then, who is accused of causing the impurity; and who are the victims? What are the processes for removing the stain, washing out or cancelling the impurity?

The linkage between pollution and place arises from Douglas' recognition that notions of secular defilement arise through the concept of 'uncleanliness [as] matter out of place' (2002, p.50). As Callaghan (2007, p.12), details, birth is 'dirty work' which brings women and health care providers in contact with potentially polluting body fluids and bacteria. Callaghan's conceptualisation of birth dirt is based in physical matter, but as Douglas (2002, pp. 81-82) recognised, birth taboos go beyond the physical to incorporate spiritual dimensions of fear, death and sexuality, and the 'work' of managing strong emotions is also part of birth and maternity care (Rayment 2010). The identification of appropriate places for birth has long been recognised in traditional cultures, but is less well documented in contemporary western contexts.

Donner's (2003, p.320) ethnographic account of birth in India describes the routines by which, until very recently, women were sent back to their parent's home for birth where they were confined to a single room 'until the period of postpartum confinement was over'. Recent social changes in India mean that women from more affluent homes now opt to give birth in hospital instead; the removal to hospital confers social privilege, because it indicates the family can afford private medical care. Donner (2003, p.331-2) also details the growing preference for medicalised hospital birth (and caesarean) amongst Indian women 'as a way of containing the polluting aspects of childbirth ... pollution and its related embarrassment were minimised by having caesarean sections'.

Confinement is also an historical feature of European birth, vestiges of which are found in debates about when women who have recently given birth should go outdoors again. As Newell (2007) explains, this arises through biblical notions of birthing women being separated from their usual social world, and re-introduced after a church blessing had taken place. In anthropological writing, the separation of women during

birth, and their removal to an appropriate place for a liminal, transitional stage and a purified or celebrated return to social life constitute the three stages of birth as a 'rite of passage' (Van Gennep 1960, pp. 41-9).

Hospital and home as 'appropriate' birth places

Almost all interviews contained examples of hygiene and pollution concepts or metaphors, which lends support to Douglas' contention that hygiene-based differentiation is near-universal (Douglas 2002). During antenatal interviews, participants often explained their hospital preference on the basis that this is the right place for birth, and contrasted this with giving birth at home, which was 'messy' and conjured associations with the historical time before birth took place in hospital. In these accounts, hospital was considered to be clinical, clean and safe:

> OK. Well basically I think it's just what I've known. That's what my mother did, that's what everyone, all my [...] you know, my family members have had their babies in the hospital, and I just think it's a safer place in case of any kind of emergency it's better to be at the hospital where there's a doctor close by.
>
> (Alexandria, second+ baby, Southcity)

Birth in hospital was also conceptualised as 'appropriate'. This alluded to the concept of moral order, through making a responsible decision and allowing staff to do their jobs in a setting which was designed for this purpose. Melody's reflections on her decision to give birth in hospital (although her own mother had straightforward home births) draw these themes together:

> I mean my mum gave birth to me at home, she never had any problems. I wouldn't want to deal with the mess afterwards, but [...] No, I just think, I just think, let the people do their jobs, let them do their job where they've got the things that they need. At home they haven't [...] got everything, I suppose, to hand.

A little later, Melody positioned home birth as an old-fashioned practice, a throw-back to previous generations when things were very different, and also associated the health professionals of the time with behaviours which would now be considered unacceptable:

> It was funny, I was talking to a lady the other day about home births because she gave birth [...] I mean she's seventy now, but she gave birth to all hers at home [...] and she was saying that the doctor smoked and she smoked, and the baby was in its Moses basket the other side of the room and they were just sitting there smoking, and drinking coffee [...] And my husband, his mum gave birth to him at home, and the midwife came and she was drunk [Laughs]. She was Irish and she was drunk, apparently!
>
> (Melody, second+ baby, Westfield)

This seems a valuable example of Douglas and Wildavsky's 'mysterious pollution'; the source of the problem is social and the midwife from the past times invokes the disreputable 'dram-drinking matrons' of English folklore (Donnison 1988, p.44). Here, Melody draws a metaphorical line between 'then' and 'now', where the past is linked to moral impropriety, and the present is clean and ordered. Another iteration of this effects a similar division between contemporary approaches to childbirth:

> A great friend of mine is a bit of a hippy mother, and she was into this thing called the 'gentle birth method', which is a rather a crazy diet which I couldn't do because I've gone off most food, or did go off most food, or else I'd be eating nothing.
>
> (Sarah, first baby, Southcity)

Here, Sarah links being 'a bit of a hippy' with a 'crazy diet', which indicates an association between alternative (non-traditional) lifestyle and presumed irrational ('crazy') thought. Through doing so, Sarah distances herself from the 'risks' of diverging from 'scientific rationality', and her positioning suggests an alignment with medical orthodoxy.

For others though, the idea that hospitals are safe and clean was problematic. In these accounts, hospitals might be described as dirty, noisy, chaotic or overcrowded, occasioning exposure to infection or (other's) social problems, such as family arguments, or witnessing babies receiving treatment for exposure to their mothers' drug dependency.

> You're more at risk because you're with people, you're surrounded by ... however many, twenty beds or something, and ... you know, another forty couples that are having their babies and you don't know their health. And so disease, not disease but you know, things do spread.
>
> (Serena, first baby, Eastcity)

> I was on an end cubicle, and the people opposite kept opening my curtain, and I kept closing it, and they kept opening it, and they had loads of people round their bed and you just need that bit of space, like you've just given birth, and it's just noisy...
>
> (Jo, second+ baby, Westfield)

> Actually when I spoke to my friend today she was saying, you know, when they did have to go into hospital for the first one it was all quite traumatic, there was a baby just down the way who was being whisked instantly into care because the mother was a drug addict...
>
> (Alison, first baby, Eastcity)

As these issues relate particularly to an 'individualist' worldview, they are covered in more depth later. Not surprisingly, when participants found hospitals to be problematic, they were usually considering alternative settings for birth:

> Well, we went through a number of circles. I didn't, I couldn't have gone to Southcity, they were just so dreadful, I think the third time they'd lost my notes, I kind of was just like, I can't go here anymore [laughing] absolutely no faith in them, they weren't very good at all. So I was quite gunning for a home birth ...
>
> (Annette, first baby, Southcity)

The appropriateness of home as a place for birth was also troublesome. As well as the problem of mess, however this was conceptualised, the use of a home for both everyday activities *and* a transformative life event posed difficulties:

> But [...] yeah, I don't know if I could give birth in my front room and then sit there the next day with a cup of tea! But lots of people have done it. I actually have the bed upstairs that my grandmother gave birth to my mum and her two sisters in.
>
> (Kath, first baby, Eastcity)

> You know, it's kind of where [...] I'll have my toast in there one morning and a baby [will be born] in there the next morning and that's [...] couldn't get my head round that concept.
>
> (James, partner of Alison, first baby, Eastcity)

Durkheim (2001) considered that the identification of rites with specific places facilitated separation between sacred and profane activities, and these participant's attempts to imagine how it would feel to have a baby in their homes appeared to grapple with notions of transgression within everyday living spaces. Others described the need to protect the sanctuary of their safe home environment:

> ...um, but it's also my private space, my family, it's the sanctuary; you know, if something went wrong you'd forever associate that room with that nasty experience, and I think when you come home you want to close the door and all the, leave all the problems outside and leave all the stresses outside. It's your sanctuary, and I think to bring [...] And also we live in a flat which is a bit difficult, the neighbours aren't going to like it if I'm shrieking for hours on end. So that was a factor.
>
> (Sarah, first baby, Eastcity)

Overall, the balance of preference within the sample was towards birth in hospital OUs. Like Donner's (2003) Indian informants, women accessing English maternity care found that hospital solved many of the problems they associated with birth. Noise, mess, body fluids, pain, fear, smells and embarrassment could all be managed within medical or clinical environments, and as Bryant et al (2007) also observed, the end point of this reasoning is a clean, safe caesarean section. The additional insight gained through discussing perceptions of both hospital and home with all participants was that when hospital is judged to be the right place, home is equally seen as a wrong or inappropriate setting for birth. Home birth posed risks to family, to the sense of self as personal and private, and threatened the sanctuary of the home as a site of protection for the family unit. Yet for others, pollution metaphors were applied to explain why hospital was the wrong setting for birth. In these accounts, the physical space of a hospital was a source of dirt, infection, and routine transgressions of privacy.

Typologies of birth place risk and safety

Using hygiene and pollution metaphors as a 'forensic resource' (Douglas 1990) led to identification of three main categories of birth risk amongst participants (biomedical risks, quality risks and iatrogenic 'cascade' risks), and also provided insight into how these competing risks were selected for attention. A further category of moral risk was also present, although less prominent, and this posed particular threats to subjective social identities. Thematic analysis suggested that different risks were ordered by interviewees into hierarchies which corresponded with their overall views about *the way things are*. Three risk 'worldviews' (hierarchies) were evident, and each was

primarily associated with a different political culture. The association between risk worldview and birth place preference represents the core substantive finding from this study. The basis for this conclusion is explained in the discussion which follows.

Categories of risk

Whilst specific risks were associated with particular cultural groups, it was also the case that most participants were concerned with at least two separate categories of risk (most commonly 'biomedical' and 'client quality' risks) and that *all* participants raised issues about the quality of maternity care services.

Biomedical risks of birth

When participants discussed biomedical risks, they often expressed fears that 'something might go wrong' during their pregnancy, labour or birth. Donna's comment encapsulated this concern:

> ...it's just, you know [...] it's the 'what if' isn't it? You've always got that in the back of your head, '**What if something goes wrong**?
>
> (Donna, first baby, Westfield, emphasis in recording)

This was often accompanied by an articulation of the need to have access to medical staff; as Homer said, 'You have all the intervention you need, straightaway'. Other researchers have also identified the predominance of 'medical risk thinking' in birth place decisions (e.g. Davis-Floyd 1994; Jomeen 2006; Barber et al 2007; Houghton et al 2008). What this analysis adds is that although concerns about the biomedical risks of birth are commonplace, these were not always a deciding factor in birth place decisions. In practice, only individuals whose core beliefs were consistent with the traditional culture prioritised medical risks over all others and chose hospital birth on this basis.

Client quality risks

Client quality risks were related to participants' perceptions of maternity care services, staff or systems of care, and these formed the basis upon which trust was formed, or could fail to develop. A comprehensive body of knowledge encompasses aspects of quality and safety assessment in health and maternity care (e.g. Donabedian 1988; IOM 2001; Arah et al 2003; Marshall et al 2003; Jensen 2008; DH 2008; King's Fund 2008), and many of the experiences described by interviewees overlap with the domains of safety and quality described within this literature. However, the interviewees' perspectives of these issues did not always align well with the formal accounts of health care quality in these publications. Their views more closely resembled Øvretveit's (1992, p.52) description of 'client quality', which is derived from business research, and includes elements which are not explicitly addressed in the health care quality evidence. Examples include access to the services (i.e. transport, parking), the perceived competence, credibility and courtesy of staff and physical tangibles such as the appearance of the environment. Øvretveit recognised that expectations depend upon 'how clients perceive the service, which depends on their conscious expectations and their unconscious assumptions' and that these may be formed in relation to a (hidden) ideal (ibid, pp.45-6). As Chapter 6 discussed, women and partners did come into services with pre-conceived ideas, and when services fell short of these, their confidence in maternity care services was eroded.

Whilst the existing literature indicated that biomedical risks would be part of the thematic framework, the category of 'client quality risks' emerged inductively from the antenatal interview data, and was particularly associated with the individualist culture but also important to the traditionalist and enclave cultures. Almost all participants were exercised about issues of 'client quality', and sought reassurance that maternity service systems were robust.

Client quality risks associated with OU maternity care included seeing a different person each time (the 'multiple midwife' problem),[1], being 'pushed from pillar to post', equipment or facilities being old or crumbling, hospitals being too busy or

[1] Sarah, first baby, Southcity 'my sister had *multiple midwives*' [during her pregnancy, labour and birth].

understaffed, and the variable quality of health professionals' manner, education and decisions. For non-hospital settings, quality risks included uncertainty about whether a supportive midwife or non-hospital service (such as a birth pool or bed at an FMU) would be available. Respondents who were particularly concerned with quality sought information from many sources, including web-based reports and comparisons between hospitals. Although they still viewed hospital as the 'ultimate safety net' (Pitchforth et al 2008, p.564), they intended to explore other options first. In this framework, this worldview is most consistent with the individualist culture, who sought to secure 'the best place to give birth, in the context of *this* pregnancy and *our* values'. More contextualised evidence about quality risks is included within the discussions of political cultures below.

Iatrogenic risks: clinical iatrogenesis, and the 'cascade' of intervention

Two different kinds of iatrogenic risks were present within the data, and it is important to distinguish between these in the context of this study. The first is the established notion that medical practice carries the risk of harm to patients (Illich's (1995, p.27) concept of 'clinical iatrogenesis'). Although the outcome of iatrogenic harm is a patient safety issue, this is understood here as a 'client quality' risk, because it arises from participants' uncertainty about whether they could be sure that safe, high quality care would be available to them.

The second type of iatrogenic risk arose where medical intervention was considered to interfere with normal birth through instigating a 'cascade of intervention' (Inch 1982, p.244). This conceptualisation of iatrogenic 'cascade' risks was put forward by participants who considered birth to be 'natural', connoting essential, normal, pure, and outside human intervention (Lawler 2008, p.48-9). For those who saw birth in this way, although hospital might be valuable in *some* instances, the natural progression of labour was *not* thought to be protected in hospital OUs *or* AMUs.

Moral risks

The moral risk category was derived from Viisainen's (2000) work with home birth mothers in Finland, who encountered resistance to their choice given Finland's cultural

acceptance of hospital as the most appropriate setting for birth. As the sample included relatively few who planned to give birth at home, this particular risk category was less prominent, although some of those who preferred non-hospital births did experience moral opprobrium, especially if they had clinical risk factors within their pregnancies or obstetric history. However, different kinds of moral risks were also evident; for example, Donald worried that home births were selfish not because of the safety risks, but rather on utilitarian grounds:

> You know, they need to provide for the needs of many whereas we're insistent on what **we** want for the needs of **us.**
>
> (Donald, partner of Rosa, second+ baby, Westfield, emphasis in recording)

Other respondents also questioned whether individuals have the right to call upon hospital staff for home birth, arguing that by doing so the few jeopardise the safety of the many, or that the provision of choice is too expensive, and drives up the overall costs of publicly funded services.[2] Women planning home births also feared they were expecting midwives to carry too much personal responsibility.

These categories of risk contribute to the risk hierarchies found within the cultural groups, and the next section expands the cultural theory framework through outlining risk selection and prioritisation and the cultural bias attached to different worldviews.

How cultural theory informed the analysis of birth place decision narratives framework

A graphic representation of the theoretical model reached through the data analysis is provided in Figure 8 (overleaf).

[2] These interviews took place in the midst of the UK 'economic crisis' (2009) but before the current Coalition government came into power.

Figure 8 Political cultures and birth place decisions

		Cultural theory: political worldviews and birth place decisions	
		Low group	High group
	High grid	**Isolate** **Excluded from choice** **Low expectations of service quality**	**Traditionalist** **Risk selection hierarchy:** **1. Biomedical** **2.Quality** **Prefer hospital (OU) and reject home and FMU**
	Low grid	**Risk selection hierarchy:** **1. Quality** **2. Biomedical** **Willing to consider OU, AMU, FMU and home** **Individualist**	**Risk selection hierarchy:** **1. Iatrogenic (cascade)** **2. Quality** **3. Moral** **4. Biomedical** **Prefer home or FMU** **Reject AMU and OU** **Enclave**

The order in which participants prioritised various categories of risk when justifying their birth place decisions generated three different risk selection hierarchies, each associated with a particular cultural group (traditionalist, individualist and enclave; see Figure 8). Deciding which risk hierarchy individual participants used was achieved through a constant comparison technique which analysed birth place preferences, the reasons provided for these and for rejecting other possible alternatives. The first priority participants used to justify their eventual preference was deduced from the main justification provided for their planned place of birth. For example, if the choice was OU and the main reason was that 'hospital is safe', then biomedical risk was considered to be the first risk priority (traditionalist hierarchy); however, if an OU was

chosen because it was new, clean and 'state of the art', then quality risks were judged to be the first priority (individualist hierarchy). Table 7.1 below shows the planned place of birth at the end of pregnancy interviews for each cultural group.

Table 13 Cultural group and planned place of birth at 36 weeks

Cultural group at 36 weeks	**First baby (P=birth partner)**	**Planned place of birth**	**Second or subsequent baby**	**Planned place of birth**
Traditionalist	Sarah	OU/AMU	Jazz	OU
	Donna	OU	Adrianna	OU
	Kath	OU	Hannah	OU
	Laura	OU/AMU	Melody	OU
	Vanessa	OU	Alexandria	OU
	Jane	OU/AMU	Marta	OU
	Carl (P)	OU/AMU	Homer (P)	OU
	Sebastian (P)	OU	Jan (P)	OU
	Harry (P)	OU		
	Dan (P)	OU		
	Eric (P)	OU		
	Alex (P)	OU		
Individualist	Samantha	AMU	Ella	OU
	Jia	FMU	Holly	Home
	Annette	OU	Ronnie	AMU
	Naomi	OU	Florence	AMU
	Hilary	Home	Adele	FMU
	Iona	FMU/OU	Jo	FMU
	Alison	Home	Michael (P)	Home
	Margaret	AMU	Eddie (P)	FMU
	Debbie	OU		
	Serena	OU		
	Andy (P)	FMU/OU		
	James (P)	Home		
	Paul (P)	OU		
	Salah (P)	Home/OU		
Enclave	Marylin	FMU	Vita	Home
Isolate	Amanda	AMU	Michelle	OU
			Patsy	OU
			Zofia	OU
			Rhian	OU
			Nia	OU
			Abi	OU
			Arabella	OU
			Cecile	OU
			Maria	OU
			Rosa	OU
			Donald (P)	OU

Table 7.1 demonstrates that the traditional and individualist cultures were dominant in this sample, that enclave participants were few, and that a substantial number of interviewees were excluded from choice (isolate quadrant), most of whom were expecting second or subsequent babies. As the defining feature of this group was isolation from the mainstream and lack of choice, it is important to be aware that their planned place of birth is not necessarily their preferred place of birth; the subsequent case histories illustrate this point further, but the information in Table 7.1 reflects the decision taken rather than chosen or preferred place of birth at the end of pregnancy.

Douglas (1982) argued that political cultures are not clear and distinct; they tend to blend and overlap, and it was usually the case that participants discussed several risk categories, and might change their perspectives during pregnancy, labour and birth. It was sometimes very difficult to determine what the predominant risk was, and these dilemmas were discussed with colleagues, not to try and select the 'right' category, but rather to understand how best to make theoretical sense of such fluidity. The changes participants made are discussed further in Chapter 8 but are mentioned here to clarify that whilst the descriptions of the cultures appear essentialist, the interviewees were always considered to be mobile (or potentially so) within and between these areas. The cultural groups are described in more depth in the following sections, and both case studies and interview data are used to illustrate these analyses. The individualist and traditionalist groups are discussed first, followed by enclave and isolates.

Traditionalist and individualist cultures

The individualist culture and birth place decisions

As discussed in Chapter 3, the individualist culture was theorised as adopting an entrepreneurial approach to birth place decisions, with a preference for personal freedom. Individualists were therefore thought likely to exercise their opportunity to choose where to give birth. About a third of the study participants had individualist approaches to birth place planning, and many participants in this group also had attributes of privileged identities (see Appendix E and Figure 9 on p.225).

Individualist participants did undertake research into different birth place options and it also became evident that their key decision-making factor was the likelihood of receiving high quality care in a particular setting. These participants were closely attuned to 'client quality' risks (Øvretveit 1992, p.52), and linked these to the physical appearances of buildings, and the extent to which they were treated as individuals as they progressed through maternity care. Their quality evaluations began with their initial experiences with antenatal care, and continued through the events of pregnancy, labour and birth.

> The experience of coming to the [clinic] was [...] actually quite grim, because they have that weird little waiting room which is like someone's living room only with all the nice bits taken out and twenty plastic chairs shoved in, and there was that poor woman there who obviously had really severe morning sickness and you could hear her barfing in the toilet just up the hall, and the toilet was grim.
>
> (James, Eastcity)

Annette made the following observations about Southcity trust, and by the time of her follow-up interview, she had elected to give birth at a different hospital:

> I don't know, I find the whole [Southcity] hospital administration very, very poor. Which is fine, but I just hope they recognise the difference between someone coming in to give birth and somebody coming in with, you know, a broken leg or something when it comes to it. I just know how easily mistakes are made, and it worries me, that's putting my faith and the life of my child in a [...] in an overrun crowded hospital full of people giving birth is a [3-second pause] [...] yes, does make me a bit nervous. But [...] we'll see.
>
> (Annette, first baby, Southcity)

Several participants compared NHS facilities with private hospitals, having experienced some aspect of private care, either during fertility treatment, or through purchasing private scans, or previous admissions for surgery in private units.

> Um [...] I have to say I would feel slightly safer if it was the [private hospital] maybe, just because they gave a bit more sort of care, um, and they're busy, you know, so many people. So, for that, but that would be top, top, top care. So I don't know[...]
>
> (Naomi, first baby, Southcity)

> I mean I must admit when I went to Eastcity to do the [fertility] programme it was very, the offices were very kind of [...] very basic, quite [...] claustrophobic, you know, whereas [at other hospital] it was a new centre that they had, and even just the images on the wall, it had a feeling of like this is as if it's a private [...] you're walking into some kind of private unit. And not to say that the same skills are not transferred, you know, that Eastcity couldn't have [achieved a successful IVF], but it gave you that feeling of like not sitting down a corridor squashed together, everyone can hear what you're saying, it was very much [...] the way they presented themselves and the way the new unit, it felt like a new unit that they would have the better facilities.
>
> (Serena, first baby, Eastcity)

Closely linked to the concept of client quality was the importance attached by individualist participants to aspects of privacy. For example, Alison had read web forum discussions about Eastcity hospital, and these reflections contributed to her decision to plan a home birth:

> I think the one that really stuck in my mind as something that I would absolutely hate was the one where it said, 'My birth was great and then I was in a ward with other mothers, new mothers, and there was a guy there screaming blue murder at his wife or girlfriend or whatever because she was

> unable to breastfeed.' And I just thought, how grim is that, when you've just given birth and you're trying to be happy and you're sort of knackered and hormonal [...]
>
> (Alison, first baby, Eastcity)

Salah had visited a friend in a maternity ward and found her proximity to others uncomfortable:

> It was, you know [...] I remember seeing her in the evening and it wasn't [...] I mean it wasn't like, you know, all dirty or distressing in any way, but it wasn't particularly warm and welcoming. I mean she was, obviously she'd had the baby by then and it was [...] she was right next to someone else [...] I think that's the big thing about NHS hospitals is that you don't get rooms, for obvious reasons, and that is what makes it quite unpleasant.
>
> (Salah, partner of Hilary, first baby, Eastcity)

Salah's partner, Hilary, was very keen to avoid hospital and planned a home birth, partly because 'you get more one-on-one care at home'. Alison's partner, James, also acknowledged that planning a home birth meant they would have focused attention from midwives:

> [...]if you have a home birth then the midwives that you get are there with you throughout, (Mm) you know, and you normally get at least one, possibly two and sometimes three, which is, um, far better and more consistent than you'd probably get in hospital.
>
> (James, partner of Alison, first baby, Eastcity)

For individualists, concern with service quality was the principle basis for birth place planning. It was not that safety was less important, but rather that the best way to ensure their births were not subject to the vagaries of NHS maternity care was to find the setting or model with the best, most trustworthy and most reassuring service. This approach to birth place planning was evident within Margaret's antenatal interview.

Margaret discussed her need to 'get stuck in and ask questions and make a nuisance of myself [...] on purpose, because I've also had friends who have had near misses, you know'. She explicitly ordered her possible birth places into a risk hierarchy, and reached a decision that she preferred AMU:

> I suppose I would see it as three different stages, a home birth would be the least, um, secure, if you like, or you'd have the least input, medically [...] birthing centre you'd have medium, and further on high risk you'd get everything you needed. So quite quickly I decided that that [AMU] was the best option, because it covered both bases for me. And that then I wouldn't have to be transferred if anything went wrong, and [...] but I could have the birth centre experience.
>
> (Margaret, first baby, Westfield)

Overall, the predictions for individualism within the cultural theory framework were borne out. Of all of the cultural groups, individualists were most open to considering different birth place options and would usually consider all that were available, including hospital OU and all non-hospital options, but the highly valued privacy offered by the non-OU options meant that these were often selected as a preference. Choice was important, and consideration of biomedical risks was also present, but these were thought to be manageable through one-to-one care in AMU, FMU or home birth settings. The observation that participants with an individualist approach conducted careful evaluations of service quality, and were also motivated to avoid situations where they had less privacy, was unanticipated by the model, but several individualist women chose non-hospital settings such as home, FMU or AMU for these reasons. As these participants saw medical safety as indistinguishable from care quality and personal privacy, the argument that quality was prioritised above biomedical risk appears tenuous. This difficulty is recognised in the literature; in their research into perceptions of environmental risk, Wildavsky and Dake (1990) also noted that individualist and traditionalist groups share very similar concerns. The next section analyses the traditionalist worldview further, allowing the difference between the two cultures to become more apparent.

The traditionalist culture and birth place decisions

Twenty respondents held views consistent with the traditionalist culture, including about two-thirds of the participating birth partners. Participants in this group had a broad range of socio-economic and cultural capital status (see Appendix E and Figure 9, p.225). The traditionalist cultural bias is a preference for tradition and order, and an acceptance of hierarchy as the best way to achieve social harmony (Douglas 1982, p.206). Within this culture, compliance is virtuous because it supports the natural order of the world (see also Cheyney 2008, p.260), and on this basis, it was anticipated that traditionalists would welcome and defer to medical authority during birth.

It was demonstrably the case that traditionalist participants expressed trust in medicine and were clear that hospital is the safest and most appropriate place to give birth. That these views were deep rooted became clear as respondents found it difficult to articulate the origins of their beliefs: Dan summed this up when he said 'it was ever thus'. Others described hospital as an intrinsically right place for birth:

> I know also that, you know, the whole process of giving birth is not sterile, you know, I know that, but I just still feel like in the hospital, it's just supposed to be done in the hospital, is just how I feel about it.
>
> (Alexandria, second+ baby, Southcity)

Women from countries where hospital care was normative were particularly adamant about the importance of giving birth in hospital OUs. The following extract is from an interview with Adrianna, who is from Eastern Europe, and took part with an interpreter present:

> **Interpreter**: (she says) her decision was based on her midwife's recommendation and on Adrianna's personal preference. She would not consider any other option and she insists on a doctor being present during labour. Medical safety is her top priority. She is really concerned about the baby's

health and felt that only an acute hospital could provide a safe environment and peace of mind for her.

Alexandria was also certain she wanted to go to an OU, and to have an epidural during labour. Her family was from an African country, and she thought her preference for hospital was related to this background:

> I think it's culture as well, for me. It's just where we're from. You only have a baby at home if you can't make it to the hospital, and even when that happens people are [...] almost ashamed to say. They'll still say, 'Oh yeah, we went to the hospital.'
>
> (Alexandria, second+ baby, Southcity)

Whilst the overriding consideration for traditionalist women was the perceived safety of hospital, and access to medical care if a problem arose, access to pharmaceutical analgesia was also a factor for some. Laura's comment provides another example of a social hygiene metaphor performing the work of distinction between different approaches to birth:

> I mean I think, I actually think home births and things are a bit hippyish, to be honest. And I'm sure there are lots of people who have lovely, very good reasons for it but I'd like to be in a hospital with doctors, medical equipment, drugs, the works, basically. I'd like to trust in the professionals, you know, and just have all the stuff around in case there's a problem.
>
> (Laura, first baby, Southcity)

Traditionalists also anticipated that health professionals would advise them about the best course of action and recommend an appropriate setting for birth, and were very different in this respect from individualists, because their default preference was to trust staff and hospitals, rather than to examine the quality of the service provided. Lawler (2008, p. 137) argued that modernist expectations of this kind are now viewed as 'retrogressive' and may provide further basis for social class-based discriminations,

but in relation to maternity care at least, these views were held by participants from a broad range of backgrounds suggesting that this relationship is not as straightforward as Lawler anticipated.

Amanda's experience at her midwife booking appointment provided an example of a deferential approach:

> Because on the booking appointment she asked, didn't she, she said, 'Do you know, have you got in your set mind what kind of birth you want?' And I said, 'No. It's our, my first, I don't know [...] I'm going to do what you advise me to do because you know more than I do.' I sort of kind of put it, I'll do what I'm told, in that kind of way, wasn't it?
>
> (Amanda, first baby, Westfield; joint antenatal interview)

Amanda's partner, Harry, had similar faith in doctors:

> I have a [...] a respect for medical workers in general that I think, because there's a possibility there is going to be complications that I'd like to put my faith in them, you know, rather than just take any chances that [...] you know.

For Dan, the technical aspects of hospital provided evidence of expertise that was reassuring:

> Um, just the kind of sort of [...] the equipment. It's kind of going back to the, to the point about the [...] when we were talking about the waiting room at the midwife place, it's kind of the other way round up there, it's nice, it looks good. And there's just obviously an air of competence to the people that [...] the woman that was doing the scan and the other people that were there as well. There were three people looking after one baby, and that obviously, they obviously know what they're doing, you can tell. You can tell.
>
> (Dan, partner of Debbie, first baby, Eastcity)

The trust placed in professional by patients, and their willingness to share control with health professionals has been described by Gray (1997) as the fiduciary ethic. The assumption of trust based on expertise and paternalism also forms the basis of the 'classical professional model', which Porter et al (2007) argued remains a normative model in midwifery practice. It is on this basis of faith in medicine that hospital is selected by traditionalists as the preferred place for birth, and although the 'client quality' shortcomings of an OU may be recognised, these are less essential than the safety and technical support that a hospital can provide:

> Yes, because you only hear bad things about other hospitals and about, I don't know, places and stuff, the way midwives, the nurses have been with you and stuff like, I've heard people saying, 'Oh they've left me on the bed with all blood everywhere, and they haven't helped me and then my baby's been hungry, they're like, "Oh you can feed your baby breast milk and we can't help you",' and stuff like that, it's just, hasn't been nothing like that. Like, you know, thanks to God that it's been really good, do you know what I mean?
>
> (Jazz, second+ baby, Eastcity)

Planning a safe, natural hospital birth

It was also the case that women with traditionalist worldviews were less likely to conform to a natural birth ideology as within this group, natural birth is viewed as risky and these risks are best managed through seeking scientific medical care. Yet traditionalists also proved to be keenly aware of normative discourses as the cultural theory model suggested, and a powerful contemporary narrative is that using drugs in labour is dangerous to the baby. Attempts to ensure mothers assume personal responsibility for the safety and wellbeing of the fetus, and to encourage abstention from drugs throughout conception, pregnancy, labour and birth are well documented, and pharmaceutical drugs are increasingly conflated with alcohol, tobacco and illegal drugs as equally harmful to babies (Ruhl 1999; Lee 2008). Some traditionalist women therefore experienced a conflict between accessing pharmacological analgesia and seeing themselves as responsible mothers, and these women resolved this through

aspiring to achieve normal or natural births in safe medical environments (OU and AMU). Alexandria described this conflict during her antenatal interview:

KC If you think about going into labour with this baby, what's the best that could happen? What's the ideal experience for you?

Alexandria Ideal experience. Oh. Um [...] two-minute labour! [Laughs]

KC Nice and quick.

Alexandria Not needing any epidural, not needing any painkiller, just a quick labour [...] would be the best for me, just being there and, you know, and just having the baby quickly and [...] That would be ideal for me. And obviously a natural birth. Yeah.

KC OK. So that's what you'd really like, although you [said earlier] that you might need an epidural?

Alexandria Yeah.

KC [You feel that] it would be better if you didn't?

Alexandria Oh yeah. Obviously I don't want to, I wouldn't want to have an epidural. If it was two hours, three hours, I'll [...] but my last one was eight hours. So there's no way I could [...] So I'm hoping this one goes quicker, and if it does ...

(Alexandria, second+ baby, Southcity)

Sarah was also clear about her preference for hospital birth, and evaluated her decision as follows:

> There seemed to be only one option and that's go to a proper NHS hospital [...]
>
> [a little later]
>
> I think I'm [...] I'm a realist as opposed to an optimist, if not a pessimist, but I, you know, there's no point looking a gift horse in the mouth, be in the hospital, have the birth that you want within the confines of safety. I'm not a

risk-taker. That's probably my character through and through actually! [Laughs]

Both traditionalists and individualists took biomedical risks into account. Yet individualists operated within a market paradigm and were keen to consider all the options available and to actively discount these rather than defer to others' judgement, whilst traditionalists were singularly clear about the medical risks of birth, had faith in medicine and hospitals and believed that birth should take place in hospital.

Isolate and enclave cultures

The next section considers the experiences of enclave women, who proved to be a small group within the sample, and isolates, who were numerous and always excluded from choice. The enclave perspective is considered first. Women (and partners) in this group generally preferred to give birth at home, or in FMUs, which were perceived as homely settings at sufficient distance from hospital that intervention would not be imposed upon them.

Enclave culture

Two participants, Vita and Marylin, appeared to hold perspectives consistent with an enclave world view at the end of their respective pregnancies. Vita wanted a home birth, and Marylin was also interested in home birth but opted to have her baby in an FMU because this was her first pregnancy, and her partner felt home birth might not be safe. Hilary, discussed earlier, wanted a home birth and appeared to have aspects of both individualist and enclave culture, and both Rosa and Donald, who were excluded from choice, also held enclave world views.

In *Risk and Culture*, 'enclave' groups are defined by their ability to carve out an alternative worldview that is separate from mainstream orthodoxy (Douglas and Wildavsky 1982). Participants who subscribed to an enclave worldview were few in number but they did differ from other perspectives, and this finding is discussed here

in relation to Marylin's planned birth in an FMU (see glossary). The FMU in question was based in a community hospital, staffed only by midwives and had no emergency medical care provision. Women who developed problems during labour or birth were transferred by ambulance to one of two OUs, each of which is a half-hour journey away. Marylin was pregnant with her first baby when we met, and described her reasons for choosing an FMU as follows:

> I just really don't want to give birth in hospital. I don't like the environment very much and I prefer it to be kind of more natural and in my own [...] frame of mind, and without intervention as much as possible. So hence why I prefer to go to the [FMU] because it's kind of more natural and they kind of leave you to it, I don't really want epidurals or anything like that, I just want to kind of keep active throughout and [...] and do it all that way.
>
> (Marylin, first baby, Westfield)

Marylin's birth place preference was linked to her wish for a natural, active, undisturbed birth without intervention 'as far as possible', and achieving this meant avoiding hospital. In the excerpt below, Marylin describes her friend's induced birth, and associates this 'more forced on you' birth with fear and pain:

> ...a close friend has given birth in hospital because she had to be induced, and the whole procedure and just [...] it just seems kind of more forced on you and kind of more [...] kind of scary rather than kind of just doing it at your own pace and kind of dealing with it and the pain and everything that's happening at that time yourself. So ideally I'd stay here as long as possible and then go to the FMU. [6-second pause] And then if things happen and it doesn't go to plan and I have to go to hospital then kind of accepted that, that's fine. But to begin with I'd rather not.

Aside from the qualifying statement at the end of this extract ('if things happen'), Marylin did not describe needing to undertake any of the difficult moral positioning

described by Viisainsen's (2000) Finnish home birth mothers. Rather, her plan to give birth in a non-hospital setting was supported by her husband and her midwives, and this seemed to be at least partly because she was healthy, with a straightforward pregnancy:

> **Marylin** If your iron levels are too low at your 28 weeks then they don't let you give birth there, and if you have gestational diabetes they won't let you give birth there. [Checking information] I think it's less, it must be less than 11. Less than 10, 11, because mine were all fine, so I've kind of been fine to go there.

Women who prefer home birth have been characterised as 'ecofeminist' (Davis-Floyd 1994) or 'natural birth activists' (Zadoroznyj 1999) and their lifestyle choices are through to reflect this. They might practice yoga, live simply and environmentally and adopt natural approaches to pregnancy and birth (Viisainen 2000, p.802). Marylin did not adopt an overt activist or environmentalist stance, although she did attend pregnancy yoga classes, NCT classes, and also had reflexology treatments when it seemed her pregnancy might go post-term (see glossary):

> so I thought as induction was so close (Mm) and I didn't really want to be induced, that was one thing I didn't want, I had a couple of [reflexology] sessions and thought, give it a go, open-minded and everything, so [...] and the contractions were a bit stronger after she had that session with me (Mm), so [...] yeah.
>
> (Marylin, postnatal interview)

Vita also planned a home birth, but because she had previously had an emergency caesarean section she was advised that her labour should take place in an OU. She wanted to avoid giving birth in hospital, because she felt that the likelihood of receiving interventions that would lead to another caesarean would be increased there. Her caseload midwife had agreed to support her wish for a home birth, but also negotiated access for Vita to the AMU, a setting intended for women with

straightforward pregnancies and obstetric histories. Vita however also felt sceptical about the likelihood of achieving a normal birth in the AMU. In the following discussion, she recounted an experience where she was being shown around the AMU, and the midwife manager was explaining to her what might happen if she were transferred there during labour:

> And sort of four-hourly checks and so on, monitoring [...] and so on [identifying data removed]. But I felt like she wanted me kind of to agree there and then, that yes I'll do that. And I was kind of thinking, well I still have a lot of trust in [homebirth midwife], that she would kind of only want to do any interventions if she really felt it was necessary, whereas I felt with the AMU it's still more like, well if you come to the AMU this is kind of how it is and, you know, oh by the way can you just agree to it?
>
> (Vita, second+ baby, Southcity)

Vita did not have a home birth in the event, and her experience is explored further in Chapter 8, but just as traditional women chose hospital and rejected the non-OU settings for birth, enclave women chose home (or FMU) and often rejected OU and AMU settings because admissions to these would lead to interventive practices. So, despite exercising agency and active choice, from the enclave perspective the options were limited. Although the association between hospital and medical interventions, or more rushed birthing, is well documented amongst women who prefer home birth, the extension of this view to the AMU, which other women regarded as a homely setting where active birth is supported by midwives, is a new finding in the context of English maternity care.

The Isolate or excluded culture

The recruitment of women with less privileged identities (see Appendix E) revealed that these participants were often excluded from birth place decisions. The earlier discussion of cultural theory argued that the isolate group was under-theorised by Douglas (1982), and Spickard (1989, p.164) dismissed this quadrant as a 'repository for social fallout' from the more dominant traditionalist and individualist groups.

However, exploring the position of women who appeared to be isolated in the terms Douglas (1982) described (that is, they were excluded from mainstream groups and professions, socially devalued and held little political power) by using Bourdieu's (1984, 1990) theories led to a development in the theorisation of the isolate group. Isolate participants certainly seemed to have reduced agency, and at first reading their narratives seemed to reveal selection of almost every risk category, suggesting not just that their risk perceptions were heightened, but that they feared the quality and iatrogenic harm risks of hospital birth as much as the medical risks of birth safety. Their ability to choose was repeatedly denied; they were both excluded *and* more anxious. Awareness of being marginalised further increased their sense of being at increased risk of clinical errors and oversight.

Through closer analysis of individual cases however, it became evident that the isolate group included women and partners who would otherwise be in the other three cultures, and it appeared that making sense of this group as a single culture was misleading. They were not given choices and invariably gave birth in OUs; for most, this was in line with their preferences, but some did not want OU births, or at least wanted to be assessed for other settings. The isolate culture is then perhaps better understood as a site of exclusion from birth place choice. Rather than being a 'repository of social fallout' as Spickard (1989) had rather ungenerously suggested, the women and partners in this group were experiencing barriers to inclusion but had worldviews that were consistent with each of the other three dominant groups. This may seem a rather semantic distinction, but it shifts the focus from viewing individuals as having perceived social failings, towards exploring the means by which people are systematically excluded, and also self-exclude, from services which are intended to be part of mainstream provision.

Evidence for this comes from a range of observations. Firstly, there were several instances where women shifted out of this group, so their agency could develop and the choice exclusion was for some a temporary experience. Secondly, when women developed agency or received additional advocacy and support, their trajectories took them towards the cultures which most closely matched their preferences and

worldviews. Finally, the apathy and resignation which Douglas (1996) thought characterised this culture could be recognised as a response to their current situations, and was sometimes a strategy to deflect attention from themselves and minimise interaction with health professionals.

Isolate case studies: Rhian, Rosa and Maria

The differences that exist within the isolated culture are illustrated here through three exemplars. Rhian, Rosa and Maria had all previously given birth and each was identified as being excluded from choice, but they had very different perspectives on this. Rhian's interview took place towards the end of her pregnancy and she described experiencing high levels of medical anxiety during her pregnancy:

> **Rhian** It's just been non-stop worry. It's only just settled in now, I'm actually pregnant, like the last ten weeks or something. So [...] it's like all hitting me now [laughing]. It's frightening still.
>
> [Later in the same interview]
>
> **KC** Yeah. Can I ask you about that? What is it that is frightening to you at the moment, about giving birth?
>
> **Rhian** Anything [...] because anything could happen, the cord can go round the neck, anything like that. That's the worrying bit. As long as [the baby] [...] I'm not bothered as long as [the baby] comes [...] quick. And I know [baby]'s OK, then it doesn't matter. Go through the pain. [Laughs]
>
> (Rhian, second+ baby, Westfield)

Although she received antenatal care at the local FMU, and thought that it would be 'nice and relaxing' to give birth there, she felt her midwives were right not to offer her this as an option. For Rhian, birth was too risky to take place in a setting without doctors and it was tempting to conclude that Rhian was not in fact excluded from making a decision; after all, she had told me that it was her choice to go to the OU. However, she also mentioned that she had not been assessed for her suitability to give

birth in the FMU during this pregnancy; the appointment during which a discussion of place of birth was planned went as follows:

Rhian Well last week I should have like, gone through all my birthing plan properly and that, but they [...] one midwife was stuck in Spain [...][3]

KC Oh

Rhian And the other [midwife] was off, so we had a step-in one, and we just quickly ticked it off and went through it like that. So [...] it's just [...] in and out, basically.

Later in the interview, I returned to the question of choice, and whether Rhian felt she has been given a choice of place of birth:

Rhian No. Not much in everything that I've had, really. It took that long to get counselling, I had three years, then they just kept giving me tablets. Um [...] then [...] before I fell pregnant [...] before I fell pregnant they [...] kept sending me to gynaecologists and they just kept saying, 'Oh go on the pill,' and [...] for half an hour she was on the phone once so she didn't even properly speak to me. They right fobbed me off all the time. But [...] I get used to it.

This section suggested a number of elements contributing to Rhian's experience. She had longstanding health problems and was used to being 'fobbed off'. The lack of assessment for non-hospital birth is another episode in the same sequence. It might have been helpful to discuss her options more fully, but her expectations were already low before the antenatal encounter was curtailed by external events. It is important to recognise that Rhian also saw herself as generally unwell, and the provision of medical support during labour at least meant that this part of her experience was formally acknowledged. She negotiated candidacy for OU care through providing a list of issues that indicated hospital was best in her case. Rhian's worldview reflected that of the

[3] This refers to the Icelandic volcano eruption which prevented flights across Europe

traditionalist cultural group and so her preference was for OU care. Rhian had a normal and relatively rapid birth at the OU, and in her postnatal interview said that despite this, she would still prefer an OU in a future pregnancy:

Rhian It's probably more relaxing in a birthing centre

KC Uh-huh.

Rhian Because there's not many people there.

KC Yeah.

Rhian But, um [...] no, it's not for me.

Rosa's interviews, and those with other women in the area where she lived, also included discussions of a newly opened AMU which somehow 'wasn't for them'. Unlike Rhian, Rosa was very keen to give birth in an AMU, and this desire was underpinned by an explicit natural birth discourse along with a concern with the iatrogenic risks of routine hospital labour care. In her previous pregnancies, Rosa had planned to give birth at home, but had been admitted to hospital during her labours. Whilst women who planned to give birth in hospital often viewed interventions as necessary and beneficial to their labour, Rosa identified a possible iatrogenic effect of a drug which was used to speed up her labour (syntocinon), and linked this to a subsequent complication:

> With [Baby B] I was put on a drip to speed up my labour... some of the research that I found out afterwards actually pointed out that the drug that they used to speed up labour, has actually been attributed to [causing] PPH [post-partum haemorrhage].

Explaining her views about birth, Rosa cited *Spiritual Midwifery*, a text by a leading US practitioner of natural birth:

> And I mean the sort of books I was reading even when I was pregnant with [first child's name] was, um [...] things like this. I mean I'm sure you've probably read *Spiritual Midwifery* so you know what Ina May Gaskin's

about. And, you know, I've got a couple of books on active birth and things like that, so I kind of don't see giving birth as a medical procedure, I see it as much more of a natural thing.

During this pregnancy, Rosa was not given a choice of place of birth, and there was also little room for negotiation:

Rosa Yeah, [midwife's name]'s told me I've got to go to hospital.

KC OK.

Rosa She said they won't let me in anywhere else.

Rosa's obstetric history included a retained placenta (see glossary) which meant she was judged to be at increased clinical risk, and that birth in an OU would be advised. Despite her preference for home birth, which her partner also shared, Rosa had come to understand that she would not be supported in this option by her community midwives. She was not able to access the local FMUs because the family did not own a car, so she hoped instead to be considered for the nearby AMU; from her perspective, this was a compromise preference where her natural birth philosophy might be supported, and given the proximity to the OU, she initially hoped that maternity care professionals would support her choice because she was acknowledging their concerns about risk by planning birth in a setting from which she could easily be transferred to the OU, should the need arise. However, and unlike Vita (discussed earlier within the enclave cultural group), Rosa was not able to negotiate access to the AMU. Like Rhian, Rosa had become used to finding that her choices were not supported. The consequences of this for Rosa's birth are explored further in Chapter 8, but her initial narrative suggested an enclave perspective and experiences of being excluded choosing a non-OU setting for birth.

Maria's situation was different again; she had a straightforward first birth and was interested in giving birth in an AMU but her antenatal care during pregnancy consisted of short, rushed appointments with different midwives. Maria told me that she

definitely wanted to give birth at Southcity, and the following extract is from her first antenatal interview:

KC OK. And when you say Southcity do you mean the obstetric, the consultant ward or the AMU? Do you know?

Maria I'm still deciding at the moment. I mean I've heard a lot about the AMU but, yes [...] I haven't really decided yet.

KC OK.

Maria Yes, I mean I've contemplated loads of different options in regards to the type of birth I would like, and an interesting one for me at the moment is like having a water birth, so that's quite interesting for me. But [the AMU], I don't really know, I'll see. [Laughs]

[A little later]

KC OK. So when [...] you say you're not quite sure yet about the AMU, what's on your mind, what do you think are the pros and the cons?

Maria Um [...] I don't think I've just really, I mean for me I'm only [...] well, 'only', I'm halfway through now so I've still got a bit of time, and I just like to [...] just, what is the word, have all my options out there for me. So I need to kind of investigate a bit more about the [AMU] and stuff and see what they have to offer for myself, instead of just like listening to what people are saying to me. So [...] I think that's just more research on my part, and I just haven't really had the time at the moment to kind of research it as much as I probably should have.

(Maria, second+ baby, Southcity)

Maria's deliberations and willingness to do research into the available options suggest that she was operating within an individualist worldview, and her straightforward pregnancy means that she should be able to plan to give birth in the AMU. However, by the follow up interview, she was disillusioned with the maternity care she had

received. This was a phone interview, which was not recorded, so the extract below is from contemporaneous field notes:

> Maria said, 'I'm just going to go to [the OU]. I decided about a month ago'. I asked about the AMU and she said there was 'no particular reason not to go there, it just seemed easier to go to [the OU]'. She sounded resigned. She's seen different midwives all the time and has had to keep explaining things each time. She said, 'I hope they improve it in the future. When I had my [child], it was different. It would have been nice if I'd had more help, there were just too many women there'.

Maria's antenatal care experience led her to feel invisible and she never got an opportunity to discuss her birth place preferences. However, her OU birth experience was more positive. Although she again had several different midwives she found that they were concerned and listened carefully to her, and this reaffirmed Maria's trust in the maternity care service. She said that in a future pregnancy, she would consider the AMU.

Each of these three women experienced barriers to choice and their accounts suggest that their worldviews are different. Rhian espoused a traditionalist worldview and was content with the limited choice she was given, Rosa had an enclave perspective and felt very keenly the exclusion from home birth (and AMU), and Maria approached her birth place decision as an individualist would but was never assessed for planned birth in the AMU. Just as Margaret and Sarah (who were discussed earlier) shared a privileged identity, Rhian, Rosa and Maria each had elements of non-privileged identities, and the effects of this seemed far reaching. This is not to suggest that this alone explains their exclusion from choice, because in some cases women with similar histories did receive extra advocacy and found their choices supported. But for those without extra support, a complex interchange took place between women and their health professionals, which apparently involved assumptions about women's preferences on the part of midwives, and beliefs about their pregnancies and about

maternity care on the part of women. Together these could perpetuate a history of exclusion from birth place choices.

Cultural theory and birth place decisions: experiences of choice

The case studies and narrative data presented here highlighted the rationales and justifications women used to explain their birth place decisions, following Douglas' argument that if individuals adopt a particular worldview, their explanations reveal how they see the universe and their part in it (see Chapter 3). Figure 9 overleaf provides an integrated analysis of the theorised association between choice exclusion and privileged or devalued identities within the different cultural groups. In this table, participants names are in green when they present as having privileged identities, amber when there is one observable 'difference' and red when two or more differences are present. The suggestion that a single difference does not affect choice, but presentation of more than one 'difference' may impact upon choice exclusion is supported here, although again, the relationship is not straightforward.

Figure 9 Privileged identities in cultural groups (36 weeks)

		Green= privileged identities, amber = one difference, red= two or more differences	
		LOW GROUP	HIGH GROUP
	HIGH GRID	**Isolate** Michelle Patsy Zofia Rhian Nia Abi Arabella Cecile Amanda Rosa	**Traditionalist** Jan Jazz Sarah Donna Adrianna Hannah Sebastian Alex Harry Jane Carl Marta Laura Vanessa Dan Alexandria
	LOW GRID	Jia Holly Michael Annette Ronnie Naomi Hilary James Paul Florence Alison Margaret Jo Eddie **Individualist**	Hilary **Enclave**

The dispersal of participants in Figure 9 suggests that the culturally sanctioned, privileged identity (as defined in Chapter 5, see also Table 5.8, p.143) is associated mainly with the individualist group. Some with privileged identities also feature in the traditionalist group; this is the most diverse group in socio-economic and cultural capital, indicating that participants with quite different backgrounds preferred hospital and shared a particular worldview that espoused faith in medical care. Those in the isolate quadrant who were excluded from choice of place of birth usually presented as

having more than two differences from the 'idealised' identity described by Hays (1996), Behague et al (2008) and Lawler (2008).

However, some anomalies are also present. Figure 9 relates to participants' preferences and worldviews at the time of the second antenatal interview, which took place in the last month of pregnancy. At this point, Hilary consistently employed elements of both enclave and individualist perspectives to explain her planned home birth, and as a result, she is represented in both of these quadrants. A separate anomaly is that four participants with non-privileged identities (Jia, Ronnie, Jo and Eddie) were able to make individualist, quality-oriented choices about where to give birth, and these are shown in the individualist quadrant at this time point. Jia moved into the individualist group from the isolate group during her current pregnancy, following her interpreter's advocacy of her case. Both Ronnie and Jo (along with Jo's husband, Eddie) had been excluded from choice in previous pregnancies, but were older, more confident and more assertive in their current pregnancy. These changes are then consistent with Bourdieu's (1990) theory that enhanced agency results from increases in cultural or social capital.

Summary and conclusion

This chapter has presented analysis related to women and partner's perspectives of birth place risk and safety, and identified new findings, some of which confirm existing research, and others which begin to detail different responses birth place decisions in the context of English maternity care.

An examination of metaphors of pollution and hygiene in birth place beliefs generally supported Douglas' (2002) argument that these are employed universally to discriminate between what is approved, and what is to be rejected or avoided. In the context of English maternity care, as in other countries, secular notions of hygiene are used to identify appropriate birth place settings, and these are premised upon ways of managing the dirt and contagion of birth between public and private spheres. This provides support for Houghton et al's (2008) observation that for some, hospital is

appropriate for birth because the home is a private sanctuary and should be protected from birth, the effects of which might be traumatic. Beliefs about the potential for hospitals to contain the 'mess' of birth also support Donner's (2003) and Bryant et al's (2007) contention that clinical, surgical birth is a rational response to cultural expectations that the polluting effects of birth should be managed in this way. From a different perspective, others felt that home provides sanctuary to the private and intimate sphere of the family, and is therefore an appropriate setting for birth, although participants clearly struggled to imagine incorporating the life-altering event of birth into the everyday routines of their home lives. This finding to some extent agrees with Abel and Kearn's (1991) and Davis-Floyd's (1994) findings that women choose home to maintain the integrity of family life, except that some women and partners in this study preferred home because it provided the best opportunity for one-to-one (private market-like) care during labour.

The use of pollution metaphors as a 'forensic resource' (Douglas 1990) led to identification of four separate categories of risk, each of which had relevance to birth place decisions. The perceived importance of biomedical risk and safety during birth has already been recognised in the literature (Barber et al 2006, 2007; Pitchforth et al 2008, 2009; Houghton et al 2008). A drive to increase continuity of care, and to provide one-to-one care during pregnancy and birth, has long been central to improving maternity care quality (e.g. Flint et al 1989; DH 1993, Hatem et al 2009. However, the importance of 'client quality risks', using Øvretveit's (1992) concept of the ways in which facilities, care processes and staff are perceived by clients, and how such perceptions guide the development of anticipatory trust in emergency or intrapartum care, has not been reported before. Although this was associated primarily with participants with privileged identities, client quality risks affected most participants, and especially those excluded from choice. This particular perspective amounted to novel information about the ways in which maternity services are perceived by women and partners, and trusting relationships (or fragmentation of these) could be seen to develop and alter over the course of lifetimes as well as during pregnancy.

Viisainen's (2000) argument that women who choose home birth are subject to moral castigation was not borne out entirely in the context of English maternity care. Those with straightforward pregnancies found health professionals supportive, and whilst some women with increased clinical risk did not find their choice of non-OU birth supported, others were able to negotiate access to non-OU services. Interviewees also identified different aspects of moral risk associated with home birth, and these were related to the appropriate use of a publicly funded service, and the potential to place other women at increased risk through demanding a greater share of a finite resource.

Using cultural theory to inform the analysis produced substantive findings about the prioritisation of risk perspectives within birth place decisions, and the data provided a new theoretical contribution in relation to the isolate culture. The thematic narrative analysis also revealed that birth risk perceptions are rooted in culturally and experientially acquired beliefs about birth. The hierarchies that individuals devise as a result of their core beliefs predispose them towards deciding to give birth in those birth settings which they perceive as being most coherent with their worldviews and avoiding those settings where practice conflicts with their personal beliefs. However it also proved difficult at times to maintain that different risk perspectives are always distinct between groups, because the cultures shared a range of concerns.

Comparisons between the four political cultures showed that participants from three dominant cultures (traditionalist, individualist and enclave) were able to make choices about where to give birth. Those in the fourth culture (isolates) were all excluded from choice in some way, and rather than being a separate single culture, participants shared risk selection worldviews of the dominant cultures, and were likely to shift towards the culture that most closely reflected their own beliefs.

The cultural framework analysis supported the idea that individualists, already privileged, benefit from choice of place of birth, because this group perceived choice to be widely available and were confident in the safety (if not the quality) of the services on offer. Perhaps more counter-intuitive is the argument that traditionalists and enclave groups engender a self-exclusion from choice. For those in the enclave

culture, going to a hospital OU or AMU was not a choice, because they would not freely opt to give birth in a setting which threatens to interfere with the natural processes of birthing, whilst traditionalists seemed equally unwilling to consider birth in any non-medical setting. These participants were offered choices, assessed for suitability for low risk settings and able to negotiate access to these. Their agency within the clinical constraints of maternity care was largely unfettered, but their subjective worldview limited the options open to them to such an extent that they would not countenance certain settings as acceptable for birth, and offering different alternatives would not be expected to unsettle these underlying belief systems.

Those in the isolate culture were excluded from choice. However, it also appeared that that women, their partners, families and their health professionals sometimes work together to make one or other choice appear self-evident, and that the 'choice exclusion' is not always simply imposed by others, but may occur when consensual risk models are implicitly supported. Although these accounts can suggest lack of agency in relation to birth place choice, there was also evidence of candidacy, through which women secured their preferred choice by foregrounding medical or familial risk. Isolates who prioritise 'biomedical' risks are then relatively well served, even though they were routinely excluded from assessments for the non-OU settings that were offered to other women. Those in the isolate group who wanted to give birth in non-OU settings are perhaps most disadvantaged, being regularly excluded from these options, and unable to confidently insist on further negotiation, at least in part because their experience tells them that this will be fruitless.

The next chapter considers the ways in which individuals altered or retained their risk perceptions in response to the events that occurred during their pregnancies. Evidence of both change and consistency is provided, and the analysis considers how individuals maintain their narrative ontological account of themselves, and the authenticity of their perspectives, when their deeply held beliefs are challenged by the events of pregnancy and birth.

Chapter 8: Change in risk perception and birth place preference Findings from the longitudinal data analysis

Introduction

This chapter addresses questions relating to the stability of birth place decisions over time. These questions were posed for the following reasons: firstly, to examine prospectively whether decisions did change, and if so, whether there were critical influences or decisional points during the course of pregnancy, and secondly to observe whether the experience of birth altered women's and partner's perceptions of birth place risk and safety, and if so, what the implications of this might be for their future birth place choices. Dagustan's (2009) UK based qualitative research suggested that if women gave birth in hospital, they were likely to opt for hospital in a future labour. Zadoroznyj (1999, p.284) argued that women were likely to make more proactive choices after their first births, and that this was particularly the case for 'working class women', although this did not necessarily extend to changes in planned birth setting. Her research took place in Australia, where the context of care includes mixed public and private provision and was also based on single, retrospective interviews.

Some findings which are relevant to this chapter have already been presented are briefly rehearsed here to provide context for the ensuing discussion. Chapter 6 included data which suggested that the timing of women's decisions could vary from prior to the first antenatal appointment to after labour commenced. It was also the case that women expecting their first babies were more open both to changing their planned place of birth, and to considering giving birth in non-OU settings. Influences upon their decisions were numerous and because participants often received insufficient information in early pregnancy, they sometimes revisited this decision following antenatal classes or tours of birth place settings. As well as being rooted in past and current personal familial history, beliefs that influenced views about birth

were enduring. These formed the basis of personal views, which could appear self-evident to the individual or couple but which did not always find resonance in the views of maternity care professionals.

Chapter 7 then revisited participants' willingness to plan birth in different settings through an analysis informed by cultural theory, which proposed that more privileged women and partners who worked from an individualist perspective were most likely to exercise choice and research the alternatives available, whilst traditionalist participants favoured OU or AMU because these provided access to safe medical care. Enclave participants opted for home, specifically to avoid OU or AMU settings. The options available to women sometimes did not reflect their expectations or even the beliefs about birth that they hold most strongly, because women preferred a place of birth that is culturally *and* ideologically coherent with their own viewpoint. Women raised in contemporary UK often have families in other countries and these influences were brought to bear. Even amongst English women whose families have lived here for many generations, birth in hospital OU is normative, because home birth is rarely a positive part of the familial cultural repertoire, and the last (historical) time that home birth was commonplace in the UK, death amongst infants and mothers was also much more usual. The nearest comparative resource UK women have is the Netherlands' high home birth rate, and the safety of this is also subject to debate which has reached the UK mass media (De Jonge et al 2009; Dreaper 2010; Evers et al 2010). It is unsurprising then that being offered a non-hospital setting for birth has a mixed reception or that couples attempt to plot a course that ensures maternal and infant safety, howsoever they conceive this to be best served.

Having made a case that birth place decisions originate in subjective worldviews and that these can be enduring, this chapter describes a variety of changes that occurred within respondents' accounts. It is important to address what is meant by 'change' in this context. Does a change in preferred place of birth signal a change in worldview? If so, how and why do such changes occur? In Chapter 3, a case was made that the cultural theory framework could accommodate change, despite accusations of determinism. Douglas (1982) thought that change could occur as persons interacted

with their social environments, a position which accords with Bourdieu's (1990, p.64) notion that actors might 'transform' their worldview through increased access to economic, social or cultural capital. This chapter provides evidence of both change and consistency, and attends to how individuals maintain their narrative ontology when their deeply held beliefs are challenged by the events of pregnancy and birth. The concepts of privileged identities and culturally sanctioned idealised discourses are revisited, and the narrative epistemology is preserved through describing how participants balanced the 'teller's problem' of authenticity whilst pursing an 'approved' (individual, choice-making) identity (Lawler 2008, p.144).

At the beginning of this chapter, the birth experiences of participants are briefly summarised in order to provide context for the discussions that follow. Some general findings about labour care in relation to women's choice of place of birth are also presented. The discussion then describes the patterns of change and consistency which occurred over the course of the longitudinal interviews, and this analysis is informed by cultural theory. The final section contains structural narrative analyses of comparative case studies, and here women's sense-making following their experiences of birth place choice or exclusion from choice, is the focus of analysis.

Birth outcomes, and experiences of birth place settings during labour

Women's actual place of birth and their mode of birth are described below to promote transparency regarding the sample, because these might reasonably be expected to influence their perceptions of birth. Although women discussed their overall birth experiences during interviews, this discussion privileges findings that are relevant to women's reflections on their birth place decisions or to their exclusion from choice.

Planned and actual place of birth

There was a difference in where women planned to give birth at the end of pregnancy and their actual place of birth depending on whether or not women were expecting their first baby. Table 8.1 below shows that women expecting their first baby were more likely to plan to give birth in a non-OU setting, but in the event, most gave birth

in the OU, either because the non-OU setting was unavailable at the time of their labour or their labour was induced. Some did manage to plan and give birth in AMU or FMU, but the two women in this group who planned home birth were transferred to hospital during labour.

Table 8.1 Planned and actual place of birth for women expecting their first baby

First baby	Planned place of birth	Actual place of birth
OU	7	13
AMU	6	2
FMU	3	3
Home	2	0

As discussed in Chapter 6, women expecting their second or subsequent babies were less likely to opt for a non-OU setting, and almost all gave birth in the OU (see Table 8.2 below). One participant wanted an OU birth but was admitted to an AMU in labour.

Table 8.2 Planned and actual place of birth for women expecting their second or subsequent baby

Second baby	Planned place of birth	Actual place of birth
OU	17	17
AMU	2	3
FMU	2	2
Home	2	1

Participants' mode of birth

Table 8.3 below provides information about modes of birth experienced by participants, and also indicates how this group compares with nationally gathered data where this is known. As in Chapter 5, this information is not provided to claim that the participants or their experiences are representative of the wider maternity population, but rather to contextualise this discussion for the research audience.

Table 8.3 Participants' mode of birth by parity

	First baby (n=18)		Second/subsequent baby (n=23)		Sample total	National average (England)
	Number	**%**	**Number**	**%**		
Spontaneous vaginal birth[1]	9	50 %	19	83%	28 (68%)	No national figures[2]
(Normal birth)[3]	(8)	(44%)	(15)	(65%)	(23)(56%)	62%
Ventouse delivery	4	22%	1	4%	5 (12%)	6.6%
Forceps delivery	1	5%	0	0%	1 (2%)	5.5%
Elective caesarean	0	0%	1	4%	1 (2%)	9.8%
Emergency caesarean	4	22%	2	9%	6 (15%)	14.8%
Total	18	44% of sample	23	56% of sample	41	

Source: Normal birth rate, ventouse, forceps and caesarean birth rates for England from Health and Social Care Information Centre (2010) Table 8 (statistics for 2008–2009)

Overall, the normal birth rate (56%) was slightly lower for the sample than would be expected, but the pattern of higher normal birth rates for women expecting their second or subsequent babies reflects Downe et al's (2001) observational study findings. The spontaneous vaginal birth rate (68%) included women who had epidurals or induced labours. Even though women experienced difficulties accessing alternative settings for birth during labour, it was still the case that fewer participants gave birth in OUs than is usual for England. The proportion of OU births within the sample was 30/41 (73%), compared to the English average of 93% (HCC 2008), and this means that the selected sites may be different to other NHS trusts in their profile of options regarding place of birth. Women are more likely to have a normal vaginal birth in AMUs, FMUs or at home (Hodnett et al 2010; Davis et al 2011). Nevertheless, those

[1]The spontaneous vaginal birth rate includes vaginal births where labour was induced and where local or epidural anaesthetic was provided for pain relief.

[2] The maternity statistics data published by the Information Centre for Health and Social Care (2010) use the Maternity Care Working Party [MCWP] (2007) definition of normal birth and rates of vaginal birth following interventions are not published separately.

[3]The normal birth rate excludes those births where labour was induced, assisted or surgical births and births where local or epidural anaesthetic was provided for pain relief.

participants who did give birth in OUs experienced levels of interventions in these settings which are similar to or above the averages in national data for England. All of the participants gave birth to live babies, and whilst some babies had short-term admissions to special or intensive care, no babies had ongoing health problems by the time the postnatal interviews took place.

Accessing labour ward in labour

One factor which altered women's plans during labour was the difficulty they encountered accessing maternity units. The problems women have in gaining access to maternity care in early labour have been reported elsewhere (Spiby et al 2006; Hunter 2009; Barnett et al 2008). Eri et al (2009) argue that this particularly affects women expecting their first babies because this stage of labour is usually longer for first labours and women may be more uncertain about whether labour has begun. However, in this sample, it wasn't only women expecting their first baby who found it difficult to gain access to the labour ward. Cecile recounted her experience after she decided to go to the OU when her waters broke at home. This birth was her first after a previous emergency caesarean during labour and she was worried about how it would go.

Cecile We call them first, and um ... the reception we get wasn't very nice.

KC OK.

Cecile Ah, they [midwives] were talking about, 'Oh ... er ...' different kind of questions like, 'Oh there's no? ... what contractions, how often?' I said, 'There's nothing to do with contraction, my delivery always started with broken water, I'm not going to stay at home waiting for more because, you know, I don't want to take chances, I'm coming anyway.

KC Yeah.

Cecile So she [midwife] wasn't happy, and I wasn't happy...

(Cecile, second+ baby, Southcity)

Several participants who planned to give birth in AMUs also found they were not able to access these. Three women expecting their first babies were no longer considered suitable for admission to the AMU because their labours were induced. Sarah could have been appropriately admitted to the AMU and went into labour spontaneously. Yet when she arrived in hospital the AMU was full, and she had difficulty persuading staff she was in labour at all, describing being almost forcibly removed from the reception area:

> Um, I was like, 'I'm not going home because ...' [laughs] I would have just sat in the corridor. Um ... and then ... they literally forced me out the door, and my waters broke.
>
> (Sarah, first baby, Southcity)

Women who planned to give birth in OUs reported waiting several hours in the reception areas before being admitted. Serena had hoped for a water birth in the OU; the extract below comes from Serena's postnatal interview and describes her feelings of claustrophobia as she waited in a corridor for admission.

> ... And it's ... it's about ... it's quite a small area. And you're trapped between, because they lock the doors at night, so you're, you feel a bit trapped in your space, and so I've got that [little] space to walk up and down. And because I couldn't sit I just felt, you feel very, um ... very much ... er ... with the other people, that they're not in any pain, that you're trying to hide your pain, you're a bit embarrassed about, well not embarrassed but, you know, you just don't ... you don't want other people around you, you just want to be doing it in your own thing.
>
> (Serena, first baby, Eastcity)

Kath's experience was similar; like Serena, she had planned a hospital water birth. Kath went to the hospital mid-evening:

> I think it was about half-eight, nine, in the evening, on the Monday evening. And, um, it was very busy. It was very very busy. (Mm) Um, and um ... so we got there, checked in, er, and it was so busy they didn't have any [labour] rooms.

She was transferred to labour ward the next morning:

> Anyway, so it was getting worse and worse and worse, when the shift of midwives came on they finally managed to get me a room ...
> ... I eventually got an epidural, er, which was good, that was about eight o'clock in the morning I think, seven, eight o'clock in the morning. And then, as I said, I was assigned a room, didn't have a water birth obviously. [KC: Mm]
>
> (Kath, first baby, Eastcity)

One consequence of this was a tendency to 'hold on' to the place that was eventually secured. For these participants, the notion that they could 'decide' where to give birth evaporated amidst the urgency of obtaining a labour room. As the other authors also found, the service arrangements for admission and early labour assessment could be a difficult experience for labouring women (Spiby 2006; Hunter 2009), but in this study, it also led women to prioritise 'gaining access' generally over securing admission to the particular birth setting they preferred.

The experiences detailed here show how women's birth plans could be disrupted by developments during late pregnancy and early labour, and help to explain why women often did not give birth in the setting they had planned during pregnancy. When women planned to give birth in non-OU settings, an overall pattern in this sample was that women expecting their first baby often did not do so, whilst those expecting second or subsequent babies were more successful in managing to give birth in AMUs, FMUs or at home. Access to AMU and OU in labour was most often problematic for women in the city trusts, although women in Westfield described similar experiences with the FMU and OUs.

Encounters with birth ideologies

A separate issue arose for a small group of participants, all of whom encountered birth ideologies which conflicted with their own more neutral perspectives. These episodes could detract from their birth experiences and led women to feeling 'out of sync' with the prevailing ideology and even found wanting by health professionals.

Ella had decided to give birth in the OU and in her antenatal interview (discussed in Chapter 6), she had detailed why medical care in labour was important to her. During her postnatal interview, she and her husband, Homer, explained that in the later stages of her labour, she had found it difficult to push and requested 'leg rests' (or 'obstetric stirrups') be attached to the bed, because she had found these helpful in her previous labour:

Ella [Laughs] I just ... I think that, yeah, so the experience with the midwife wasn't very nice, I mean I think the labour was probably totally OK, quite short and, I mean the pushing was quite tough but ... But I think there was no communication with the midwives, or they didn't ... she didn't tell me anything, and so the only thing I wanted was I wanted the leg rests. I said, 'The last time I could only push hard with that, so I want that please,' and they didn't agree. She ... [laughs]

Homer It was really difficult. At first she [midwife] only agreed to put them halfway through, you know, in a way ...

Ella But she didn't agree for like the first one and a half hours. Um ... even for after two hours we requested a doctor, we said, 'We want a doctor now, just that they have a look, because two hours is a long time.' Um, and then the doctor came and then they put the footrest and then I could actually push...

[A little later]

... And the other midwife that came later, I think she's ... the head midwife or so, she was telling me [laughing], and she told me, '**You** are not cooperating!'

(Ella and Homer, second+ baby, Southcity, emphasis in recording)

What Ella and Homer did not realise until after the birth was that Ella had been admitted to the AMU rather than the OU. In the AMU environment, women are encouraged to move around in labour and routine use of 'leg rests' is avoided. AMUs are characterised by a 'philosophical orientation' towards normality (Hodnett et al 2010, p.3), but this was not something that Ella had sought, and was at odds with the couples' own longstanding preference for OU medical care, but their wish to give birth in a traditional labour ward appeared to go unnoticed.

Others had much more positive experiences of non-OU settings. Adele described the environment and décor of the FMU where she gave birth:

> And it was just lovely, like even down to the carpet was nice and it was just, I don't know, it just felt really lovely, and it smelt nice as well, it just all felt and smelt … And they said, 'Oh your partner can stay, we've got pull-out beds, and if you've got other children they can stay and we do this and that,' and it was all very much like, whatever you want, we can do.
>
> (Adele, second+ baby, Westfield)

However, like Ella, Adele found tenets of the 'midwifery model' difficult to cope with. She described the following experience after an otherwise very positive water birth:

> Um, I felt … I … I'm the kind of person, it sounds really awful but you know when you watch like the films and the women give birth and they give you the baby straightaway and all this, I was really not like that at all, like I had her and then I had to get out of the water and then onto the bed thing, and they kind of brought her over and I was very much like, I really need her to be clean, I don't want to hold her, I don't like … and I felt disgusting, and I thought, I need to have a shower, I need to brush my teeth, I need to be … I didn't like feeling horrid and yucky. And I wasn't really in any pain and once I'd been checked over and I felt a bit guilty, because I really wanted to say

like, obviously I'm really pleased like the baby and everything but I just *desperately* want to feel clean and fresh and nice about myself so that I can relax a bit more. And there was a midwife who was a bit old-fashioned that came in, and she kind of, she wasn't that keen on me going off, she was like, 'You've got to bond, you've got to bond, you've got to bond with the baby.' And I kept saying, 'Oh OK.'

Holly had a home birth in a birth pool which she described as 'ideal' and 'relaxing', with midwives who were 'caring, supportive, you know, and friendly', and she made the following observation:

> And I think, um, although I wanted to have the baby at home and I wanted to do it fairly naturally, I think I wasn't, I'm not sort of completely ... um ... I don't really know how to put this. I'm not, I suppose, um ... I suppose I still do see the value of things like [vaginal] examinations at the right times and things like that [KC: Mm] because you need to know where you are, you know, they're ... you need to know whether the baby's moving down, what's going on. And I suppose, um ... maybe, I'm not sure, but I think maybe, um ... with having the baby at home I think I sort of maybe had to ask for more intervention than I would, obviously than I would have had to in hospital.
>
> (Holly, second+ baby, Eastcity)

It is relevant to the later discussion to note that each of these participants was associated with the individualist culture, but some women within the isolate culture also found that birth places, particularly non-OU settings, espoused birth ideologies which were different to their own. The difficulty of being 'with woman' or 'with institution' is discussed in midwifery literature (Hunter 2004; Finlay & Sandall 2009; Rayment 2010), but to date, this debate has focused on conflict between midwives, and on the emotional work that midwives do trying to manage the demands of the organisation whilst providing woman-centred care. However, these accounts suggested that midwives made some assumptions about the kind of care that women wanted based on the birth setting they were in, and that although women valued the

care and support they received from midwives, they experienced discomfort when their own ideas about birth and infant care differed from the philosophy promoted by staff.

This contextual information points to broad variation amongst women's experiences of birth with some emergent patterns, and these experiences raise questions about how labour and birth, with either admission to or failure to access preferred settings, changed women and partner's perspectives of birth place risk and safety. These issues are explored further below, as the discussion shifts towards an exploration of change in participants' preferences and worldview following birth.

Change and consistency in worldview during pregnancy and following birth

The analysis of change in women and partners' perceptions of birth place risk and safety was informed by cultural theory (Douglas and Wildavsky 1982), and builds on the observations contained in the previous chapter. In postnatal interviews, women and partners were asked whether their experience had altered their view of birth, and where they would plan to give birth in a future, hypothetical pregnancy. The analysis revealed a further difference between participants expecting their first babies, and those expecting their second or subsequent babies, and these are presented separately. For each group, a diagram summarises the overall direction of change, and differences between the political cultural are then examined through thematic analysis of narrative data.

Changes amongst participants expecting their first baby

Of 28 participants who were expecting their first baby (18 women and 10 partners), six had different perspectives following the birth, at the time of the postnatal interview. Table 8.4 below details these changes, the most common being a shift from an individualist, choice-oriented perspective, to a more traditionalist, risk-averse approach. This change became evident through their accounts of the pregnancy and

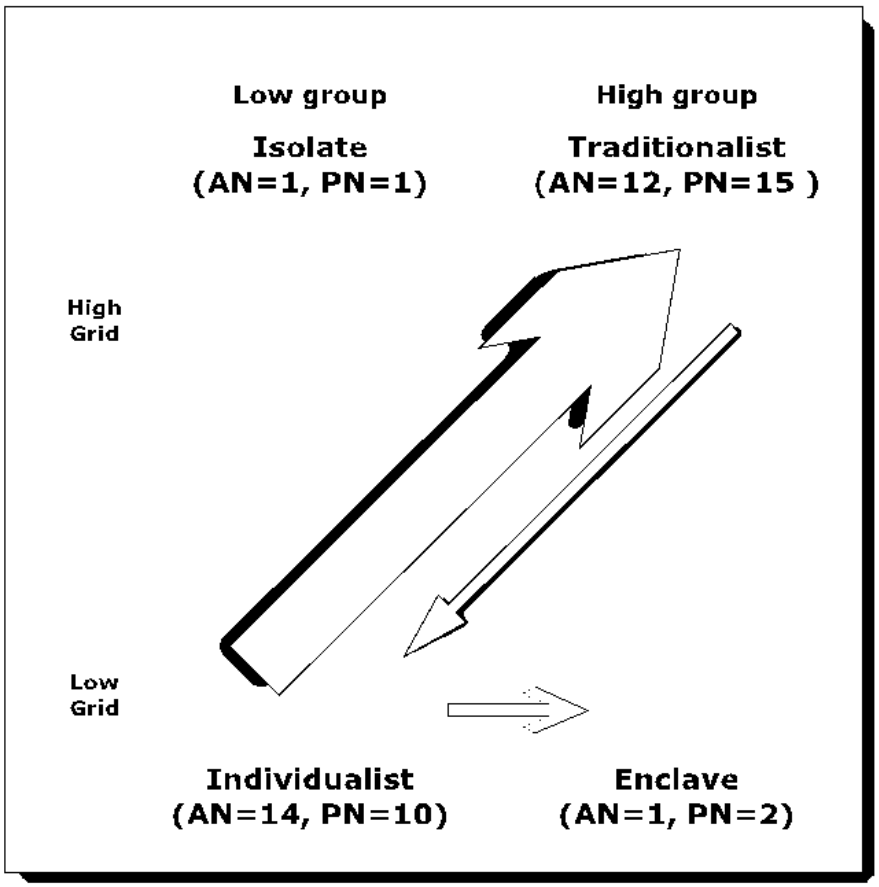
birth, and also in discussions about where participants would plan to give birth in a future pregnancy.

Table 8.4 Changes amongst first time parents following birth of the baby

Participant	**Antenatal quadrant**	**Postnatal quadrant**
Eric	Traditionalist	Individualist
Naomi	Individualist	Traditionalist
Iona	Individualist	Traditionalist
Serena	Individualist	Traditionalist
Alison	Individualist	Traditionalist
Hilary	Individualist/Enclave	Enclave

Figure 10 below provides a visual representation of changes amongst political cultural groups following the birth of a first baby. The arrows symbolise the strength and direction of change, and the numbers in brackets indicate how many participants were associated with each quadrant before (AN) and after (PN) the babies were born.

Figure 10 Changes and consistency in political cultures: first baby



Six out of the eighteen first time parent participants had altered postnatal world views (Table 8.4); amongst the remaining twelve, postnatal perspectives either reflected or strengthened their antenatal views. These patterns of change and consistency are discussed in more depth below. Two cultural groups (enclave and isolate) had only one member amongst first-time parents by the time of the final antenatal interview (at 36-40 weeks). Twelve participants were in the traditionalist quadrant at the end of their pregnancies, and fourteen were in the individualist quadrant. Although this discussion focuses mainly on findings from the postnatal interviews, changes were not limited to the postnatal period. Two participants, Jia and Samantha, had shifted from isolate to individualist perspectives during the course of their pregnancies, and in each case this occurred following provision of continuity of care by an interpreter and a midwife respectively. One birth partner, Salah, moved from a traditionalist position to an individualist one over the course of his partner Hilary's pregnancy.

Consistency within the traditionalist culture

Eleven out of twelve first-time parents who were in the traditionalist culture beforehand remained in this group after giving birth, and although for some, their preferred place of birth for a future pregnancy changed, the direction of change was almost invariably towards a more medical setting; four traditionalist interviewees (Sebastian, Sarah, Jane and Laura) reappraised their willingness to consider birth in a non-OU setting, and said that they would only consider OU for any future birth. One male partner provided the sole exception to this; Eric (Annette's partner) moved from a traditionalist to an individualist perspective after Annette's straightforward first birth (in hospital) reassured him that a future non-OU birth could be safe and therefore feasible.

Examining consistency: experiencing monitoring and intervention during first labour

The explanation for the observed consistency and the increasing prioritisation of biomedical risks seemed rooted in participants' experiences of maternity care during labour. Women are more likely to receive interventions during their first labours than during any of their subsequent labours (Downe et al 2001; Bragg et al 2010), and amongst the traditionalist group were six women expecting their first babies, three of

whom had 'normal' deliveries (although one baby was subsequently admitted to neonatal intensive care), one who had a ventouse delivery, one a forceps delivery and one an emergency caesarean during labour. It is perhaps unsurprising that traditionalist participants who did experience interventions became more convinced that birth is risky, because this after all confirmed their prior scepticism about the safety and unpredictability of birth (see Chapter 7). Access to longitudinal accounts provided an additional indication of why these beliefs become enduring, and why experiencing even a difficult hospital birth, long associated with postnatal morbidity and slower recovery from birth (Glazener et al 1995; Thompson et al 2002; O'Mahony et al 2010), is recounted in terms that convey a sense of being rescued by obstetric intervention. Jane chose OU birth because she felt a first birth was safer in hospital, and had an assisted delivery:

KC Did this experience [instrumental delivery] change the way that you think about giving birth? Do you now think it is safer or riskier, than you'd anticipated?

Jane I think it is riskier than I had anticipated. I had no idea that it would be so difficult to get my baby out! There is no way I would have been able to push her out myself and I wouldn't have been able to have carried on without any pain relief..

(Jane, first baby, Southcity, postnatal interview)

In the context of chronic illness, Frank (1995) describes the 'restitution' narrative as one where medicine intervenes to return people to health. According to Frank (ibid, p.83), this is a 'culturally preferred narrative', one which perpetuates medicine as curative, and able to transcend the threats to health, and this certainty that obstetric intervention rescues women and babies from birth is arguably the core of the cultural presumption towards hospital OU birth. However, even traditionalist women with normal births judged birth to be more risky in retrospect, and they described learning this through their experiences of monitoring and surveillance during labour. In her antenatal interview, Sarah said that although she would prefer to give birth to this baby in hospital, she might consider a home birth in the future. At the end of her

pregnancy, Sarah planned to give birth in the AMU, but as discussed above, the AMU was full when she arrived at the hospital, and she found it difficult to gain access even to the labour ward. In her postnatal interview, she no longer felt that a home birth was something she would plan in the future:

KC You said that you possibly could be swayed in a future pregnancy into having a home birth, but you were clear that the first birth ... [would be in hospital]

Sarah Is that what I said last time? [referring to the antenatal interview]

Kirstie Yeah.

Sarah Yeah, I think I've changed my mind. Yeah. No, I would, um ... definitely have a, um, go into hospital.

KC Right.

Sarah I felt safe there.

KC OK.

Sarah Particularly since, um, it wasn't ... it was reasonably straightforward [KC: Mm] but there were a few complications [KC: Mm] ... um, with [baby's] heart beat and, um, so I think that, no I definitely would have it there. I think I'd be more stressed having it at home.

(Sarah, first baby, Southcity, postnatal interview)

Naturally enough, complications involving the baby's heart beat provoked anxiety. From participants' perspective, the idea that a baby's heart might be fading, slowing, or rapidly increasing suggested an emergency situation, and hearing the heartbeat continuously during labour signified minute-by-minute awareness of (and responsiveness towards) the baby's resilience to labour. Continuous monitoring in labour is intended to identify any alterations in heart rate that might suggest the baby has a compromised oxygen supply. This intervention also has a high false positive rate, and routine use of continuous monitoring is associated with an increase in assisted and caesarean births without clear benefit in neonatal outcomes, although this is difficult to assess because of the rarity of the outcomes studied (Alfirevic et al 2008). When alterations in fetal heart rate do occur, these might be either physiologically normal or

indicative of problems, but the interpretative skills lie with staff, and parents can only relay their concerns about the sounds that they hear.

During her interview, Sarah explained that the baby's heart beat dropped during contractions, and although no other interventions were required, it was clear to her that this was a cause for concern because the staff wanted her to stay in the OU rather than be transferred to the AMU, as she had requested on her birth plan. The indication of possible abnormality in the midst of an otherwise normal and relatively short labour, combined with the explicit message that this labour should not take place in the AMU were sufficient to persuade Sarah of this, and she was happy to remain on the OU:

> … they wouldn't move me to the [AMU] [Mm], which is fine. To be honest in that case I didn't care.
>
> (Sarah, postnatal interview)

Changes amongst 'individualist' first time parents

Individualist participants prioritised service quality risks during antenatal interviews and generally felt either that birth was safe, or that they would be quickly provided with medical care if this were required. Ten of the 14 individualist participants remained in this cultural group throughout pregnancy and after birth, but 4 women (Naomi, Iona, Serena, Alison) shifted towards the traditionalist culture after experiencing difficulties during their first labours. With hindsight, these women determined either that birth was more risky or unpredictable than they had realised, or that hospital care was of better quality than they had thought. Like Sarah, Serena thought she would now be less likely to plan a home birth in the future:

> **Serena** Um … if there was the centre [AMU], like you were saying, available then I'd definitely go and try that. Um, because I feel, unless … I don't know now because of me tearing whether I can do natural birth. I'm sure I can. I don't know. Um … or whether … if I was to get pregnant

again there's a slight risk that … I have to have a caesarean because it's too … I don't know, I don't know how things work.

[A little later]

KC OK. Because you mentioned in your antenatal interview that maybe if you were to be pregnant again you maybe would think about a home birth in a future pregnancy. Do you still feel like that or do you think …

Serena No, I think that I would probably … probably not.

(Serena, first baby, Eastcity, postnatal interview)

In contrast, those individualist women who perceived their births as straightforward were usually more willing to consider a range of possibilities for future births.

Annette had always been interested in a non-OU birth, but her partner, Eric, was not keen, so she gave birth in hospital. Her birth was rapid and straightforward and although she envisaged that another quick labour might mean that home would be a good option, she also found the hospital care reassuring:

KC So now you feel like you're glad that you did go to [hospital OU]?

Annette Yeah, I am glad we went in there now, so […] you do feel a lot more supported, it takes the anxiety away. Again, because you never know what's going to happen. So if there had been any sort of complication at all, then um […] then, you know, that would have been a very different matter.

KC Mm.

Annette And we, you know, you don't know what's going to happen, do you, so…

KC You don't. No. But you said a couple of times in the antenatal interviews that maybe for a future birth you might think about a home birth.

Annette I think I'd *have* to, I think that's the only thing, I just […] I'd be happy to go to, um, [OU] again or look at another hospital,

> depending on where we live. Now having done it once I would, you know, that, that [...] having done that and gone through that experience it was fine, [Mm] so I'd certainly think about it. But yeah, it's just whether we [...] can physically get there [Mm] in time for the next one! [Laughs]
>
> (Annette, first baby, Southcity)

Whilst Annette had eventually planned an OU birth, Hilary wanted a home birth throughout her pregnancy. As discussed in Chapter 7, Hilary's antenatal interview narratives contained elements of both enclave and the individualist worldviews, but after the birth, she moved more towards a clearer enclave perspective. Hilary was transferred from home to hospital late in the first stage of labour and had a ventouse delivery in hospital. She had always allowed for the possibility that she may need to go to hospital during labour and did not seek to actively avoid OU or AMU, as the enclave participants did. However, unlike traditionalist and individualist women who had complex births, she was that sceptical about the argument that being in hospital was necessary for birth. In her postnatal interview, Hilary explicitly questioned the logic that experiencing interventions in hospital confirms the necessity for giving birth in this setting:

> ... some of the people I know that had babies at the same time, [KC: Mm] and they all had much more complicated deliveries, much more medicalised, um, but always intended to be in hospital, and a lot of them have come out of it going, **'Oh we're so glad we did it in hospital because if we'd been at home, you know, he would have died, or she would have died,' and all that [...] nonsense.** Which just isn't true, of our situation at least, you know, we had plenty of time to get to [Eastcity], which takes no time anyway, um [...] it was a really positive experience.
>
> (Hilary, first baby, Eastcity, postnatal interview, emphasis added)

Hilary's reflexive response to the 'restitution narrative' also constitutes a moral hygiene metaphor, because she drew a discriminating line between her own birth, and

other 'more medicalised' births, which arise when people decide to give birth in hospital. Hilary said that she would plan a home birth again:

> Yeah, I mean if we're still in this house or in this area I would definitely [...] um [...] do the same thing again. [KC: Uh-huh] So [caseload] midwives with a view to having a home birth.
>
> (Hilary, first baby, Eastcity)

Although most women from both individualist and enclave cultures who succeeded in giving birth to their first baby in non-OU settings thought they would do the same in a future pregnancy, there were exceptions to this. Iona sustained a tear during a rapid delivery in an FMU, and felt that if she had been able to have pain relief, she might have been able to give birth more slowly and avoid the perineal trauma. She still had problems with wound healing when the postnatal interview took place, which was two months after the birth:

> **Iona** It was her shoulders [...] that did it. Unfortunately. Head was fine. And then I was impatient.
>
> **KC** Oh OK.
>
> **Iona** [Laughs] They [midwives] didn't actually tell me to stop, but I knew that I needed to but I couldn't. I just wanted [...] I wanted out.
>
> [A little later]
>
> **Iona** Yeah. I liked the fact that I could stay and it was much more homely, I suppose, atmosphere at [the FMU] because it's [...] not a hospital atmosphere really. **But I'd [go to the OU and] have pain relief next time**.
>
> (Iona, first baby, Westfield, emphasis added)

Summary of change and consistency following first births

Although in most cases, women's worldviews remained consistent following first births, five women with an individualist worldview modified their stances. Four shifted towards the traditionalist culture; in response to the events of birth, these participants

reappraised birth as more medically risky than they had thought (as in Serena's case), or hospital OU as capable of providing better care and more reassurance than they had realised as Annette suggested. The willingness to consider different alternatives remained, but OU was more central to these postnatal accounts. Another (Hilary) shifted towards a clearer enclave worldview. The only woman expecting her first baby in the isolate quadrant remained in the same situation following the birth. Perceptions of birth experience also moderated these changes, and whilst it was unsurprising that those with straightforward first births in non-OU settings (AMU or FMU) would usually (but not always) plan to give birth in the same setting in a future pregnancy, an unexpected observation was that women who had straightforward first births in hospital OU would largely plan to give birth in the same setting in the future.

Change and consistency after second and subsequent births

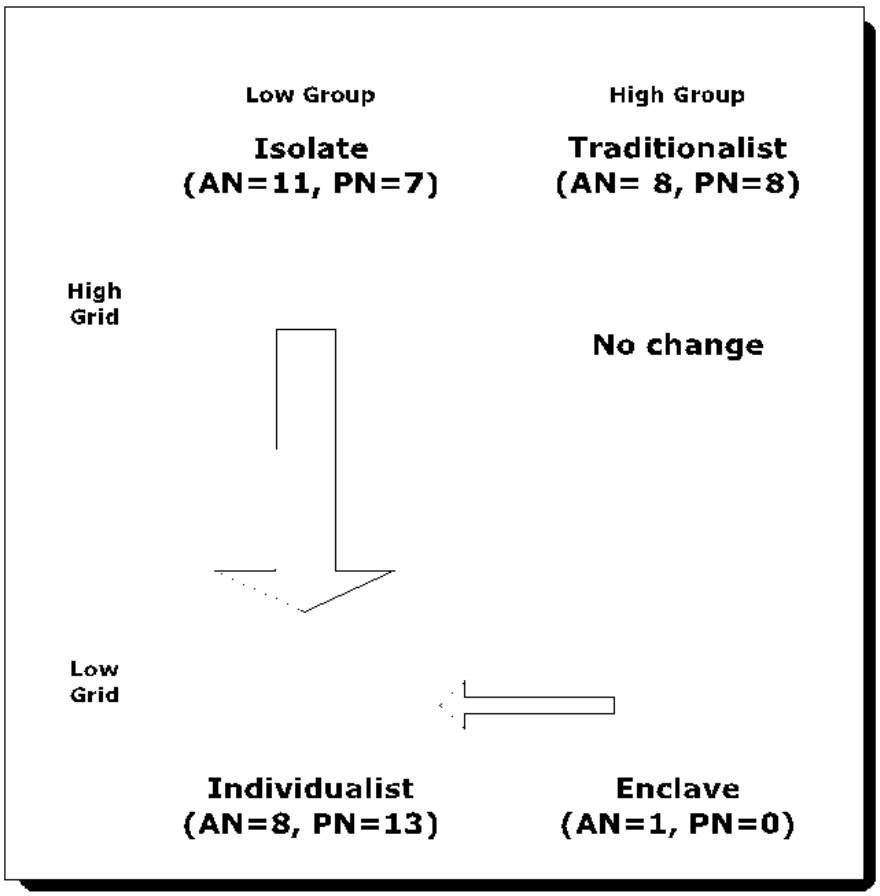
Whilst there was some degree of change amongst women and partners following birth of a first child, this was much less so for participants who gave birth to second or subsequent children. Only five participants provided postnatal accounts which suggested a change in perspective. Most changes involved the isolate participants, and the overall direction of change was towards increased individualist perspective.

Table 8.5 Changes and amongst participants who gave birth to second or subsequent babies

Participant	**Antenatal quadrant**	**Postnatal quadrant**
Maria	Isolate	Individualist
Cecile	Isolate	Individualist
Nia	Isolate	Individualist
Rosa	Isolate (enclave)	Individualist/enclave
Vita	Enclave	Individualist/enclave

Figure 11 below summarises the limited changes observed amongst participants following second and subsequent births. As in Figure 10, the arrows represent the direction and numbers making the change, and the numbers in brackets indicate how many participants were associated with each quadrant before (AN) and after (PN) the babies were born

Figure 11 Change and consistency after second and subsequent births



Twenty-eight participants were expecting their second and subsequent babies, including 23 women and 5 birth partners. There was virtually no change amongst the dominant traditionalist and individualist cultures. Participants in these groups retained consistent views, and in the postnatal interviews, traditionalists would only consider OU in the future, whilst individualists still varied between OU, AMU, FMU and home, but tended to prefer the non-OU settings.

In the enclave group, Vita's birth experience led her to distance herself from the natural birth worldview, and this is considered in more detail later. The significant changes that took place amongst women expecting their second or subsequent babies were amongst those in the isolate group. Nia, Cecile and Maria each shifted into the individualist group after birth, but as discussed in Chapter 7, these participants had a worldview consistent with the individualist culture beforehand, but had been excluded from making a choice about where to give birth. Nia and Maria experienced good quality care in labour; Maria's positive birth experience was also discussed in Chapter 7. Nia's birth experience illustrated the benefit of having continuous care during a potentially complex labour. She wanted a vaginal birth (in a hospital OU) following a previous caesarean section, but during the antenatal phase she had little expectation of this and did not feel she could depend on receiving support from midwives during labour, fearing that 'every little thing could go wrong' in hospital. She changed her view after experiencing continuous care from a caseload midwife who attended her throughout the labour:

> The midwife, that was excellent. I called her, I was feeling pain, and she came to my home and she assessed me, and I was two centimetres. So she told me to stay home for a bit. But later when the pains were stronger I rang her again and she came back [to my home]. And I was getting well dilated, and she told me to meet her at the hospital. So she met me there. And everything worked well.
>
> (Nia, Southcity, second+ baby, postnatal interview)

Cecile's case was a little different and her experience is one of the case studies considered in more depth later. Of all the cultural groups, the isolate quadrant was associated with most mobility. The women whose worldview shifted in this way experienced transformative agency (that is, agency which occurs in the face of social constraint) and according to Bourdieu's (1990) theories, this occurred because women expanded their own cultural and social capital through being older, more experienced mothers, and also gained additional capital via the advocacy and support of others (Behague et al 2008).

Although some women underwent positive shifts towards the individualist culture, these were a minority. Most remained in the isolate culture, and might even be described as even more excluded, because their present births had not given them reason to reconsider their worldview and the life pattern of exclusion was again replicated. Amongst the other cultures too, the observed tendency for participants was towards conservatism and no change in preference for birth setting. This pattern helps explain why women expecting their second or subsequent babies had often made their decision about where to give birth before seeking antenatal care in early pregnancy (see Chapter 5), and contributes an insight into the reluctance of women, even those with straightforward obstetric histories, to contemplate non-OU births in later pregnancies.

Summary: reflections on birth and change

Overall, the pattern within the sample was of consistency and increasing conservatism about the biomedical risks of birth. Through conducting longitudinal, prospective interviews, it became evident that, with some exceptions, women were increasingly unlikely to revise their risk perceptions and modified their worldview and birth place preferences as parity increases. First-time parents who started with a traditionalist worldview found extra confirmation for this. Women's experiences of monitoring, surveillance and problems accessing care during labour confirmed their pre-existing belief that birth was risky and unpredictable, even when labour turned out to be straightforward and their birth was normal, without clinical interventions. Most first-time parents who started in the individualist culture also retained this worldview, although after complex births, four women shifted towards the traditionalist worldview. These women juxtaposed their medical and quality risk perspectives after experiencing either birth complications or better quality OU care than they anticipated, or both.

Only women who had straightforward births in non-OU settings, or had planned out of hospital birth but been transferred to OU care during pregnancy or labour, thought they were likely to consider non-OU settings in a future pregnancy. None of the

women participants reconceptualised birth as less risky than they had previously thought and so amongst first-time parents, either consistency or increased risk aversion was observed most often. For those who took part when they were expecting second or subsequent babies, the conservatism was even more apparent. Amongst this group, those who opted for non-OU settings were women who had actively planned these in previous births, and either succeeded, failed to gain access in labour, or been transferred into OU during labour.

These changes amounted in practice to an increased resistance towards alternatives to OU for most of the participants over the course of their childbearing careers, and a persistent orientation towards non-OU settings for a smaller group. The earlier chapters sought to establish that access to choice of place of birth is neither straightforward nor equitable, and the accounts presented here show that this has an impact on women's experiences of birth. Whilst space does not allow an in-depth analysis of each participant's birth, this chapter ends with two focused comparative micro-analyses of birth place choice exclusion and inclusion. These show how choices affected women after their births and were selected because the insights they provide have particular relevance to contentious issues raised within the debate about birth place choice.

Making sense of birth place choice inclusion and exclusion

Postnatal reflections

The case studies discussed here illustrate how different experiences of choice are incorporated by women into their postnatal accounts. The closer attention paid here to narrative episodes provides an opportunity to access what Somers' (1994) described as ontological narratives or individual accounts of sense-making in response to events. Although still partial, and necessarily manufactured within the interview context, these nevertheless reveal some of the identity work undertaken by women as they reflect on their births in relation to the expectations and hopes they held during pregnancy. The two discussions centre around four women. Vita and Rosa both had enclave worldviews and preferred a non-OU birth, and the first discussion compares their

respective experiences of choice inclusion and exclusion. The second case study contrasts Florence and Cecile's sense-making of their births after Florence was supported in her choice of AMU and Cecile's preference was not met.

'But what do I know?' Making sense of birth when things don't go to plan

Vita and Rosa had both given birth before when they took part in the study. Vita has been identified with the enclave culture because she wanted a home birth, a desire which was underpinned by the logic of keeping birth natural and integrated with her family life. Rosa had once wanted home birth for very similar reasons but by her current pregnancy felt excluded from *any* non-hospital setting, and was therefore associated with the isolate culture. Both had pregnancy histories complicated by obstetric risk factors which meant birth in an OU setting was recommended for them.

Despite their similarities of outlook, Rosa and Vita's experiences of birth place choice were very different. Rosa had previously tried to plan a home birth more than once but each time was transferred into hospital. The reasons Rosa gave to explain this pointed to a difference of professional opinion between two community midwives, one of whom supported home birth and another who was more reluctant to agree to it. Each time Rosa was assessed as suitable for home birth but asked by a midwife to transfer into hospital during labour. On the second occasion she had a normal birth but a complication arose during the third stage when the placenta was retained. This problem meant her obstetric history now indicated additional risk and Rosa had accepted that home birth was no longer an option. On the other hand, she still wanted to be considered for a birth at the AMU, where she felt she would have the best chance of a normal birth without intervention, but her midwife said that this was not possible.

Vita, on the other hand, *was* able to negotiate access to her local AMU and to home birth support despite her obstetric history including an emergency caesarean section. Vita's access to the AMU may have been facilitated both by her privileged identity and by the additional support she received from a caseload midwife. In terms of their social identities, both Rosa and Vita are white, married, graduates and experienced mothers.

One factor that separated them was that Vita was employed outside the home whilst Rosa was not, a distinction that may have suggested to health professionals that Rosa's family is more 'traditional' in outlook. A second difference was that Rosa did not use received English, and spoke with a regional accent. Despite appearing 'on paper' to have many attributes of a privileged identity, Rosa's case suggests that she either presented as having, or was perceived by her midwives to have, a devalued identity, and highlights the continuous interplay of attribute, perception and identity conferral within social life. Rosa's partner, Donald, explicitly argued that their choice was limited because they lived in a socio-economically deprived area.

Donald Um ... I was talking to a friend and she said that she was desperate for a home birth but she wasn't allowed to have one ... um ... and all sorts of excuses were made. And they eventually found out it was due to her locality, where she was based, because it was a high risk area.

KC Oh right.

Donald So ... midwives don't want to be there. So she was bamboozled into going to hospital.

(Donald, Rosa's partner, antenatal interview)

Below, Vita and Rosa's different antenatal perspectives on choice and birth place preference are compared. First, their antenatal narratives are presented (Table 8.6) and then their postnatal reflections on what actually happened are summarised in Table 8.7. Within the tables, the interview data is reduced or 'parsed' into 'acts', as in a play, or sets of stanzas, following the conventions described by Riessman (2008, pp.77-103). The words are those of the respondent and used in the same order as they are in the interviews, but reduced to a minimum to convey the sense of the discussion, rather than being fully presented in context. This provides an opportunity to compare key points of transcripts, which would be difficult using the full text.

Table 14 Vita and Rosa: Antenatal perspectives of birth place choice

	Vita (enclave)	**Rosa** (Isolate/excluded from choice)
Choice perspective	**I decided** on home birth One midwife said I didn't stand a chance But lots of other people encouraged me	They've told me I've got to go to hospital I don't have any choice
Preferred place of birth **Home is …**	I want a water birth at home Home is my place - I get to stay in control	I'd prefer the [AMU] But they won't even entertain the idea Twice, I've booked to give birth at home, Each time I've been sent in during labour.
Hospital is …	Small, dark, bare rooms – and the bed! When I look in those rooms I just think, **bed** … Everything's written down in the book (of guidelines) but it's never exactly clear why they do what they do… (but I'll go there if it becomes necessary, of course)	Well, it's the luck of the draw. Some staff are lovely, others rude and bullying, they often disagree with each other (and with me) I've had some horrible experiences and some positive ones You just don't know what'll happen But they stick to their textbooks And they make it more difficult
AMU is…	too near Labour ward to be normal	I'd prefer the AMU But I don't have any choice I don't have a right to appeal.

At their end of pregnancy interviews, Vita was still planning a home birth and had secured support from her partner (Michael) and from a community caseload midwife (Mary), whose input was instrumental in instilling confidence in both Vita and Michael. They had discussed their planned birth with Mary at length, and Vita was willing to transfer into hospital in the event of any problems; she trusted Mary's judgement. Rosa was also more upbeat at this point. She had moved area, and a community midwife had proposed a water birth in hospital, which Rosa was happy about. However, neither birth turned out as planned (see Table 8.7 below):

Table 15 Vita and Rosa: postnatal reflections

	Vita	**Rosa**
Birth narrative (postnatal interview)	When I went into labour, the midwives didn't come I was alone I tried, but it wasn't working I went to hospital They said, you should have a C-section I had a CS It was better than last time The surgeons were great	I went to the hospital, I was 7cm dilated The midwives said a water birth was too much of a risk. I couldn't relax and I asked for an epidural The heartbeat dropped, They said I needed a CS Then it got better and they sent me back to the room. I was failing to progress It was hard to push They wanted to do a ventouse But the midwives fought my corner Eventually, [baby] was born. I was home the next day
In a future pregnancy…	If they advised me that CS was safest I'd probably just say, OK I'd have liked a natural birth, but it wasn't to be	If I had another baby, I think I probably would just go to the OU.
Evaluation	It could have been different (But what do I know?) Hospital is **their** place (they get the 'home game advantage')	It's kind of disappointing, but it doesn't help That I have awkward babies.

Vita's birth fell on a day when her trusted midwife was not available, an eventuality they had planned for, but which in the event proved more problematic than they had realised. Another caseload midwife attended the birth, and Vita did not feel the same connection with her. Vita spent a long time alone during early labour despite informing the caseload practice when contractions started. She wanted to use the birth pool for pain relief but was afraid to do so in case it was 'too early', meaning that she might

inadvertently slow down the labour and end up in hospital with 'delayed' progress. Eventually, she asked the midwife to come out to her:

> … it was a bit like, 'Well I would like you to come actually!' [laughs] **Now**, kind of thing …
>
> (Vita, postnatal interview, emphasis in recording)

When the midwife did arrive, Vita used the birth pool but by this time, the water did not provide effective pain relief, which increased Vita's anxiety. She asked the midwife for gas and air, but:

> **Vita** I think she was a bit reluctant to give me the gas and air… wanting me to be a bit further along, she was saying something about … it being better to wait a bit or something, and I was just like, 'I don't want to wait.' [Laughs] I don't think she was being mean, I think she was following guidelines that presumably … you know … she's been given.
>
> **KC** And how … do you know how you felt inside when she said that?
>
> **Vita** Um … I was a bit irritated because I was in pain anyway, but …
>
> (Vita, postnatal interview)

Vita recognised that the 'stand-in' midwife was following labour care guidelines and although the midwife's intention may be to help Vita progress in labour by withholding pain relief, the realisation that the midwife was 'with institution' (Hunter 2004), rather than 'with Vita' drew her attention to an unanticipated difference between 'this midwife' and 'Mary':

> I just felt that [Mary] was so experienced, and so knowledgeable, and did seem to be on my … like I say, we didn't really have communication issues, she just seemed to know what I was talking about

Edwards' (2005) study with home birth women contains similar accounts of midwives importing medical management of birth into their homes and for some this was unwelcome, whilst others were reassured by this evidence of midwives' clinical skills and competence. For Vita, the midwife's adherence to 'the book' was problematic. In Vita's transcript, a pattern emerges between the supported home birth she had hoped for, and the 'absences' she experienced, which culminated in her feeling the pain to be out of control, and requesting transfer to hospital for an epidural. Shortly after the epidural was placed, the baby's heart beat dropped and her obstetricians recommended a caesarean, which Vita and Michael agreed to. Both felt that 'this' caesarean was much better than the previous one, in the sense that it was more controlled, Vita was conscious and Michael was with her, and the surgeons were 'great'. But Vita's evaluation is wistful ('it could have been different') and contains the counterpoint of Mary's absence. The segment below refers to a discussion which took place between Mary and Vita after the event, where Mary seemed to suggest that Vita and Michael could have waited to see if the heart beat rectified before proceeding to a caesarean. In the text below is presented in the order that it was spoken, but the line breaks help illustrate how Vita interposed her account with mentions of Mary's absence:

> ... and that's when [Mary] said, 'Well ...'
> well **she wasn't there**, **she said later on**,
> 'Well maybe if you'd waited ...'
> [A little later]
> Maybe I would have made a different choice if
> ... **if she had said** ... if **someone had said,**
> 'Well this often happens, why don't we wait a little bit longer,'
> but nobody did, so.
>
> (Vita, postnatal interview, emphasis added)

Vita's rejoinder, 'but what do I know?' is particularly poignant in the context of her earlier interviews, when she talked at length about her own research, her awareness of medical literature, statistics, midwifery literature and 'lay' experiential knowledge.

The advantage of these 'knowledges' proved less substantial in the absence of the hoped-for professional midwifery support, and her experience of unmanageable pain meant that her knowledge of 'natural birth' was also brought into question.

Rosa's postnatal account had many features in common with Vita's experience. Midwifery support for a water birth was lacking, she had a long labour, an epidural when she became exhausted, and ultimately a pressured delivery with midwives guarding the door against the threat of ventouse or caesarean because *she* was failing to progress. From the beginning of her narrative, Rosa's agentic position is different to Vita's. Rosa is more deferential and accepts the barriers to AMU as 'real', whereas Vita does not particularly countenance either home birth or AMU as beyond possibility. Yet Rosa is not defeatist as she accepts medical advice up to a point, but also engages midwives through asserting her candidacy and preference for a natural birth. By the time of her postnatal narrative however, her voice is passive and it is left to others to 'fight her corner'.

Both women were resigned to the thought of any (hypothetical) future birth being in an OU in their postnatal interviews: for Vita, a natural home birth 'just wasn't to be' and for Rosa, her 'awkward babies' do not help. Although Vita perhaps felt she had a choice during pregnancy, and Rosa became convinced of the same, both these particular choices turned out to be illusory. This comparison illustrate two cases where active choice was asserted or attempted in contravention of clinical risk protocols, and was neither explicitly refused nor fully supported. In post-hoc analysis of births, it becomes easy to suggest that disappointment is inevitable when women with complex pregnancies want to achieve 'normal' births in low risk settings, but both Vita and Rosa were encouraged to believe that alternatives were available during their pregnancies. Although each was philosophical about the outcomes of their births, a sense of deflation persisted. Both had also experienced a reshaping of their identities as 'natural birth mothers', as the events of their labours required them to accede to medical birth models. In their postnatal evaluations each distanced themselves from the enclave worldview and it is arguable that their sense of loss could be related as much to the loss of a hoped-for natural birth identity as to the loss of a natural birth.

Making sense of birth outcomes: when birth choice is supported and when not

Chapter 7 presented an argument that individualist women who made relatively neutral choices about planned place of birth were better able to make sense of the events of birth, without feeling that they, or their bodies, had failed. In this context, the term 'neutral' refers to an ability to make decisions that were effectively either free from, or at least reflexive about, birth ideologies. Although participants who shared an individualist worldview often did value 'normal' birth (where this means vaginal birth, without epidural anaesthesia), and frequently aspired to give birth in midwife-led settings, they were different to enclave participants because they actively endorsed clinical and technological expertise in a manner which initially appears similar to the traditionalist view of obstetric medicine. However, individualist participants perceived expertise (from any specialty, including midwifery and obstetrics) to be an available commodity and had a 'cornucopian' view that their clinical needs would be met as and when they arose (Douglas and Wildavsky 1982, p.162). The individualist position therefore does not endorse the traditionalist view that birth is medically risky, but neither does it privilege the enclave paradigm of birth as a 'fundamentally safe' process (Davis-Floyd 1990, p.187) which is subject to interference in hospital. Instead, individual choice was considered more important than affiliation with an ideological stance, and it follows that women with this worldview who found themselves excluded from choice might struggle to come to terms with this.

This final case study illustrates the consequences for women's sense-making following birth when one contentious choice was supported, and another refused. Here, Cecile and Florence's different experiences are contrasted, as each woman dealt quite differently with birth scenarios which featured infant asphyxia.[4] These cases are intended as interpretations of these participants' particular accounts in a manner that might inform or add nuance to how we think about birth place choice. They are not intended as stand-alone as cases with wider or transferable implications, but rather to

[4] In the interviews, each woman used the term 'asphyxia' (see glossary) to refer to some degree of oxygen deprivation affecting the baby during birth, so this term is retained here.

provide an authentic account of these unique experiences in the wider context of societal constraints upon birth choice.

Cecile and Florence each had individualist perspectives, but Cecile's preference for an elective caesarean following an emergency caesarean in a previous labour was not supported by her hospital team on the grounds that she had given birth vaginally before her emergency caesarean. Cecile was one of the participants who had more than one difference from the idealised template discussed earlier. She was non-UK born and spoke English with an accent from her first language. Cecile was not convinced that a normal birth would be safe so she was excluded from choice of mode of delivery, as well as from choice of place of birth.

Florence's situation was quite different. In a previous pregnancy, Florence had wanted to give birth in AMU, but was transferred to obstetrician care before the labour commenced, and advised to give birth in the OU. She had a positive experience of OU care, after receiving midwifery support which helped her achieve a normal vaginal birth; after this experience, she concluded that her maternity team had been unnecessarily cautious when they insisted she give birth in the OU. Reasoning that it was sheer good luck that she had found a sympathetic midwife in her first labour, and that the OU was too much of a lottery for her to feel confident the same would happen again, she again selected AMU during the current pregnancy, and negotiated access even though her labour featured some risk features that meant her admission contravened the AMU's access criteria. In some ways, Florence's antenatal risk perspective was similar to an enclave view; however, her willingness to give birth in AMU to reduce the risk of poor quality OU maternity care suggest that she was also working from an individualist, quality-oriented perspective. Florence had a 'privileged' identity and background, and was able to assert her preferences, using active agency and also candidacy to make a case for being treated as though her labour was straightforward. Just before the extract below, Florence explained that she had seen a community midwife at 4pm, and had a vaginal examination which showed her to be 4cm dilated and contracting regularly. The interchange with the AMU midwife takes

place at 10pm the same day, indicating that her labour has not progressed in the intervening 6 hours:[5]

Florence: ... with only 4cm in the afternoon the midwife said it probably was 4[cm] but she couldn't put 4 [cm] on the sheet because then she would have to have me admitted into hospital [OU].

KC Oh OK.

Florence: I was still 4cm at midnight [...] that was quite um [...] I was really disappointed by that because that was a real characteristic of [an earlier] labour.

KC Oh I see.

This was consistent with Florence's antenatal interview where she discussed knowing that she could cope with even a long labour without pain relief, but that because the hospital tended towards being over-cautious, she thought she may need to 'push' to be admitted to the AMU. The extract below is from Florence's antenatal interview, and here she refers to her previous birth.

Florence I did want to use the AMU but they wouldn't allow me to because they had measured the baby, I was about a week overdue, I was a week overdue when [baby] arrived, they measured [baby] at five days overdue, thought [baby] would be nine and a half pounds, took one look at the size of me and said, 'No, we're just not letting you.' And I think if that was the case the second time around I would push much, in fact I know I would push much harder for the AMU

[A little later]

KC So they [hospital staff] really felt that because of the possible weight of the baby you should go to the obstetric unit.

Florence Exactly.

[5] 'Normal progress' in labour is a contested term (e.g. Neal et al 2010), but current UK guidelines acknowledge that 'progress' is not always linear, and suggest 5–12 hours as normal for first stage of second/subsequent labours (NCCWCH 2007, p.138).

KC But with hindsight you think that was a bit …

Florence Over-cautious.

KC Over-cautious, yes.

In her postnatal interview, Florence described having prolonged first and second stages of labour, and giving birth in the AMU, but the baby had some breathing difficulties:

Florence … the cord was wrapped around [baby's] neck, so [baby] was slightly asphyxiated during the birth process

KC Oh OK.

Florence Um as I say, when [baby] was […] [baby] was delivered at [time of birth] it just took them 4 minutes to resuscitate [baby] and get [baby] breathing. [Baby's] Apgar score[6] was 2 um when [baby] was born and that was because [baby's] heart beat was very strong throughout but no reflexes or breathing or anything. It was 9 five minutes later.

[A little later]

Florence … because obviously you need a little bit more than [an Apgar score of 2] to survive, but um they managed to resuscitate [baby] quite quickly and [baby] spent a couple of hours in the special care baby unit but just for a couple of hours and then [baby] came back up to us

KC So overall what was that like? Did you feel good that you'd managed to give birth in the [AMU]?

Florence Very good. Really, really good, I managed to get away without any tears or stitches which I think at [4kg] was a minor miracle.

(Florence, second+ baby, postnatal phone interview transcript)

[6] See glossary: An Apgar score of 2 at birth is indicative of a need for resuscitation but recovery to 9 or 10 at five minutes is reassuring.

Here, Florence focuses on achieving a normal birth, and the baby's admission to special care is not central to her evaluation. This is partly the result of a co-construction, because I invited her to comment on managing to give birth in the AMU rather than the experience of her baby's admission to special care ('did you feel good ...'). My question changed course mid-stream because this was a phone interview and as I could not take Florence's facial expression or body language into consideration I felt reluctant to directly pursue a subject which might be distressing. However, earlier in her account, Florence comments that the resuscitation 'just' took five minutes and that the baby was 'just' gone for a 'couple of hours', and this couching of the baby's special care admission as very transitory seems to substantiate the observation that Florence was able to minimise this event within her overall positive account of the birth. Later in the interview, she dwelled more on the moments of birth and feeling overwhelmed when her room suddenly filled with people. Although it was a dramatic time, it has not defined her experience within this postnatal account. Rather, it was an event that required expert intervention and was quickly and positively resolved.

This was not the case for Cecile, whose long labour ended with an assisted ventouse delivery. At the very beginning of her postnatal interview, Cecile recounted that things had not gone well, and she said she wished she'd listened to her 'inner voice' and argued more for an elective caesarean:

> And, er, I think if I had just had caesarean, but I don't know what would be the outcome of caesarean [KC: Mm-hm] but obviously [caesarean] is better for baby, I think. [KC: Mm] Not for myself, but definitely for baby. [KC: Mm] Because [baby] had some asphyxia because of the length of the delivery.

Unlike Florence, Cecile was very preoccupied with the events of the labour and the implications for the baby's future health:

> **Cecile** Yeah, well because [baby] had lack of oxygen, and er, well I was thinking about like, in future would it affect [baby], (Mm) will [baby] have special needs or something? But hopefully not, (Mm)

because, **well they say the scale, Apgar scale, it was 9. I said, 'Why 9?' [Laughs] 'What's the matter with [baby]?'** But she said, 'Oh after 5 minutes [baby] was 10, [baby] had 10,' because of the colour of [baby's] skin, [baby] was a bit bluish, so [baby] was [...] [having] kind of lack of oxygen. But she said, 'All is fine, it happens to all [...]' Well they always say it's fine, you know.

KC Mm. But you're not sure.

Cecile [Sighs.] No, and er, it was long labour. [KC: Mm] I thought [this] child would be quick, [KC: Yeah] and it was long labour, it was like 24 hours.

(Cecile, second+ baby, home postnatal interview, emphasis added)

Each interviewee's account includes information about the baby's Apgar score and descriptions of asphyxia, but the mothers have entirely different perceptions of these. Cecile's baby had much higher Apgar scores (9 and 10), suggesting that the baby was healthy and did not require resuscitation, but this did not reduce Cecile's anxiety ('Well, they always say it's fine, you know'), and she articulates a fear of future developmental problems for the baby as a consequence of her own 'failure' to secure a caesarean. Florence's baby's Apgar scores were much lower (2 and 9), and the baby was treated for respiratory distress with a short admission to special care, but Florence does not volunteer any similar concerns about the baby's future well being; this does not mean that she did not have such concerns, but only that in her narrative presentation of the birth, this difficulty is temporary and resolved without repercussions.

Later in her interview, Cecile described the process by which she was 'talked out of' an elective caesarean, despite her own misgivings:

Cecile They were really encouraging, yeah, like saying, 'Oh we can't see [...] there's nothing, um, which can stop you from having a natural birth, so let's discuss natural birth, and like put this caesarean aside. [KC: Mm] So many pluses,' and they start talking about

pluses. So then at the end of conversation you think, yeah, there are many pluses. [Laughs]

KC Mm.

Cecile It wasn't equal discussion about [...] both ways of having a baby.

KC OK, so the discussion was ...

Cecile Mostly, yeah, they concentrate on natural [...] and dismiss the opportunity for caesarean because they say, 'Oh [...] they're more complicated, there are so many things, you know, to go with it. [KC: Mm] I can't see why can't you have natural.'

Although this experience may not be usual, Arabella (discussed in Chapter 6) also requested an elective caesarean and whilst her circumstances were different, she experienced similar pressure to have a normal (vaginal) birth. Discussing the risks and benefits of vaginal birth after caesarean section (and caesarean at maternal request) with women is a strategy recommended for reducing caesarean section rates. But weighting the discussion towards vaginal birth is not consistent with current guidelines for practice (e.g. NICE 2004)[7] and privileges the practitioners' goals above those of the woman, or at least assumes that women share the same goals.

These cases contrasts the ways Cecile and Florence made sense of birth events after their experiences of choice were so different. Florence seemed to construct and interpret the events of her births in a positive light, although it is not necessarily the case that being supported in her choice of AMU alone contributed to this sense-making. This explanation does not take into account the different socio-economic contexts of these women's lives; Florence had a privileged social identity, whilst Cecile was audibly different. The reflections of others whose preference was in some way thwarted, or who were unable to secure their preferred place or mode of birth, also included self-blame for perceived failure to secure what they wanted, especially as others clearly manage this.

[7] An update of this guidance is due for publication shortly

Summary

This chapter has explored both change and consistency in participants' accounts of planned place of birth. Women's birth place decisions took place over the course of pregnancy, but most of the changes discussed here occurred after birth. The longitudinal, prospective design produced new knowledge about birth place decisions over the pregnancy and birth time frame, and these findings are summarised here.

A key finding was that most women who gave birth in OUs remained conservative about birth place planning for subsequent births. Within this sample, the trajectory of change (where this occurred) was towards an increased sense of birth as risky or uncertain, even if the birth was normal and occurred without intervention or pharmaceutical pain relief. There is an expectation within maternity care that women might have their first birth in hospital OU and then feel more relaxed about a future birth in a non-OU setting, but this rarely materialised. However, women who planned and achieved birth in AMU, FMU or at home would usually plan to do the same next time, and the same was usually true if women planned non-OU settings but were later transferred to OU during pregnancy or labour.

Participants very rarely reconceptualised birth as less risky than they had initially thought after going through labour. These findings were presented separately by parity, and those expecting their second or subsequent babies seemed even less likely to change their worldview after birth, suggesting that these views become increasingly entrenched during the course of a woman's childbearing 'career' (Thomas 2003). The adage that birth can only be considered to be safe in retrospect is part of the biomedical rationality for hospital birth (e.g. Feldman & Freiman 1985; Beecham 1989). Women's exposure to medical reasoning during pregnancy and surveillance and monitoring during birth seemed to accentuate for them the strength of this argument. With few exceptions, even normal births were judged afterwards to have been rescued by intervention, rather than being envisioned as eventually or intrinsically safe. However, the multiparous group within this sample had prior birth experiences which covered a historical time frame of up to 20 years, so it is not necessarily the case that

this pattern would recur in the future, and given the research design, this observation may also arise from the purposive nature of the sample.

Chapters 6 and 7 outlined how the events of pregnancy often situate hospital birth as normative, and this chapter presented further data about women's experiences in late pregnancy and labour which showed how their access to chosen birth places could be frustrated. This happened either because new clinical risks became apparent, or because they could not gain admission to non-OU settings in labour (or to birth pools within OU labour wards) because units were busy, and while they waited to be admitted, their levels of discomfort and anxiety increased. Women expecting their first babies were particularly affected by this. This group was more likely to have planned a non-OU birth and less likely to have achieved this.

The analysis was informed by cultural theory and at the beginning of this chapter a question was raised about the meaning of change within this theoretical model and whether a change in birth place preference would signal a change in worldview. Broadly, the answer to this is that it does, and this could help to explain why change was less likely than consistency and conservatism.

Women who planned to give birth in hospital because they believed birth to be medically risky (described here as traditionalist in outlook) incorporated the interventions they experienced into restitution narratives (Frank 1995) which served to confirm the rightness of deciding to give birth in hospital, so that hospital OU was reaffirmed as the only appropriate place to plan to give birth. When women with these beliefs had normal births in OU settings, the signalling of risk and uncertainty they encountered through surveillance technology and discourse about the progress of labour persuaded them that a safe outcome was uncertain, and this informed their intentions to give birth in OUs again in the future. Within cultural theory, the resistance to change observed amongst the traditionalist group is explained through the theorised value placed upon deference to expertise, and maintaining the status quo (Douglas and Wildavsky 1982).

Women who planned to give birth in non-medical settings on the basis that birth is natural and safe (enclave worldview) also found these different beliefs about to be confirmed if their pregnancies were clinically straightforward, and this consistency is explained through the ethic of group loyalty practiced within this culture (Douglas 1982, p.198). If their experience of FMU or home was positive, they would usually plan to give birth in a non-OU setting in a future birth, even if they had been transferred into hospital during the course of labour. Those with increased clinical risks in this group tried to maintain their belief in natural birth, but found this challenged by events and by inconsistent support from health professionals for their birth preference. Eventually, they distanced themselves from the natural birth worldview but the numbers involved were small, and it is particularly likely that their inclusion came as a result of purposive recruitment, because these participants wanted to share their experiences.

Women and partners who during pregnancy had believed birth to be generally safe but foresaw problems in care quality (individualist' worldview) and had positive experiences of care quality either in OU, AMU, FMU or at home would generally opt to give birth in the same setting in a subsequent labour. However, women expecting their second or subsequent babies who planned a non-OU birth sometimes found that the birth ideologies practised by midwives were at odds with their own values and preferences. Others in the individualist group experienced events during their labours as indicative that they had underestimated the medical risks of birth and the quality of OU maternity care. The individualist shift towards a more traditionalist worldview is also suggested by cultural theory although the development is more subtle; in this group alone, medical support was seen as a commodity to be accessed. Their ability during the antenatal phase to envisage several eventualities within their imagined future labours, and to see these neutrally as possible outcomes rather than as emotionally charged or imposed upon them, allowed individualists relative liberty from birth ideology. But as discussed above, it could also mean that clashes might occur if birth ideologies were imposed upon them.

Douglas (1982, p.182) also argued that the 'single cultural value that justifies the movement towards low grid is the unique value of the individual person'. This appears borne out in the case of isolate participants who sometimes moved towards the individualist culture after received interventions by advocates who supported them, or else developed a stronger sense of themselves as authoritative, experienced mothers. In each case, their individualism was more prominent, and better catered for.

The changes observed here were incremental rather than radical, and one of the advantages of collecting the data prospectively was that it became possible to observe how views held previously became difficult to recall. Instead, the 'new' reality was incorporated as having always been present. This analysis draws on Ricoeur's (1984) thinking in relation to the hermeneutic nature of time within narrative, which holds that the sequence of events (or plot) does some of the work of producing coherence for the speaker. An experience is interpreted retrospectively as though the currently held belief was 'always the case', and the 'ontological narrative' remains consistent because any repositioning is premised upon the pre-existing worldview.

The final part of this chapter presented comparative case studies which explored women's sense-making following birth. The findings are necessarily tentative, but begin to suggest that the opportunity to be engaged in decision making about place of birth, and to be positively supported even if the preference is contentious may alter how women feel about themselves and their births afterwards. This is a complex proposition, but in each of the cases discussed there was opportunity to support choice and maintain clinical safety, because the women were willing to trust the judgement of health professionals who listened to and supported them. The implications of the longitudinal findings are discussed more extensively in the following chapter, which summarises the full findings from the research, and then situates these in relation to existing knowledge and evaluates their implications for maternity policy and practice.

Chapter 9: The experience of deciding where to give birth

Narrative constructions of moral selves in English NHS maternity care

Introduction: What has changed since *Changing Childbirth*?

This chapter summarises the findings from this study, and contextualises these in relation to the conceptual literature discussed in the earlier chapters. The implications of the findings are also discussed, and ways in which these confirm or extend what was known prior to this research are reviewed, and the strength of the theoretical contribution to the field of study is evaluated.

The starting point for this study was that in contrast to most industrialised countries, England has pursued a policy of choice of place of birth for almost 20 years, but that the home birth rate has barely changed in this time. Recent years have seen a modest expansion of births in AMU and FMUs, so that according to the latest published data, approximately 7% of births now take place in settings other than OUs (HCC 2008). The policy premise for providing choice of place of birth was that this would lead to better experiences for women, and greater satisfaction with the experience of birth, and these sentiments that have been echoed in subsequent policy directives (Department of Health 2007a; Shribman 2007), but there is little evidence that women's experiences of birth has changed, and intervention rates have only increased (e.g. Downe et al 2001; Johanson et al 2002; Bragg et al 2010).[1]

Part of the explanation lies with the limited availability of options. As Dodwell and Gibson (2009) and NCT (2009) show, most UK women live in areas where their options are constrained either by local provision or by travel times, or both. For women in rural areas long journeys also incur extra costs, and mean that women are away from their

[1] Also http://www.birthchoiceuk.com/Professionals/index.html for UK rates of induction of labour, assisted delivery and caesarean section over time, since 1990.

young families (Pitchforth et al 2008, 2009)[2] yet despite these drawbacks, many still preferred to give birth in more distant hospital OUs. To explore why it is that almost all births in England still take place in hospital, this research sought to detail the experience of making a decision about where to give birth, to explore socio-cultural perceptions of risk, and risk selection, whilst documenting the influence of normative discourses upon these, and to observe the extent to which birth place decisions were stable over time, or shifted in response to the events of antenatal care, pregnancy and birth.

The study also aimed to understand how women arrive at different choices, why some feel they have little or no choice, and why preference for hospital maternity care appears to be so enduring, given that women with straightforward pregnancies are more likely to experience surgical or assisted births and their sequelae[3] in an OU labour ward (NCCWCH 2007; Davis et al 2010; RCOG 2011). These issues are relevant to the safety, quality and sustainability of maternity services, and the accounts analysed here suggest that women and their partners had many different interpretations of choice and of birth place safety and risk, and also worked to demonstrate their appropriateness as moral citizens and responsible parents-to-be. Key contributions arising from this research are first outlined, and the implications of these are then explored in further depth. Following this discussion, the theoretical contributions arising from the use of Douglas and Wildavsky's (1982) cultural theory and Bourdieu's (1984, 1990) theories of social practice and distinction are evaluated.

[2] Pitchforth et al's papers refer to a study in Scotland, but the same factors affect women in rural or mountainous areas of England.

[3] These include abdominal and perineal wounds, disrupted bladder bowel and sexual function and mood disorders including depression, particularly after assisted deliveries (Lydon-Rochelle et al 2001, Thompson et al 2002)

Birth place decisions in a socio-cultural context

Before this study was undertaken, Barber et al (2006, 2007), Houghton (2008), Jomeen (2006, 2007) and Pitchforth et al (2008, 2009) had also conducted UK-based research into women's preferences for place of birth, and their experience of making birth place choices. In relation to planning place of birth, Jomeen (2007) and Pitchforth et al (2009) challenged the idea that a prospective choice is feasible, arguing that real choice is illusory (Jomeen 2006, 2007), and is better understood as '**informed** decision making within the contexts of existing conditions and circumstances' (Pitchforth et al 2009, p.47, emphasis added). The themes of constraint and agency were taken up in this research through adoption of Bourdieu's theoretical concepts; recognition that birth place decisions may be either made by women, or imposed upon women is reflected in the use of the term 'decisions' rather than 'choices' in the main study title, and by the focus on individual subjective experiences.

Exclusion from choice of place of birth

Using cultural theory as an analytic framework revealed that just under 25% of participants were excluded from choice, and the challenges of recruiting these particular women into the study suggest that the true extent of choice exclusion is also underestimated within this research. This level of exclusion is higher than previous estimates; Barber et al (2006) noted that 13% of their sample reported having no choice and Pitchforth et al (2009, p.45) reported that choice was often constrained by eligibility, even when alternatives were raised with women. Through applying Bourdieu's concepts of economic and cultural capital as an analytic framework, the study also demonstrated that exclusion from choice was distributed unequally within the sample; privileged women were able to access and avail themselves of choice, but less privileged women proved more vulnerable to exclusion. The narrative analyses demonstrated mechanisms whereby socio-economic or cultural capital attributes became conflated with clinical risk factors during negotiations between women and midwives and that eligibility was at times constructed by midwives on the basis of social as well as clinical appropriateness for birth in alternative settings, although

research with a more robust design would be required to test this further. On the other hand, interventions of advocacy and carer continuity also mitigated this problem for those most at risk of exclusion from choice.

Influence of primary antenatal health professionals

Barber et al (2006) considered that midwives were more likely than GPs to inform women about the options of home birth or AMU. Jomeen (2007) similarly argued that GPs frame choices within a medical approach, and limit these by discussing only hospital OU alternatives. Overall, these findings were supported by this research. Women who saw their GPs first during antenatal care were provided with choices of one or more hospital OUs and rarely mentioned home birth, AMU and FMU, although there were exceptions to this rule, where GPs and obstetric consultants provided women with in-depth information about the local alternatives available to them, including home birth. Midwives were more likely to discuss alternatives with women, but despite this, women often only received selective information about birth place choices from their midwives, and midwives were just as likely as GPs to frame the alternatives within a medical risk-based approach. Barber et al (2006) and Jomeen (2007) therefore both identify the importance of engagement with women during antenatal care, but perhaps overstate the difference between midwife and GP encounters. From women's perspectives, midwives often provided limited and conflicting information, and GPs did at least provide consistent advice, even if this was medically oriented.

Barber et al (2006) also suggest that midwives' opportunities to inform women are reduced because women have made their decisions about where to give birth before initiating antenatal care. However, by gathering prospective accounts from women expecting their first babies separately from those expecting their second and subsequent babies it became evident that whilst multiparous women have indeed often decided where to give birth before seeing a midwife (based usually on the events of their earlier births), those expecting their first babies were much more open to considering all alternatives available, and were more likely to plan to give birth in non-

hospital settings, although the events of labour often meant that these plans were not realised.

Choice and agency

By including both women and partners in narrative interviews, this research revealed agency to be nuanced beyond the categories proposed in earlier studies. Pitchforth et al (2009, p.42) suggested that women approach choice differently, and describe a distinction between *'active choosers'*, who fight for the choices they want, or *'acceptors'*, who are more willing to follow professional advice. Although Pitchforth et al (2009, p.44) argued that acceptors are not without agency, Houghton (2008, p.63) described women as 'fatalistic' and Jomeen (2007, p.488) found women to be 'overwhelmingly complicit with the loss of control and choice'. The findings from this study suggest that Pitchforth et al's (2009) categories can be expanded to include three further experiences of agency. These are 'candidacy'[4] (successful negotiation by women on the basis of their self-perceived risk status), then 'delegated agency' (where either party deferred to a partner's decision) and 'relational agency', denoting a decision made by a woman that takes into consideration the needs or preferences of others (Mackenzie and Stoljar 2000; see also Edwards 2005). The narrative analysis also revealed that beneath expressions of resignation to hospital birth on the part of 'acceptors' lay careful strategies for managing various demands through investing resource in areas which were more central to women's lives; that is, women picked their battles, and because place of birth was not necessarily of overall import, their energies were employed elsewhere. Acceptance could also be part of a rational strategy for women who preferred a more traditional or classical relationship with professionals, for whom compliance was a morally appropriate behaviour that allowed relationships to be conducted on a deferential basis.

Partner influence

Houghton et al (2008) reported that partners were largely indifferent to planned place of birth, and intended to support women's preferences, although they were more

[4] Adapted from Dixon-Woods et al (2006)

comfortable if women opted to give birth in hospital. However, through conducting separate longitudinal individual interviews with partners, it became evident that when partners favour hospital, this is because they feel hugely responsible for safety of their partner and baby in the context of home (or FMU) birth. Men's responses were also informed by social expectations that they should be responsible and supportive partners (see also Finnbogadóttir et al 2003; Locock and Alexander 2009; Dolan and Coe 2011; Miller 2011), and this cultural narrative led them to withhold their own anxieties, whilst they worked towards understanding their partner's reasons for preferring a non-hospital birth. Not all partners wished to be involved in the study, and those who did were usually more affluent and educated, which limits the transferability of this finding. However, there is a basis for further study into partner experiences of birth and antenatal decisions.

Responsibilisation and moral identity work

Jomeen (2007, p.e196) and Pitchforth et al (2009, p.46) observed that the need to present as responsible risk managers during pregnancy further limits women's ability to express their birth preference, and this mirrors Viisainen's (2000) Finnish study with home birth mothers. Although few women who wished to give birth at home participated in this research, amongst those who did were some who did not experience stigmatisation, and others who did. Through using cultural theory alongside an exploration of valued and devalued identities (Lawler 2008), it became apparent that women needed to do less moral identity work if they were privileged and had straightforward pregnancies; the moral jeopardy associated with home birth arises in English maternity care when women who request this do not fit the expected middle-class and educated image, or have clinical risk factors present. However, a separate moral issue arises for English women and partners arose as a consequence of using a publicly provided NHS service. Some argued that it was selfish to use up more of the limited resource (midwives) than they were entitled to by planning a home or FMU birth, and others argued that if they kept midwives out of hospitals, then this put other women at risk of experiencing emergencies in under-staffed units. Moral complexities therefore affected women beyond those planning a non-hospital birth, and these also contributed to the decisions women made.

Safer hospital birth

Longworth et al (2001), Barber et al (2006, 2007), Houghton et al (2008) and Pitchforth et al (2008, 2009) all report women's overall preference for hospital OU care, and provide evidence that this is due to the belief that hospital is safer, because equipment and trained staff are present. This preference has also been linked to a theorised increase in women's anxiety about birth risk and labour pain (Green et al 1998). This research also found that most women prefer hospital birth, and cite safety as the main reason for this; however, hospital preference was not universal. Some women actively sought alternatives to hospital OU, the strength of women's beliefs about hospital varied, and the perception of hospital as safe seemed to increase with parity.

The adoption of a cultural theory framework to this question gave rise to a set of substantive contributions to this field. The first of these is that three sub-groups within the population had different risk hierarchies in relation to birth. The group described by Douglas and Wildavsky (1982) as 'traditionalists' opted for hospital OU on the basis of medical risk and were averse to alternative settings, 'enclaves' preferred FMU or home birth, where they believed labour could progress without interruption, and 'individualists' were most open to considering all possible birth settings, but focused on aspects of service quality. The details of these are discussed further below. A fourth group, described as 'isolates', consisted of those who were excluded from the other three political cultures *and* from choice of place of birth, for a range of reasons.

Linked to this was the observation that for two groups (traditionalists and enclaves), adherence to specific belief systems meant that their preferences were relatively inflexible, meaning that some of the proffered alternatives were either unattractive or actively discounted as feasible choices. Through following these individuals through pregnancy into the postnatal period and investigating any changes that occurred, it also became evident that the overall likelihood was that risk worldviews were either stable, or that individuals reappraised their earlier reflexivity and became more conservative about birth risk. A decrease in risk aversion was rare, and only seen in those women and partners who had previously planned to give birth in a non-hospital setting.

This is the first time that a study into socio-cultural perceptions of birth risk (as opposed to birth preference) has been conducted within the context of contemporary English maternity care, although the research builds on previous studies from a range of other nations (e.g. Davis-Floyd 1994; Nelson 1983; Martin 1987; Donner 2003; Liamputtong 2005). Davis-Floyd's (1994) study amongst US women found two separate models of birth, which she described as technocratic hospital birthers and holistic home birthers. Davis-Floyd (1994) also observed a third, hybrid category which she found more difficult to explain within her anthropological framework. This study builds on her work by maintaining the concept of a structural worldview influencing women's birth models, and adds substance to the hybrid model through identifying the individualist worldview, which is associated with consumer choice but retains a technocratic faith in biomedical practice. Although the individualist group actively sought the best quality care they could identify, the importance of quality dimensions was also consistent across the study sample.

The cultural theory analysis drew upon the concept of 'pollution' metaphors, which Douglas and Wildavsky (1982) argued are used by cultural groups to distinguish between practices that are socially approved, and those which attract a sense of opprobrium. This helped identify differences in the ways that cultural groups thought about potential birth places. Hospital birth was described as clean and hygienic and home birth as messy or dangerous by the traditionalist group (see also Donner 2003; Bryant et al 2007). The enclave group considered the hospital environment to pose a threat to natural birth, whilst home was envisaged as the site of normal family life, and the individualist group characterised communal spaces as polluting and private spaces as rarefied and clean.

Changes over time and postnatal sense-making

The cultural theory model also informed the analysis of postnatal data, which suggested that women's sense-making following birth was similarly influenced by their cultural group and worldview. Jomeen (2007) found that when women's expectations of choice were unfulfilled, they experienced negative emotional responses to the

events of birth. This research found similar instances of emotional upset following birth, but once again, this experience was not universal or equitable. Women who had been denied choice found it particularly hard to come to terms with the events of birth, and this compounded the inequity of being excluded from choice initially. It seemed that those who were not supported in their choices blamed themselves or their bodies when their experience was poor. On the other hand, women with an individualist worldview seemed able to assimilate birth events more easily, because they had always been prepared to give birth in the most appropriate environment and felt less anchored to particular settings, or birth ideologies.

Through conducting postnatal interviews, Houghton (2008, p.64) found that the experience of birth, whether positive or negative, acted as a source of confirmation that birth was unpredictable and should take place in a hospital OU. This research supports Houghton's finding, and the longitudinal interview method also revealed that women reconstructed their beliefs on the basis of these experiences, and had difficulty recalling that they would once have considered an alternative setting as safe. This insight arises from the hermeneutic narrative approach, and has important implications for the ways in which maternity services engage women during their first pregnancies. Through exploring the cultural narratives about idealised identities in pregnancy and social life, it became possible to demonstrate that the influence of such norms pre-dates pregnancy and to document the replication and reproduction of normative ideals throughout pregnancy, birth and the early postnatal period.

The key findings from the study are discussed in greater depth below. The initial part of the discussion revisits women's antenatal experiences of birth place choices, and evaluates the use of valued and devalued identities to denote structural constraint or enablement in the context of English maternity care. Although the influence of social norms in relation to birth has previously been identified in the literature, the narrative approach used here provides more detailed evidence of the significance of different cultural narratives operating at several levels; these are interrogated here, and an explanation of their role in perpetuating culturally sanctioned normativity is suggested.

The discussion continues by outlining key findings in relation to cultural theory, which represent a core theoretical contribution arising from this research. The findings from the longitudinal data are summarised, and the impact of birth place choices upon women's intentions for hypothetical future births is appraised. The final section then evaluates the overall contribution of the theoretical frameworks.

Cultural narratives, cultural norms and birth place decisions

This study aimed to explore the impact of cultural norms on birth place decisions, because discourses of risk are invoked as explanations for increased anxiety about birth, but the processes by which this is thought to occur are rarely explained. To address this issue, Somers' (1994, p. 617) 'dimensions of narrative', were used as an analytic tool. These dimensions describe different levels of narrative discourse and discriminate between individual ontological narratives, societal public narratives and historical 'masternarratives', such as 'enlightenment' and 'progress' (Somers 1994, p.619, see also Chapter 4). This exercise revealed a range of co-existing discourses which merged within participants' accounts of 'the way that things are'. Master narratives were an important influence and provided little room for negotiation, and these are likely to be the key abiding source of normative cultural values. Public narratives, which point to traditions, formed the basis of cultural norms of identity; the *idealised* concepts woman, mother, father, partner, consumer, pregnant woman, health professional or patient, and these were secondary influences, which could be explored more reflexively by participants. The implications of public and master narratives for birth place decisions are discussed further below.

Cultural master narratives and birth place decisions.

The 'enlightenment' and 'western citizen' master narratives contained values which were taken by participants to be so central to contemporary living that they were generally accepted as unarguable or taken for granted. These discourses were important within respondent accounts, and were often invoked when uncertainties or conflict were present. For example, when birth partners were anxious about planned

births in AMUs, FMUs or at home, they questioned the medical safety of these settings, and when women with complex pregnancies preferred non-hospital birth, they justified the *rationality* of their decisions and worked to demonstrate that they had weighed up the evidence and believed their births would be *safe(r)* in the settings they had chosen. The pattern of these justifications emerged as rooted in the western conceptualisation of citizens as autonomous and rational individuals.

Bury's (2001, p.271) observation that lay beliefs about health draw heavily on biomedical knowledge is relevant here, because the cultural norm of hospital birth has developed alongside the shift of birth into hospitals and hence has its origins in biomedical perspectives. Normal hospital birth is one element of the cultural meta-narrative which endorses western science and medicine as vital and beneficial, and views as deficient those developing nations which fail to invest in biomedical birth. It is arguably this broader context, in a sense much larger than any hospital or even nation state, which maintains the normative drive towards hospital birth.

Although public faith in science and medicine is thought to be troubled in contemporary times by a crisis in trust (e.g. Kelleher et al 2006; Millstone and van Zwanenberg 2000), this position has been challenged. As O'Neill (2002) argues, such a crisis might be better understood as a mood of suspicion amongst the public, arising from critical media coverage of government and public institutions. In this research, most respondents expressed certainty that hospital could protect women or babies during birth, and only a minority opposed the necessity of medical supervision during birth. This small group were the sole participants to engage in the kind of risk reflexivity that Beck (1992) suggests is commonplace during late modernity. However, the fate of those who contemplated or took decisions that were against medical advice was to be eventually abandoned by health professionals, and this indicates that at least at the margins of choice and control, a consensus remains in favour of biomedical rationalities over and above women's choices. This position has been subject to recent ethical critique by Kingma (2011, p.3), who argues that women's right to bodily autonomy in birth choices supersedes the potentially competing interests of the infant and the mother in terms of what constitutes the safest birth. Essentially, Kingma

proposes that the proportionality of the risks involved should be taken into consideration, but in practice, details of risks and benefits attached to potential birth settings are not explained to women and partners. In this respect, antenatal care lags behind medical care in other fields,[5] where shared decision-making models create an expectation that detailed information about potential risks and benefits will be provided before decisions are taken (Charles et al 1999; O'Connor et al 1999; Elwyn et al 2000; Joosten et al 2008; Hacking et al 2011), and this carries implications for how birth place discussions are practised by both midwives and medical practitioners.

That's just the way it is: socio-cultural endorsement of hospital birth as normative

Belief in hospital birth is such a formative part of upbringing that participants found it hard to articulate how they had come to share it ('it was ever thus'); public opinion leads women to hospital unless they actively resist this by going their own way in the face of potential opposition. Those pregnant with their first babies may never have considered anything other than hospital birth and exposure to media accounts of birth as dangerous do little other than heighten perception of risk.

In this context, it becomes difficult to evade what Machin and Scamell (1997) term the 'irresistible nature of the biomedical metaphor'. As women and their partners encountered antenatal care, the need for hospital was continually reinforced by health professionals, both GPs and midwives, who urged them to choose a hospital and book as quickly as possible. Even in the NHS trust where women routinely saw their midwives first, a normative biomedical pattern emerged by default, as midwives always told women about hospital facilities but provided limited information about some of the alternatives only to selected women.

When women preferred hospital, their decision was rarely remarked upon (except where a local non-hospital setting was being actively championed), whereas those who preferred alternatives found they were subjected to continuous risk (re)assessment

[5] There are exceptions to this, including one study which describes prenatal genetic testing and counselling where detailed risk and benefit information *was* shared (e.g. Heyman and Henriksen 2001), however this initiative was limited to a particular locality and there is no evidence that this is standard practice.

throughout pregnancy and birth. By these processes, hospital birth is constructed as normal across numerous social domains, eventually constituting a *'doxic'*, or *'objectively real'* truth (Bourdieu 1990, p.68; Webb et al 2002). In comparison, birth in non-hospital settings is regarded as exceptional and requiring increased surveillance, and the implications of this are that if alternatives to medicalised OU maternity care are to be successfully adopted into mainstream practice, then the discourses and practice that strongly privilege OU care as normative need to be changed (see also Dagustan 2009). Although there is some evidence that this has started to happen, at least for women with straightforward pregnancies, hospital birth still remains the default option. For example, the 'One Born Every Minute' documentary, which broadcasts at prime time, features an NHS hospital trust which in fact has an AMU as well as an OU, yet the differences between these facilities are not highlighted, 'out of hospital' births are not featured, and despite the opportunity presented by this programme, it would be very difficult for the viewer to recognise or differentiate between the birth place alternatives which are provided by the hospital trust.

Identity, choice and exclusion

The experiences of women with devalued identities

Through exploring women's experiences of birth place decisions and drawing upon a diverse sample, it was clear that women with devalued identities had a different experience, and were more likely to report having no choice of place of birth. In fact, women in this group were likely to experience exclusion from choice on a number of grounds, even though they often wanted a natural or normal birth. Clinical risk was an important confounder as women in this group had poorer general health and obstetric histories. This suggests that current admission criteria for non-hospital settings should be recognised as presenting a systemic barrier to choice of place of birth for these women, because through being more proactive, women with valued identities but equally complex pregnancies *were* able to gain access to birth in AMUs, and to home birth support. As discussed, there were also instances where women had straightforward pregnancies and obstetric histories, but were less likely than their more advantaged peers to be offered low risk alternatives, and also less likely to

actively pursue these, due to feelings of resignation, and low expectations of being welcome or suitable for home birth, FMU or AMU care.

As Fannin (2003) and Newburn (2010) discuss, AMUs are decorated to resemble middle-class western bedrooms or boutique hotels, and although the intention may be to enhance comfort, less affluent participants reported that the AMU was not for them. While it is not clear why they felt this was the case, it seemed that even where available, the AMU was not always offered to them, and accounts from others who had given birth in these settings suggested to them that there was insufficient medical cover at AMUs, and that bottle feeding was discouraged. Following Bourdieu's (1984) thesis of social distinction, this represents an example whereby affluent class habitus contributes to the exclusion of women from different backgrounds through the exercise of dominant cultural capital and taste. This may not be consciously intended, but that is precisely how Bourdieu (1984) theorised privileged values to operate in social life. Bourdieu's 'virtue from necessity' thesis also predicts that more functional (in this context, clinical) environments feel more appropriate to those from less economically advantaged milieux. This contributes an insight into less privileged women's preference for hospital, which occurred even though they anticipated they would experience brusque treatment or poor quality care; their main aspiration for birth was to hope that the baby was healthy and their hospital stay as short as possible. This finding builds on and to some extent troubles Nelson's (1983) observation that working class women were passive and preferred medical intervention. Her general argument is upheld (despite the passage of time) but the picture seems more complex than Nelson suggests. The narrative method shows that life experience contributed to the development of passivity, and greater familial exposure to illness and obstetric risk underpins the expectation that medical care may be required, so that whilst these may generate the perception of passivity and accepting interventions, they are not necessarily intrinsically part of a social class situation, but instead are formed as a consequence of experience and become part of a self-replicating cycle.

The finding that some women with devalued identities believed they should give birth in hospital despite their misgivings about care quality is also important; experience has taught them that they are unlikely to be treated kindly and respectfully in OU environment and providing choice does not improve this situation. As the midwife participants in Barber et al's study (2006, p.612) reflected, care in non-hospital settings could prove elitist whilst busy understaffed main ward[s] then cope with everything else. This finding is commensurate with recent critiques by Fotaki et al (2005, 2008) and Robertson and Dixon (2009), each of whom argues that consumer choice in English health care currently fails in its aim to be socially redistributive.

Bourdieu's (1984) theories are critiqued as being overly deterministic, but also offer a route towards increased personal freedoms through the proliferation of cultural and social as well as economic capital. The experiences of women with devalued identities are discussed again later in relation to changes over time, and this analysis suggested that despite experiencing constraint and denial of choice, some women with less privileged identities *did* become increasingly proactive (especially as their social capital was enhanced, through becoming an older or a more experienced mother), and others were helped through targeted advocacy. The presence of such measures within NHS maternity care could then be argued to counteract *some* aspects of exclusion from choice of place of birth.

The experience of choice for women and partners with privileged identities

Women with privileged identities were generally more likely to feel they had a choice, and to be offered the full range of alternatives within their localities, although information about other nearby trust facilities was not available to them, and this could limit their perceptions of the alternatives. A further finding amongst more affluent participants was that privacy was sought after, and perceptions of privacy were used to discriminate between high quality care environments which resembled private (meaning non-public sector) providers, and the more communal shared spaces found in large OU maternity wards. The longing for privacy is enshrined within consumerism (Young 1997, Nippert-Eng 2010), and the link between adequate privacy and high quality care was frequently made by participants. In this context, quality

meant opportunities to form trustworthy, dependable relationships with individual health professionals (relational quality), and to separately be able to feel trust in the health care providing organisation (the 'client quality' effect, Øvretveit 1992). In relation to gynae-oncology, Brown et al (2011) found that trust developed through interpersonal relationships between women and health professionals, and that once formed, this was not dented by broader discourses of risk.

Concerns about privacy and trustworthiness of maternity care provider services were central to many decisions to give birth in AMU, FMU or at home, because these settings were thought to present opportunities for better quality care, such as one-to-one midwifery support, in a less frantic environment than the hospital ward. This suggests that whilst maternity services position these as advantageous due to the less interventive clinical model, they are in fact attractive to women for quite different reasons, and the implications of this are discussed again later, in relation to individualist birth place preferences.

Exploring cultural norms within dimensions of narrativity brought into relief the interrelationship between these, and the ways they become worked into ontological accounts of birth place decisions. The evidence that cultural master narratives have a strong influence on women and partners' decisions is not necessarily novel, yet this does begin to detail the kinds of practices and discourses that serve as sources of constraint in the particular context of English maternity care. It also provides a basis for broadening the discussion beyond how women and partners respond individually to birth place choices. The wider influences of media communication, debate and discourse also need to be considered, along with the signals and messages that are relayed by professions and providers in the course of everyday practice, because both public and master narratives informed respondents' ontological accounts. Houghton et al (2008, p.61)'s argument that women's views of birth risk are 'negatively distorted' is supported in principle, but this research also points to several sources of distortion. These were not limited to women exchanging 'dramatic' accounts of birth; as Houghton et al also suggest, distortions arose because health professionals 'emphasised the importance of screening...to determine risk status' (ibid, p.61). Risk

perceptions were again heightened by routine monitoring during labour and birth. Participants' anxieties were therefore exacerbated at junctures which proved to be very memorable to them, and these experiences became integrated into their accounts of birth, so that even normal births were conceptualised as medically risky, with the benefit of hindsight.

Cultural selection of risks as an explanatory model

Douglas and Wildavsky's (1982) cultural theory of risk selection was used to explore individual socio-cultural perceptions of risk, through applying a group-grid framework to birth place risk decision-making. This approach led to one of the key theoretical contributions to emerge from the study, which was the identification of three different hierarchies of birth place risk and safety, each of which was coherent with the cultural bias of the group in question.

These three cultures also differentiated between particular settings as appropriate for birth: traditionalists favoured hospital OU as the safest setting to give birth but rejected home and FMU as inappropriate. Although some traditionalist participants were initially willing to consider AMU, in the event, each opted to give birth in the OU. Individualists judged all settings to be safe, but attempted to enhance the likelihood of receiving high quality care, often favouring AMU, FMU or home on this basis. Enclaves considered birth to be safe and natural and judged home (or possibly FMU) to be the most appropriate setting; this group rejected OU as threatening to the physiological normality of labour and regarded AMUs as false simulations of homeliness. A separate sizeable group was excluded from choice, and often from feeling that they are welcome in the alternative settings provided by their local NHS trusts.

The key theoretical developments are as follows. Firstly, women's birth place preferences were mediated principally by perceptions of birth risk, safety and institutional trustworthiness rather than by the birth philosophy that might be attached to a given setting, which has important implications for providing

personalised support during birth. These findings build on Davis-Floyd's (1994) US study, and provide a possible explanation for her observation of a sub-set of women who opted for home birth without necessarily rejecting the biomedical paradigm or embracing a holistic natural birth model. Davis-Floyd (1994, p.1133) recorded that this group were different to holistic home birthers; she thought that they retained a sense of Cartesian mind-body separation and sought control of the body, rather than letting go and allowing nature to take its course, but she found it difficult to explain this hybrid model of controlled home birthing. In this research, both individualist and enclave women opted for birth at home (and in other non-hospital settings), and whilst the enclave group adopted an integrated model of birth similar to that of Davis-Floyd's holistic home birthers, the individualist women retained their faith in science and medicine, but opted for home, FMU or AMU to secure better quality, more personalised care. In these instances, the principle *form* of control was over the service being provided to them, rather than over the process of birth, and the source of the women's control was their wealth of economic and cultural capital, not their personal adherence to an alternative birth model. Davis-Floyd (1994, p.1133) begins to suggest that the technocratic home birthers are in fact developing towards a more coherent, integrated model, but my analysis suggests that the individualist preference for home/FMU/AMU birth is intrinsically different, and coherent with their worldview, but at odds with the expectations of professionals in those settings.

Secondly, and in relation to this, when women did choose to give birth at home or in FMU on the basis of a holistic natural birth model, they were very discreet about the ideological source of their birth paradigm, rarely discussing this openly within the narratives. Caution is needed here because the numbers involved were small and their decision to participate could have arisen as a consequence of feeling embattled given the countervailing discourse in favour of hospital. Yet in each case, the holistic paradigm was implied, or revealed after more direct questioning, suggesting that the natural birth ideology may either be in decline, or actively suppressed within the master narrative of enlightenment rationality. With one exception, women's partners rarely gave credence to the natural birth paradigm; if women wanted a non-hospital birth, partners saw this as a way of securing better quality NHS care, rather than

avoiding medical interventions. This does not necessarily mean that natural birth ideology was not influential; interviewees *did* mention NCT[6] classes and natural childbirth texts, but it did seem that in the context of a cultural rapprochement with science and medicine, women had learned not to associate themselves too closely with natural birth models.

Traditionalist culture and birth place decisions

Views consistent with the traditionalist culture were adopted by just over a third of the respondents, and this group included around two-thirds of partners. To recap, the traditionalist group preferred order and accepted organisational rules. Almost all opted to give birth in hospital OUs, because their hierarchical model suggested that birth was medically risky, and that NHS maternity care might not always be ideal, but could protect women and babies from coming to harm. Following birth, the traditionalist group was almost entirely stable, and it was far more usual for other groups to move towards traditionalism than for traditionalists to change their position. Overall, Douglas' (1982) predictions about the traditionalist compliance with medical knowledge were borne out, except that pregnant women in this group did not always reject alternative therapies (particularly water and relaxation for pain relief), and often wanted to give birth 'normally' with limited pharmacological analgesia. However, this may be a response to the idealised norm of motherhood which positions responsible mothers as eschewing any drugs for pain relief, because of the possible of effects on the baby. This particular difference is arguably in keeping with a concern to maintain the status quo of societal reverence for motherhood, and concurs with the theorised traditionalist sensitivity towards discourses of idealised norms.

An insight gained through the narrative analysis was that amongst the traditionalist group, it was not just that hospital was *the* appropriate setting for birth, but also that home (or FMU, and to some extent AMU) were inappropriate. In a subtle counterpoint to the enclave concept of home as haven, traditionalist women and partners were clear that the home-as-haven should be protected from the uncertainties and

[6] The NCT has distanced itself from 'natural' childbirth, instead promoting 'normal' birth (Kitzinger 1990), but in participants' accounts it remained associated with 'natural' birth teachings.

potential tragedies that birth might involve. This can be interpreted using Douglas' concept of secular purification (Douglas 2002, pp. 78-86; Twigg 1999). As other authors have also argued, birth is body-work, liminal and poses risks of contamination, and removal of the threat from the home environment is a way of managing this problem (e.g. Clark and Davis 1989; Davis-Floyd 1990; Donner 2003; Callaghan 2007). Hospital birth then means birth in a place of clinical *and* social hygiene, and the more clinical the better; this rationale is associated with preference amongst women and health professionals for planned caesarean sections (Bryant 2007), a logic that is currently replicated in many countries with technological health services or private market models (see also Davis-Floyd 1994; Donner 2003; Murray and Elston 2005; Liamputtong 2005; McCallum 2005).

Traditionalist deference to medical authoritative knowledge

Traditionalist respondents (including those isolated respondents who would otherwise have been traditionalists) were also identified by their deferral to medical and midwifery authority. They often tolerated and sometimes actively endorsed professional control over birth decisions, regarding these as within the domain of the expert. Although they welcomed information and being invited to discuss decisions, they expected health professionals to make suggestions and steer them in one direction or another, suggesting that they anticipated a mixture of classical professional control and bureaucratic rules-based practice (Porter et al 2007) as the situation demanded.

O'Connell and Downe's (2009) meta-synthesis of hospital midwifery concludes that in practice, most midwives do work in the bureaucratic model, and so it is likely that traditionalist oriented women find their preference resonates with existing practice norms, confirming that this is how things are. Although this was particularly evident within the traditionalist group, it is also likely that women *generally* find it hard to directly criticise hospital staff. Midwifery professional literature debates the extent to which midwives are able to be with women rather than with institution (e.g. Hunter 2004), and Green et al (1998) similarly found that women had variable experiences of maternity care but were reluctant to criticise midwives or doctors. As Rayment (2010)

argues, hard pressed midwives are also subject to organisational constraints that prevent them from providing woman-centred care, and findings from this research infer that some women have grown to *expect* their midwives (and doctors) to be 'with institution'. They are not blind to the drawbacks and may be upset by inconsiderate or unkind care, but to some extent at least, supporting the smooth running of the organisation, and by extension, professional expertise and control, is a moral act. Returning to the traditionalist group, acceptance seen from this perspective does not constitute apathy, but instead is a deliberate practice with personal, moral coherence that responds to cultural narratives and witnessed norms. The situation may not be ideal, but the alternatives (including choice of birth in non-hospital settings), which may destabilise the organisation and its staff, are worse.

Individualist perspectives of birth place choice: establishing the quality and trustworthiness of maternity care

In contrast with the traditionalist group, personal freedom and autonomy were important to the individualist culture, and this group was theorised to espouse free market ideology, and to be more resilient to cultural norms because of their relatively low grid position (Douglas 1982, 1992). Again, about a third of the sample had views consistent with this culture, and it was also the case that there was a degree of overlap between individualists and traditionalists as Wildavsky and Dake (1990) also noted. Most individualists shared the traditionalist faith in the professional practise of medicine (but were more ambivalent about midwifery practice, which was appraised as less prestigious), and most traditionalists had some degree of concern about quality of care. Individualists differed most clearly from traditionalists because their sense of being safe meant that they established a risk hierarchy which prioritised the quality and trustworthiness of the maternity care providers, and dedicated time and resource identifying the best quality care possible. Despite their preparedness to try alternatives, the only change following birth for this group was a shift towards more traditionalist perspectives amongst those who had given birth to their first babies.

Although Douglas (1992) conceptualised individualists as risk takers and thought that this group would reject imposed rules, the cultural concern with birth safety meant

that this approach was deemed unlikely in relation to birth place decisions (see Chapter 3). However because individualists were generally confident in the safety of medical care and referral systems, they did not see birth in different settings as risk taking and this afforded them some resilience to the discourse of normative hospital birth, during pregnancy at least. Like traditionalists, individualists were willing to delegate control over birth, but only at a much later stage, when medical interventions or escalations towards operative birth had already occurred. In this sense, they resembled Davis-Floyd's (1994) technocratic hospital birthers, but were even closer to her technocratic home-birth hybrid, having a similar sense of trust in technology and expertise, but based on their choice to purchase or select a professional service as the need arose.[7]

The pursuit of quality

For these participants, seeking high quality care was paramount, and their perceptions of quality were derived from a sense that institutions were trustworthy based on the 'facework' undertaken by organisations (Walls et al 2004, p. 135; drawing on Giddens 1991a and Goffman 1967). Working from this perspective, individualist women might choose to give birth in either hospital OUs, AMUs, FMUs or at home, and as discussed earlier, their choice of non-hospital settings was not always predicated on a natural birth philosophy. In fact, most were willing to use medical pain relief, and some were uncomfortable with what they perceived as new age behaviours such as establishing skin-to-skin contact, or breastfeeding a new baby in a birth pool. Being subject to tenets of the midwifery model which they did not agree with was one of the few negative consequences of birth in non-hospital settings. The importance of secular hygiene rituals alluded to earlier therefore also affected women's experiences of non-OU care, and the experience of having a normal birth ideology imposed in non-hospital settings is deserving of further attention. The assumption that breast feeding, skin-to-skin contact, and time for bonding was universally welcomed by all who gave birth in non-hospital settings proved unfounded and could prevent 'isolate' women from

[7] In Davis-Floyd (1994), the 'purchase' of service occurs through the US private health care market, but in this research, individualists also purchased a range of services including doulas, 'private' antenatal scans and courses in childbirth preparation or hypnotherapy and relaxation.

considering a non-hospital setting or disrupt individualist women's sense of achievement following birth in FMU or AMU. Although this was experienced by a small sub-group of participants, dogmatic practices such as these failed to sensitively capture the ranges of different support that women required.

Keeping birth private; who's excluding whom?

Bruner (1990) observed that the symbolic meaning of private has shifted over time from being a source of suspicion,[8] towards more contemporary interpretations, which derive from western ideals of individualism and autonomy. The extent to which these concepts are consensual even within western society is challenged by the feminist scholarship concept of relational autonomy and further troubled by multicultural health care in western settings (e.g. Young 1997; Mackenzie and Stoljar 2000; Edwards 2005; Gilbar 2011), but in the context of this research, notions of the private were central to individualist accounts, and also appeared as a secondary concern in traditionalist and enclave accounts. These conceptualisations of private touched on a number of domains, including the private market (access to which denotes success through affluence), and the private sphere (for example of home life, compared to work or public lives). These were linked in turn to the concept of privacy, through which individuals create bounded spaces for personal, intimate or confidential activities. As Young (1997) and Nippert-Eng (2010) both argue, being private almost always involves purchasing something, whether it is space, leisure time, individualised services or a home.

Twigg (1999) outlines the significance of private spaces as those where individuals may express their authentic selves, and feel at ease, comfortable and secure, partly because they are in a position to control access by others. Angus et al (2005) add that home functions as a site of safety, seclusion and maintenance of identity. Privacy is also a prerequisite for intimate behaviours and bodily functions; Twigg (ibid, p.395) describes how older people with disabilities are resistant to having baths in day

[8] 'In later periods of European history, privacy was equated with secrecy, concealment and a shameful desire to shelter from the gaze of the community. As one seventeenth-century preacher put it, "The murderer and the adulterer are alike desirous of privacy"' (The historian Thomas (1989), quoted in Bruner (1990), p.136).

centres, regarding this as a 'private act in a public place', and the requirement to attend an institution to give birth may also be experienced in this way. Attempts are made to provide a home-like or bounded setting, but this exists in 'strange territory which belongs to someone else' (Lock and Gibb 2003, p.132).

Seeking privacy is also a means of separating the self from the hoi polloi, and this was especially important to individualist participants, who spoke of the need to avoid hot, crowded waiting areas or busy postnatal wards where other people's noise, smells or behaviours could spill out between flimsy separating curtains. The observation that this underpins individualist preference for non-hospital settings also highlights some politics of exclusion. As discussed earlier, the signalling achieved when FMUs and AMUs are decorated to replicate boutique hotels is that affluent people belong here; this is not the place for those who do not share middle class tastes and values.

Reflecting on the influence of individualism within English maternity care

The prevalence of individualist views amongst pregnant women and their partners was important and unexpected, and suggests a way of separating out global expectations of maternity care which can initially appear contradictory and confusing. In her introduction to the second edition of *Natural Symbols,* Douglas (2003, p.xxviii) describes Wildavsky's belief that there was 'only one, right, truly liberal way to organise society, that is, from the corner of the individualist culture'. Although Douglas saw things differently, this is essentially the premise of public welfare through citizen-consumerism (Clarke et al 2007) espoused by current health policy.

Following Lupton's (1997b) reflection on the Australian mixed public and private health care model, the insight suggested by these findings is that both relational and consumerist models of choice operate within the population accessing publicly provided English maternity care. For the purposes of the discussion, they are described as distinct but some women drew on aspects of each, which may mean that these exist on a continuum, rather than being entirely discrete. The observed pursuit of private models is also instructive, because this can be seen to have informed the development of private market-*like* services, which are philosophically at odds with universalist

provision (although not with consumerist policy), and which provide an ideological model of care which is not always sought by the women who prefer these settings. These findings are tentative due to the purposive nature of the sample, but have interesting implications for the development of 'patient reported outcome measures' proposed in current health policy (DH 2010, p.54), because they suggest that different sectors of the population have competing expectations of health care. Privileging one group's preference may perpetuate disadvantage in another; again, Fotaki's (2010) thesis that choice may cause rather than limit inequities is upheld, especially if better quality care is provided in settings which are either unavailable to or unappealing for the majority, who continue to receive intrapartum care in settings which are increasingly threatened with resource depletion.[9]

Enclave culture and birth place decisions

Enclave groups were often controversial within Douglas' work (Douglas 1982, 1992, 2006; Douglas and Wildavsky 1982), and were characterised as sectarian, anarchic and likely to foment trouble. In theorising this group, a link was drawn with the enclave valorisation of nature to suggest that this group would be home birth mothers, who might foster a lifestyle that is different to the mainstream and would pursue the holistic, integrated model described by Davis-Floyd (1994). This assumption was borne out in the study, but it was also clear that in English maternity care, home birth mothers had different experiences depending on the level of risk associated with their pregnancies, *and* with their level of economic and cultural capital. As discussed, it was also the case that few women and partners fitted into this category, and although that may be due to self-exclusion from the study, this fits with the estimates in the literature that only around 5-15% of women opt for home birth (see Chapter 2). What this study adds is that this estimate is made up of women who hold three separate perspectives; enclave women who positively reject hospital OU and AMU settings, individualist women who choose home birth to secure one-to-one care in a private environment, and isolate women who would consider home birth but are excluded through the mechanisms of social and clinical distinction discussed earlier.

[9] See King's Fund (2008) and Sandall et al (2011) for full discussions of midwifery staffing resource challenges and appropriate deployment of staff in different birth settings

Relatively privileged participants with straightforward pregnancies who wanted home or FMU births did *not* encounter stigmatisation, although they sometimes needed to negotiate with intimate partners. This is not to say that there is broad cultural acceptance of home birth in England,[10] but rather that there is increasing acceptance of home birth as safe for some, carefully selected women, as the professional consensus statement proposes (RCOG/RCM 2007). Although obstetric support for this is somewhat qualified (RCOG 2007), there is still sufficient policy and professional approval for this to be a feasible choice for appropriately assessed women. This represents a contemporary example of 'benign' paternalism, which has arguably been a consistent feature of English birth place policy since the 1950s (see Chapter 1), and may help explain why the position of home birth women in England is different to that of the Finnish women interviewed by Viisainen (2000). Finnish women have a health care policy and system which does not sanction home birth, and the few women who pursue this then find their identities as mothers are morally compromised. In this research, moral jeopardy only occurred when women were perceived to be more at clinical risk than the consensus statement permits (RCOG/RCM 2007). As the exercise of clinical risk assessment was not contested by women from less privileged backgrounds, these women were not able to pursue their preference for birth in non-OU settings when clinical risk was identified, and women's own accounts also suggest that clinical risk assessments could also conflate aspects of cultural or economic capital lack with clinical risk assessment.

A separate finding was that, just as traditionalist women reject non-hospital settings as inappropriate for birth, enclave participants rejected hospital *and AMU* environments. According to their worldview, AMUs are simulacra where home like features create a vestige of a private domestic space, but in reality the territory is medical, being contaminated by physical proximity to the OU and by the shared OU/AMU boundary objects of birth management protocols and medically trained midwives. FMUs are liminal; the territory is no longer medical, but it is still somebody else's *place* and birth

[10] Current printed media debates indicate that this is not yet the case (e.g. Fraser 2010; Harrison 2010)

is managed according to medical time-based protocols, which as McCourt (2009) and Edwards (2005) argue, install clock time and efficiency targets within labour and birth. Cheyney (2008) noted a similar finding amongst contemporary US home birth mothers, but this is the first time that some women's aversion towards AMUs has been documented in the UK context, and suggests that where home birth services are not provided, or become less dependable due to trust staff covering AMU as well as community home births, some enclave women may be admitted to AMUs under effective duress, because they see this environment quite differently to how it is perceived by others.

Isolate exclusion from birth choice

The isolate quadrant was earlier argued to have been poorly theorised in Douglas' work (see Chapter 3). During the course of the empirical analysis for this study, it became clear that instead of being a separate single group culture, its members would in fact be in one of the other three groups if they had not been marginalised or excluded from choice, and this observation represents an empirical development of Douglas and Wildavsky's (1982) cultural theory model. The consequences of this exclusion were discussed earlier as a key finding because the mechanisms by which this occurred are argued to be intrinsically linked to the exercise of capital by dominant groups, and the conferral and self-conferral of devalued aspects of identity. The use of an integrated theoretical model drawing on both Douglas and Wildavsky (1982) and Bourdieu (1984) was most pertinent to theoretical analysis of isolated individuals' experiences.

In the context of this research, 'isolate' participants made up about a quarter of the sample, and as these individuals were most difficult to recruit, it is likely that in practice more women are excluded from choice in this way. The unacknowledged affiliations to dominant culture worldviews amongst these participants provide one explanation for the relative mobility of this group. As these participants shared the cultural biases and preferences of the groups from which they were excluded, those who shifted their position over time followed a trajectory towards their 'real' cultural group; that is, the group with which they would be associated, were they not socially

isolated or excluded in some way. Changes also occurred in response to alterations in cultural or social identity, since young women gained acknowledgement as older, more experienced mothers. For others though, the experience of exclusion from choice was compounded during sequential pregnancies, and their sense of exclusion retained.

Changes during pregnancy and birth

The tendency towards stable worldviews

The justification for a longitudinal study design was to explore the extent of change in birth place preference amongst women and partners. To recap, the overall picture was one of stability; by and large, participants did not change their views during pregnancy and birth. If anything, their views became more conservative after their first births, and hospital preference became increasingly entrenched over the course of childbearing careers. Preferred place of birth was consistent for traditional and enclave women, who preferred hospital or home respectively, and individualists were most likely to change between possible settings, as would be expected. This finding supports Dagustan's (2009) and Houghton's (2008) observations that experiences of hospital birth, whether positive or negative, reify the necessity of hospital. However, the study partially contradicts Zadoroznyj's (1999) finding that Australian working-class women, who were unable to access the private hospitals available to wealthier women, were galvanised into adopting a more proactive birth model by the events of their first births. Zadoroznyj's assertion that first labour is an important moment with implications for subsequent births is not contested. However, the conclusion that less privileged women's birth models changed was not borne out in this study. Resignation to future hospital births was more usual amongst women with lower levels of economic or cultural capital.

The finding that planning birth in hospital during a first labour is associated with eventual reinforcement of the necessity of hospital during labour presents a major challenge for maternity services. This suggests that the optimal time to encourage non-hospital birth is during a first pregnancy, but second and subsequent labours are

usually judged to be most appropriate for birth in non-hospital settings, and provided the first birth was not surgical, a shorter and less complex labour would be anticipated. There is an abiding and historical professional view that first births *are* more likely to be problematic, and even though current clinical guidelines do not endorse this, some research does indicate that there is some increased risk for first-time mothers and their infants (e.g. Evers et al 2010).[11] It is unclear whether this relates to factors intrinsic to first pregnancies (such as longer labours) or to the quality of care that is provided during home labour or transfer to hospital.[12] The difficulty arises because women's first labour experiences suggest to them that birth is more risky, uncertain and altogether more difficult than they had anticipated, and this is the only experience upon which individuals can draw for their next birth place decisions. The professional knowledge that subsequent labours are shorter and easier seems neither convincing nor necessarily relevant to women's own anticipated births.

An exception to stability: isolate mobility during pregnancy and after birth

A minority of isolate women were also quite mobile within the cultural theory model; most moved into the individualist group, and some towards the traditionalist culture. These changes happened either because they received extended advocacy from interpreters, family members or midwives, or because their own self-perceived agency was enhanced, and they became more individualistically oriented. This suggests a separate facet of success within NHS maternity care, as the women who were most marginalised received targeted extra support from caseload midwives, or from interpreters (who performed a similar function of continuity). They benefited from this overall, although their consequent reliance of practitioners with strong ideological adherence to normal birth models sometimes meant that they were also vulnerable to being persuaded to give birth in non-hospital settings. However, the majority of isolate women were not vulnerable enough to attract support of this nature, and the failure to address their preferences hence went unnoticed.

[11] This study was conducted in the Netherlands, and contributes to the current debate about the safety of midwife-led home birth in that country.

[12] The findings of the NPEU 'Birthplace' cohort study, which address the same question in the context of English maternity care, have yet to be published at the time of writing.

Sense-making: does choice help women make sense of birth sequelae?

A number of participants reported difficulties coming to terms with the events of their birth, and this problem is thought to occur following both normal and assisted births (Downe 2001), although it is associated more with assisted births (Small et al 2000), and also with hospital rather than home birth (Dahlen et al 2010). There is currently insufficient evidence that place of birth increases satisfaction, or reduces psychological morbidity, particularly in relation to more recently provided non-hospital settings (NCCWCH 2007), although Hodnett et al's (2010) recent review does support the notion that satisfaction is increased following birth in AMUs. In the context of this research, reduced satisfaction and negative emotional sequelae were reported by some women whose preferences had not been met, and also by those who felt they had been persuaded to give birth in a non-medical setting. These cases were small in number overall but the level of distress this incurred was marked. Whilst it could be the case that women whose choices were being contested were motivated to participate in the study, they were all recruited before the birth took place, and as discussed in Chapter 8, women had similar modes of birth (normal or assisted/surgical birth) but responded quite differently to these.

This finding is not isolated, but augments others researchers' observations that giving birth in non-hospital settings may sometimes predispose women towards negative feelings following birth, especially when this does not turn out as planned (e.g. Jomeen 2007; Christiaens and Bracke 2009). The use of persuasion or encouragement, which may be undertaken to ensure that alternative birth settings reach levels of sustainability, might then be positioned as potentially harmful in some cases. This would be particularly so if such encouragement occurs without a full discussion of risks and benefit, or without recognising that women's worldview may mean they are more likely to adopt a deferential approach within medical encounters. Giving credence to women's preferences for alternative birth settings is important, but it is equally necessary to be sensitive to a situation where women feel they are taking a leap of faith or going against their inner judgement by giving birth in a non-hospital setting.

Even when planned hospital birth experiences were poor, most participants would still plan future birth in hospital (albeit maybe with a different NHS provider, or even in another country). One explanation afforded by cultural theory is that this allows faith in organisations or professions to be upheld, whilst blame is attached to themselves or their bodies' capacity for enduring labour. Rather than opting for less medical settings in the future, women who were orientated towards a traditionalist prioritisation of biomedical risk instead believed that their interventive births demonstrated the necessity of hospital and taught them that imagining natural or normal births belonged to their time of being an inexperienced novitiate (see also Dahlen et al 2010). Individualists were overall less likely to report negative emotional consequences, even when they experienced interventive births, and this seemed to be because they felt they had made the right choice and received the medical attention they needed. Most women planned to give birth to future babies in hospital OU and the only exceptions to this were those individualist or enclave women who had planned to have their first babies in AMU, FMU or at home during their first pregnancies, and had either succeeded, or been transferred to hospital during labour.

Summary

To some extent, the UK has been successful in expanding access to non-hospital birth, but actually giving birth in a non-hospital setting remains a minority experience, and any unintended consequences of this policy are *not* currently recognised. This is problematic given the potential numbers who experience these consequences. Even this small scale study found women who were pressured into giving birth in non-OU settings despite their misgivings, others being persuaded into normal birth and midwife-led care when they actually prefer medical or surgical birth, and many who are excluded from AMU and FMU so that their only real option is a hospital birth. The research design did invite accounts from individuals who had something to say on this topic, but the design was prospective, so individuals had often agreed to participate before these postnatal issues arose, suggesting that these findings are probably not solely an artefact of the study design. However, limiting the study to a three-month follow up meant that any subsequent changes would be missed, and it is possible that the sense of hospital being so necessary might recede as the events of birth become

more distant; a longer follow up or cohort study could address this question more satisfactorily.

Evaluating the theoretical contribution of the study

This research contributes both new theoretical knowledge and iterative advances to what is known about the experience of deciding where to give birth in English NHS maternity care. The findings are underpinned by two theoretical frameworks; Douglas and Wildavsky's (1982) cultural theory (in turn informed by Douglas' earlier work on pollution and grid-group theory[13]), and Bourdieu's theories of economic, cultural and social capital and the exercise of social distinction through approved tastes (Bourdieu 1984, 1990), and the linked contribution of these theoretical frameworks is evaluated here.

Epistemic limitations of cultural theory

In Chapter 3, various critiques of cultural theory were addressed, and these broadly divided into post-structuralist and post-modern critiques of determinism and reductionist thought within the model. An appraisal of the study findings based on these critiques would be likely to argue that the cultures were found because they were sought. This is the basis of Adams' (1995) and Boholm's (1996, p.71) claims of determinism and 'gruesome tautology' in cultural theory, and of the argument that conferral of cultural categories upon individuals is not justified in a period of history when identities are multiple, fluid and shifting.

In response to the problem of determinism, the complexity of isolate experiences was brought usefully into relief using a structuralist approach which demonstrated the potential for political exclusion. Cultural theory also provided a theoretically derived explanation for tacit approval of professional control amongst some participants, and evidence of resistance to natural birth models of midwifery care. Each of these facets

[13] Douglas 2002 [1966] and Douglas 2003 [1970].

might have been obscured if the research had incorporated a post-modernist theoretical stance.

As Harvey (1990, p.117) argues, post-modern thinking 'shuts off ... other voices ... by ghettoizing them within an opaque otherness'. If a post-modern paradigm had been applied here, the experience of those who had traditional ideas about how they would be treated as patients, and how they in turn should treat the maternity services, start to disappear from the frame because there is less space for a modernist experience in post-modern research. On the other hand, Beck's (1992) thesis of reflexive responses to risk in modernity informed analysis of the enclave group, and demonstrated the reception of risk reflexivity by others (including professions) and both Giddens (1991) and Beck's (1992) theories of subjective reflexivity in response to uncertainty have potential application to questions of birth place decisions.

This study was also premised within a hermeneutic realist paradigm (see Chapter 4). The intention was to regard experiences as both real *and* politically and culturally constructed (Liamputtong and Ezzy 2005, p.37), which only stands if the epistemological limitations are also recognised. The explanation offered by this study is partial, imperfect and contains uncertainties, and the cultural positions identified are expected to change over time. On the other hand, the objection that cultural theory might fail to accommodate change proved unfounded in this research context, as individuals could and did shift their risk perspectives and identities over the longitudinal time frame of the study. The hermeneutic approach provided an additional means of accounting for the ways that worldviews were revised so that earlier perspectives were lost in the newer postnatal narratives. This has useful application to understanding the heightened risk perceptions found during follow-up interviews. It also explains increased resistance to non-hospital alternatives in second and subsequent pregnancies, when clinically assessed risk appears reduced to practitioners, but is perceived as uncertain and potentially high by women and their partners. On balance, it seems reasonable to suggest that despite its determinist antecedents, cultural theory has value for interpretative studies, and that some of the

problems identified in relation to cultural theory arise partly through the less flexible application required by quantitative methodologies.

Using cultural theory with Bourdieu's (1984, 1990) theories of social practice and distinction

Overall, the theoretical frameworks which informed the study were complementary, and the analysis of risk selection benefited mainly from the use of cultural theory. It is difficult to judge whether the presence of different risk hierarchies would have become apparent without the use of this framework, but the use of Douglas and Wildavsky's (1982) hygiene and pollution metaphor as an analytic device, and the opportunity to test the data against the assumptions of cultural theory ensured the analytic process was robust. The weaknesses of cultural theory lay in the under-theorisation of the isolate culture, and a lack of application to the exercise of power. The work undertaken here offers *to* cultural theory a strengthened theoretical understanding of how the isolate group is composed, which has potential application to the context of health care choice and exclusions.

There is some overlap between the grid-group model and the exposition of different forms of capital, because Douglas drew on Bernstein's (1971) work on the reproduction of cultural capital through education and speech when developing grid-group. But the more nuanced analyses of how identities are constructed and conferred would not have been feasible within the limits of cultural theory, and Bourdieu's more detailed theorisation in *Distinction* (1984) was valuable here. Despite this being a rather dated and determinist theory of French social class, the ideas of cultural and social capital usefully expanded the analysis and were amenable to modification using Lawler's (2008) more recent application of UK-based concepts of socio-economic and cultural capital.

These frameworks were therefore separately valuable and each had something different to offer the analyses undertaken during the research; together they provide a new way of thinking about birth place decisions from the perspectives of individuals as they progress through pregnancy and birth. The implications of these study findings for

policy and practice are outlined further in the concluding chapter, and the weight of these are evaluated in the context of the research design.

Chapter 10: Conclusions and implications for policy, practice and future research

This final chapter evaluates the study methodology, and outlines the implications of the findings for policy, practice and future research. The study was small in scale and the findings are not at this stage generalisable; further research would be required to gain a more comprehensive sense of whether they hold true within the wider maternity care population, however some key messages with relevance for policy and practice do emerge, and these are recorded here.

Methodological limitations of the research

Reflecting on the value of interpretative research, Riessman (2008, p.184) recounts Charles Bosk's 'central question'...'All field work done by a single field worker... why should we believe it?' This is particularly pertinent in the case of doctoral research, although this particular study was never an isolated endeavour. Ideas were tested and arguments examined throughout, because the study was linked with two interdisciplinary research centres[1] and subject to regular academic supervision and collegiate peer review. Nevertheless, the research has several limitations, and these are detailed here.

First of all, this is a relatively small study (although probably as large as a single investigator qualitative enquiry ought to be), which was undertaken within the confines of three NHS trusts in England. It was time-limited, and the follow up postnatal interviews took place within three months of birth, but it is possible that longer term follow-up might have found that women and partners had developed different perspectives.

[1] King's PSSQ and the NPEU 'Birthplace in England' programme of research

The field of investigation was also subject to rapid and ongoing political change, as is often the case in health services research. This has not necessarily impacted upon the conduct of the study, but could alter the reach and influence of the findings. Balancing these issues is the fact that the study was rigorously peer-reviewed during the NIHR application process, and subsequently commissioned, which meant it was adequately funded to support travel, methodological training, access to translation services and opportunities to engage with practitioners, fellow researchers and members of the public.

Transferability of study findings

The study participants included individuals whose worldviews resembled each of the four political cultures proposed by Douglas (1982, 1992, 2003) suggesting that theoretical saturation was reached; yet the sample was not 'representative' in a quantitative sense. This is not a limitation as such, because the study was designed to be interpretative, and the intention was that any conclusions should be of sufficient theoretical rigour to inform debates about practice. That is, service users, policy makers, researchers and practitioners might reflect on whether the ideas presented here are an authentic account of the issues, and whether the interpretation is recognisable, or reflects context appropriately. However, the non-probability sample means that the 'political culture' concepts are not currently generalisable to the wider maternity care population. Although the potential for application to a cohort or observation study exists, the problems other researchers have experienced whilst attempting to operationalise cultural theory within quantitative studies (e.g. Sjoberg 1997, Douglas Caulkins 1999) suggest that any such application would need to be carefully considered.

The core limitations of the study may be summarised as follows. The research is interpretative and based on a small and purposively recruited sample; if the conclusions drawn are judged sound by research audiences, they should inform future research and current debate rather than changing practice. Despite these restrictions of influence, the study does offer a new and different way of thinking about culture

(beyond cultures of nation, religious, class or ethnicity) which has application to maternity care. Enhanced 'cultural competence' (Leininger 1991) with respect to the observed differences of perspective amongst the sample could improve maternity care experiences. This would benefit both those excluded from choice of place of birth and others who are included but still poorly informed about the alternatives to OU, or about the clinical implications of maternity care in different settings.

Implications and recommendations for policy and practice

The findings suggest a range of implications with relevance to policy and practice, and to women and their partners as service users. These are detailed here in order of the strength of support within the data for the given proposition, and the extent to which these may benefit the maternity care population generally.

Birth place decisions during antenatal care: policy implications

A key finding from the study was the dearth of good quality information upon which to make informed decisions[2]. There was a sense that this was 'once' a straightforward choice made at booking, but above all else, this research shows that contemporary birth place decisions are complex, and that each individual woman or couple is influenced by the immediate socio-cultural and familial context, by clinical risk assessments and prior experiences of maternity or health care and by wider cultural narratives of birth risk, safety, appropriateness and the 'responsibilisation' of pregnant women and fathers-to-be. The added complexities of different settings *and* models of care suggest that this decision merits more focused attention, and should be considered a complex treatment decision akin to those currently managed by shared decision making or decision-navigated approaches (Charles et al 1997, 1999; Elwyn et al 2000; Hacking et al 2011).

[2] Where Bekker et al's (1999, p.iii) definition of an informed decision is applied: '...a reasoned choice is made by a reasonable individual using relevant information about the advantages and disadvantages of all the possible courses of action, in accord with the individual's beliefs'.

A linked implication relates to the importance of first birth experience to women's overall childbearing career. Although further research is needed on this topic, it may be the case that particular attention should be paid to first pregnancies and labours. Similar concerns are currently being addressed by an Australian initiative to improve first birth experiences and reduce medical interventions (Ryan 2011).

There is widely available general information about birth through NHS resources, NHS choices websites and participants valued these. However there was little information about local services, their scope and coverage. Basic information about non-OU settings (such as opening times, virtual 'web' tours, admission criteria, availability of water births) was not available to women, and they had no way of comparing their own local services with what was available in neighbouring NHS trusts. Clinical information (such as transfer rates, interventions by planned place of birth, outcomes and complications) was even harder to access. It is particularly important that women should have access to data that is contextualised to their own pregnancies; those planning home births for example might be given an average rate of transfer into OU during labour, but not told that the true rate differs widely between first and second or subsequent births. A recent Canadian consensus panel statement reached a similar conclusion, recommending the development and implementation of:

> ...tools designed to provide easy access to information about childbirth, the process of decision-making, and to help women understand the meaning and magnitude of individual risk factors.
>
> (Canada Consensus Panel 2011, p.6)

Antenatal care: implications for practice

As well as providing information contextualised to individual pregnancies, a further key recommendation is that all women should be routinely provided with information about the different birth place services provided within their NHS trust. Women generally wanted to know what was available, even if these options were clinically

contra-indicated for them, and to understand the basis on which they might be considered suitable (or not) for admission to AMU, FMU or home birth services.

Home birth is the option that women were most likely not to be told about, and widening access to this service would mean ensuring that this is always discussed with women; most women did not want a home birth, but some were never offered home birth although they would have been open to considering this option. A clear description of home birth services and eligibility for accessing these would also indicate to women that these services are provided and that broad access to these is supported, subject to clinical risks being assessed and discussed. Male partners were conflicted about home birth due to anticipating that they might be responsible for the safety of their partners in the absence of medical care. When home birth is under consideration, it would be helpful to address men's perceptions of home birth early in pregnancy and to explain the steps taken by midwives and providers to ensure that home birth services operate on principles of safe, high quality care.

Some women were particularly resistant to non-hospital birth options; this was more often the case amongst women who originate in countries with high rates of OU birth (or whose own parents originate in these countries), and amongst UK born women from less affluent socio-economic backgrounds. When women felt strongly that OU was the best and safest place of birth, they could also become anxious if health professionals insisted that they were at low risk and could give birth in a non-hospital setting; this suggests that it is important to explore both where women plan to give birth, and their reasons for this, and to take these into consideration when options are discussed.

That women would prefer to be told about birth settings for which they may not be considered suitable, yet might also prefer not to pursue non-OU options, may appear contradictory. This arises as a consequence of finding that different groups of women want different things in relation to place of birth. However, because women did not object to these issues being discussed, it would seem that clear information about risk

and benefit of possible alternatives should be shared, and that women then have opportunity to decide over the course of pregnancy what their preferred place of birth might be.

Women expecting their first babies also wanted an opportunity to receive information about possible birth place options, but did not want to have to decide at the booking appointment where they planned to give birth, or which model of birth care they might prefer. Most wanted a chance to talk to their health professional about their preferences when they were about six months pregnant, but before completing birth preparation classes or tours. Those expecting their second and subsequent babies had often decided early in pregnancy where to give birth, but some were open to different options as the pregnancy progressed.

Care quality

A wealth of published research and reports include recommendations for improving the quality of NHS health care in general (Appleby et al 2011) and in maternity care specifically (e.g. HCC 2008; King's Fund 2008; Sandall et al 2011), and these are not repeated here, but in particular relation to birth place decisions, the following recommendations arise from the study.

All participants wanted maternity services of reliably better quality; some had poor experiences of care quality, and others had very good experiences but were surprised by these, having spent much of their pregnancies feeling anxious about the kind of service they would encounter once they went into hospital during labour. An important finding was that respondents generally prioritised actual service quality above opportunities for choice. This is not to suggest that AMU, FMU and home birth settings were not appreciated by those who were able to access them, but rather that the majority who were not able to give birth in these settings, for whatever reason, would prefer:

- Reliably high quality care on OU labour wards, including support to achieve an 'optimal birth' (Murphy and Fullerton 2001; Sheridan and Sandall 2010) when other complications are present, or when their pregnancy or medical history meant that they were advised to be in hospital but were anticipating a normal birth.
- Freedom to opt for OU care when they preferred this, which may suggest that advocate-supported consultations (see Hacking et al 2011) or similar should be used for contentious decisions such as when caesarean birth is requested after a previous difficult birth experience.

Also, all women would benefit from improved arrangements for admission to OU, AMU and FMU during early labour.

Policy and practice implications with relevance to particular groups

Women and partners who are excluded from choosing where to give birth are of key importance in terms of both policy and practice. Their exclusion appeared to be systematic, because it reflected structural inequalities when devalued identities were used as a proxy for these, although this hypothesis needs to be tested further. Were the observation borne out, there is a good argument for working towards reversing this tendency by highlighting cases where several structural attributes may interact together, placing women at increased risk of both choice exclusion, and poorer quality care experiences overall. The evidence that women with multiple vulnerabilities received extra support suggests that this may already occur, and that interventions such as caseload midwifery practices are appropriately targeted to women with extra need, although with such a small sample it is not clear that this happens as a general rule. The women who experienced choice exclusion in this study fell somewhere in between having privileged identities and multiple barriers to exclusion, and may represent a significant proportion of the maternity population.

Narrative accounts confirmed that exclusion also occurred as a consequence of previous life experience, and this contributed towards low expectations of health care; sometimes, saying that there was no choice concealed that it was easier and safer not

to divulge hopes and aspirations about birth, even if these were modest. The heterogeneity within the excluded group suggests that this is likely to be a 'wicked problem' (Rittel and Webber 1973) with multiple causes, and simple solutions are unlikely.

When women with complex pregnancies chose to give birth in non-hospital settings, they undertook extensive research and sought support from health professionals. Few pursued this course, and most were not supported in their choice. Even those who managed to secure support found they were abandoned at times when they needed support during labour, reflecting the common experience of being left alone during labour in hospital. Meeting the requirements of women in this position is complex, but their need for accurate, high quality, individually contextualised information is particularly great.

On the other hand, some women who preferred non-hospital births distanced themselves from the natural birth discourse favoured by midwives in these settings, and this was sufficient to prevent some using AMUs or FMUs, and affected the birth experience of others. Sensitive support for women who opt *not* to have skin-to-skin contact, or exclusive bonding time or who plan not to breastfeed is needed in these settings, because being pressured to behave differently transgressed boundaries of intimacy and privacy, leading women to experience feelings of shame or even revulsion. In relation to this issue, midwives will have undoubtedly have genuine concerns about promoting breast feeding and positive parent-infant bonding relationships, but this finding seems important and is offered in contribution to ongoing debates about sensitive practice of normal birth midwifery.

Implications for models of care

Women who did prefer to give birth in AMUs often saw these as the 'best of both worlds' (Newburn 2010), where clinical safety was assured by proximity to the OU, and a personalised model of midwifery care was also available. However, this study suggests that gaining access to AMUs disproportionately favours affluent women,

although this may not be the case in NHS trusts where AMUs serve a larger proportion of pregnant women. The research identified the importance of homeliness and privacy afforded by these units, but also highlighted that apparently exclusive décor might be off-putting for some women. However, it also likely that the smaller AMUs would appear more attractive if women felt they were welcome to bottle feed as well as breast feed, and that the women (and partner's) preferences regarding skin-to-skin contact were also sensitively explored rather than imposed rigidly. On the other hand, the data does not support the default admission of women with straightforward pregnancies to AMUs in order to increase uptake of these services; women who want medical supervision clearly prefer OU environments, and if choice of place of birth is to be a reality, then a decision to birth in an OU should be supported.

Future research

The finding that many individuals are effectively excluded from choice may have relevance to health care generally, as well as to maternity care. Estimation of the proportion of individuals at risk of exclusion from choice could be achieved through secondary analysis of existing population data sets, and the data from this study could also be used to further test the political culture concept empirically using health economics techniques for preference elicitation and trade-offs.

In relation to ensuring that sharing contextualised information becomes part of antenatal care practice, research undertaken in similar fields broadly supports the use of shared decision making models (Charles et al 1999; O'Connor et al 199; Elwyn et al 2000; Joosten et al 2008) or 'navigated decision making', which also incorporates client advocacy (Hacking et al 2011), but the benefits of these in settings other than physician encounters in medical and surgical practice has not been evaluated. It is likely that these models have applicability in the field of maternity care, and shared or advocate decision making models could be developed and tested in this field of practice.

The experiences of either exclusion from or persuasion into different models of birth were both problematic, and the suggestion that being able to actively choose influences women's sense-making during the postnatal period is deserving of future study. The examples encountered here were too few to form the basis of strong conclusions, yet the emerging pattern is resonant with other research. This issue would lend itself to a dedicated qualitative study, and if the association were strengthened then further prospective research using a larger sample may be appropriate.

Concluding remarks

These research findings demonstrate that birth place decisions are taken by some, but imposed upon others, and that maternity care is at odds with other areas of clinical practice through failing to provide women, partners and health professionals with sufficient information upon which to make informed, contextualised decisions. Supporting birth place decisions requires high quality antenatal, intrapartum and postnatal care for all women, preparedness to accept women's preference for either medical consultant-led care *or* midwife-led care, and promoting shared decision making even if this leads women to opt for medical birth rather than normal birth; in essence, this degree of choice was not available to women who participated in the study.

Bury (2004, p.52), commenting on the valorisation of science in modernity, argued that '...scepticism about experts...does not mean that science and technology have lost their central place in the culture', an observation which was upheld in this research. Women and their partners largely accepted that there are times when clinical events might intervene and disrupt planned place of birth, and prepared for this eventuality; the normative hospital birth discourse remains an abiding and influential cultural resource which has broader reach than individuals and service providers alone. To provide a cultural context where birth place decisions are made by, rather than on behalf of, women and their partners requires something of a sea-change within societal as well as professional discourses of birth place risk and safety. The history of

professional pluralism and engagement with women and their representatives in English maternity care at least provides sound basis for incorporating differing and competing views when birth place decisions are made.

Appendix A Research protocol

The 'Birth Place Decisions' research protocol (Version 2, January 2010)

A prospective, qualitative study of how women and their partners make sense of risk, safety and uncertainty when choosing where to give birth.

Summary

The aim of this study is to provide a detailed and rigourous account of how women and their partners make decisions about intended place of birth during pregnancy. The study will use a qualitative approach, to access in-depth data in the form of narratives that reveal how both mothers and fathers/partners choose an intended place of delivery. The study is an adjunct study to the current NPEU 'Birthplace' research programme (www.**npeu**.ox.ac.uk/), which will provide important evidence about birth outcomes in relation to place of birth. It is also part of the Kings NIHR Patient Safety and Service Quality (PSSQ) 'Innovations' programme, which is led by Professor Jane Sandall, the main academic supervisor to the project.

This study will provide in-depth data about the influence of socio-cultural factors (such as parity, social class, proximity to services, cultural importance of 'control', perceptions of risk and safety) that may influence women and their partners' choices about intended place of birth. The study will also address a gap in the theoretical knowledge base, by exploring the role and influence of partners and by describing how 'real world' choices about intended place of birth are made.

The aims of this study are as follows:

1. To describe the process of making decisions about place of birth in contemporary NHS maternity services from the perspectives of mothers and their partners, and identify factors that affect these choices.

2. To explore perceptions of risk and uncertainty in relation to place of birth (obstetric unit, midwife led unit or at home).
3. To provide in-depth evidence about extent to which perceptions of risk are shared, disputed and negotiated
4. To identify new theoretical knowledge about how mothers and their partners make decisions about, or choose, an intended place of delivery, and to consider the influence of social, cultural and demographic contexts upon these decisions.

Plan of investigation

Study design

The research questions of this study require access to detailed, individual data from mothers and from their partners, and this will be gathered through semi-structured, in-depth interviews. Qualitative methodology is appropriate for this project, in view of the requirement for data from individuals in their natural settings that can be interpreted and understood in context. The objective is to gain access to respondents' accounts of decision-making in relation to intended place of birth and to do this a 'narrative' approach will be used. Narrative research focuses on chronological accounts of events and provides an opportunity for respondents to reflect and discuss key decision making points and how their own personal context might have influenced these (Liamputtong and Ezzy 2005). The study will employ a narrative approach to examine the experiences and beliefs of respondents from their own perspectives within the social world, and will also draw on risk theory to explore how issues such as gender, culture and power might influence individuals' actions in response to uncertainty and risk in child birth.

Methods of data collection

This prospective, qualitative study will use a three-stage prospective interview design. Data will be gathered through semi-structured, in-depth interviews, which will be conducted with both pregnant women and their partners (where partners have also consented to take part). Where possible, women and their partners will be interviewed

separately. This is to allow individuals to discuss their own thoughts and feelings, without these impacting upon their partner. It is also one way to access personal views as distinct from a united 'couple view' which may be presented in a joint interview. If the couple are not comfortable with this approach however, but are willing to take part, the joint interviews will be conducted in the first instance.

The 'main' antenatal interview and postnatal follow up will each take approximately one hour. There will be an interim telephone interview (with women only) in the final month of pregnancy. This is because it is recognised that changing health status or other factors may change the intended place of birth during the course of the pregnancy, and the aim of this interview is to find out whether the initial decision has remained stable.

The first interview will be held in the antenatal period (12-32 weeks) and the postnatal interview will be held between 6-12 weeks following birth. Interviews will be recorded onto a digital recording device (with respondents' consent). The rationale for the timing of the first interview is that at this early stage, women (and their partners) will have been asked to think about where they wish to give birth, but will not consider the birth to be imminent. This provides a window of opportunity to identify any influencing factors, and to assess the strength of such factors, given the context of the individual respondents' lives.

Study site

It is intended that data collection for this study will be hosted in NHS trusts with existing provision of consultant care, midwife led units and home births, because this will most closely reflect the proposed choices outlined in *Maternity Matters* (DH 2007a). Research interviews will take place in either a health facility or at home, as nominated by the respondent.

Since this study was funded, access negotiations have taken place with the following trusts:

1. Eastcity NHS trust NHS trust (which provides consultant led care and also has a 10% home birth rate)

2. Southcity NHS trust,(which provides an 'on site' midwife led birth centre adjacent to a consultant led unit)
3. Westfield NHS trust (which has two 'freestanding' birth units, that is, birth units which are not attached to a consultant led unit, so that in the event of requiring enhanced levels of care, women and neonates must be transferred to a different hospital approximately 20 miles away).

The criteria for selection of the study site will be as follows:

1. The trust provides pregnant women with a range of choices that may include consultant obstetrician care, midwife led care for 'normal' deliveries and provision for home birth
2. The trust agrees to host the research
3. The research can be conducted within the costing and resources outlined for this study, and application for NHS research costs arising from the study (as detailed in Section 7) will be made via the appropriate Comprehensive Local Research Network.

Sample and sampling strategy

The sample for this study will be made up of women and their partners. Qualitative sampling is very different to quantitative sampling, where representation is a guiding principle. In qualitative research, samples are usually relatively small but include a wide range of individuals, because the intention of the research is to increase understanding as much as is feasible within the natural constraints of the study. This project will use both theoretical and purposive sampling (Liamputtong and Ezzy 2005) to identify respondents from various subgroups. The aim is of this sampling strategy is to include individuals who fit the criteria for the study, and also fit into various groups which the evidence base suggests are relevant. In this study, it would be useful to include primiparous and multiparous women, women from different social classes and women from different cultural groups along with their identified partners, who may be from the same or from different groups, to help to ensure heterogeneity in the study respondent group.

Selection/inclusion criteria

- Pregnant women referred for booking at the identified NHS trust at <20 weeks gestation (This time frame has been selected so that all the prospective data is drawn from a defined early pregnancy period, and is gathered before a time when delivery would be considered imminent, and when parents are likely to still be in the process of choosing where to give birth).

- Partners identified by the pregnant women respondents. In this study, the term 'partner' will be used to denote a significant person from the respondent's perspective. This may be husband or other sexual partner, but could also be a close friend or birth partner in the case of single women. Given that many single women use maternity services, it would be important not to exclude this group from the study. Women will not have to identify a partner if they do not wish to, and partners will not have to take part – they will be treated as separate respondents with the same process of information giving, time to consider taking part, and informed consent.

- If a woman wishes to take part, and her partner does not want to, then the woman can still be included in the study. The reverse situation is unlikely to occur, because partners will only be invited once pregnant women have indicated they are willing to take part.

Exclusion criteria

- Women over 20 weeks pregnant at time of booking (because these women will not have had the 'early pregnancy' opportunity to think about where to give birth

- Women under 16 years of age at booking, because this younger age group are likely to be more dependent on their families for support and less in a position to make a decision on their own about where to give birth. It would also be more complex to obtain informed consent from respondents below the age of 16.

Other than these two categories, there would be no requirement to exclude women on the basis that their pregnancies may be considered 'high risk'. This is because whilst maternity care guidelines do make clear that women should be given appropriate guidance in relation to any risks that may affect their pregnancies, services are also asked to respect women's choices even when these are contrary to best professional advice. The opportunity to understand *why* women may sometimes make choices which differ from their professional care givers could be missed if women were excluded from the study on the basis of risk.

Sample size and range

The aim is to recruit a sample of at least 30 and up to 60. The sample will be comprised of approximately half women and half partners. The purposive sample would include primiparous and multiparous women, women from different socio-economic and cultural backgrounds, and their partners.

Women will be interviewed at all three stages: antenatal, final month of pregnancy and postnatal. Partners will be interviewed twice, at the antenatal and postnatal stages.

Diversity

The cultural and ethnic diversity of the sample would be generated from the population receiving care at the identified host NHS trusts. This study will endeavour to include respondents who do not speak English as a first language, in view of the fact that one in five babies in the UK have mothers who were born outside this country (ONS 2007) and resources for translation have been identified in the study budget to facilitate this. It would be unrealistic to try and include a wide range of ethnic groups within the sample and this would also mean that the study findings would not reflect the demand on most UK maternity services, but it is possible that some respondents may not be able to speak English well enough to be confident to participate and the 'language line' translation service (or equivalent) will be accessed for research purposes in this eventuality.

Individuals from these groups may feel excluded from research because of language barriers, cultural barriers or a lack of access to information about research. Inclusion of individuals without English as a first language can increase research costs (Murray and Buller 2007) due to the need for translation during interviews, and for help to understand responses within the cultural framework of the respondent.

Whilst it is difficult to accurately anticipate the number of respondents without English as a first language that would come forward to participate, the study proposal includes a set up budget for interpreter costs which would be used to translate information sheets into the languages most commonly used by the local population and then to help make arrangements for interviews. The costs of providing translation during interviews and cultural interpretation of the texts are more significant and these have also been included in the study budget.

Diversity may also encompass the range of social and demographic groups that exist in contemporary culture, and the study aims to recruit respondents who vary in age, relationship status and socioeconomic background. The involvement of three NHS trusts will also reflect geographical diversity of city and urban/rural areas and incorporate different models of service provision.

Amendment 1, January 2010

Introduction of £20 vouchers to facilitate recruitment of individuals who do not ordinarily participate in qualitative research

The study has been recruiting from September 2009 – December 2009. The study aimed to recruit up to 10 women from each site (30 women in total, including the third site of Westfield NHS trust) plus partners.

Recruitment targets have been achieved at Southcity trust, and five women from Eastcity trust have also been recruited during this period, and two from Westfield NHS trust. Although some socio-economic diversity amongst the sample has been achieved,

this has been limited, and most of the men and women who have agreed to take part are from more affluent areas, are white, and speak English as a first language. The inclusion of women who are not white, or who do not speak English confidently enough to take part in a research interview, who are below 20 years of age or are single remains an important goal of the study, because the inclusion of perspectives from such respondents would help generate theory about the extent to which some views are common to NHS maternity clients (regardless of cultural differences), or, alternatively, whether there are any differences amongst women that might have cultural, social or religious antecedents. As mentioned earlier, this purposive qualitative sample does not seek to be exhaustive or representative of the local population, but should be diverse enough to challenge (or support) cultural tenets which are taken to be universal (such as hospital being seen as the safest place to give birth).

In the initial application, the intention was to recruit without offering vouchers, because of both methodological and ethical considerations. The methodological concern is that the quality of the data may be reduced if individuals take part for financial reasons, but for the purposes of this study, that is not necessarily the case. This is because the study is attempting to access people who experience barriers to research, so that data from more 'difficult to reach' respondents are likely to strengthen this study. However, accessing those who do not usually participate in research has, not surprisingly, proved challenging. In addition to submitting this amendment, I have been working with local maternity managers to actively identify women from these groups for recruitment purposes, and will continue to do so. The practical consideration of language difficulty has been met through resource for translation and interpreters, but this has not helped with recruitment. Some individuals have said that they do not have time to participate, which is reasonable given that many have young children, jobs and/or studies to contend with, along with their pregnancies. As the study involves interviews lasting an hour, it seems reasonable to offer vouchers in some recompense for the time that people make available. The ethical concern that offering an incentive makes it harder for less

affluent participants to turn down an invitation to participate (Saks and Allsop 2007, p.117) is harder to answer, but the provision of £20 in vouchers does not seem unreasonable in recognition of the time involved and does mean that respondents' contribution to the research is recognised. The purpose of this amendment is to increase the diversity of the study sample which in turn will enhance the overall value of the research to the NHS and to the public through widening participation in the study to include a broad range of perspectives. A secondary reason is to explore whether this approach does help support recruitment of harder to access respondents in a qualitative study of this nature, which will be of benefit to other researchers facing similar situations.

The arrangements for providing vouchers are that I will provide participant information sheets as usual (V3 dated 10 Jan 2010), and allow potential respondents time to consider these. I will then contact them in 2-7 days (as normal) to ask if they are willing to take part, and if they agree, I will make arrangements for the interviews to take place. When I make the arrangement, I will ask which type of voucher they prefer, and take these with me to be given at the end of the interview. The information sheet specifies that no cash alternative is available.

(End of amendment 1, no further changes made to protocol).

Data analysis and study rigour

Primary data (transcripts and other data sources) will be stored and managed using N Vivo software for qualitative data analysis. Data will be analysed using a grounded theory based comparative thematic approach, and individual data 'sets' (i.e. all interviews over time for a given participant) will also be analysed using a 'narrative analysis' approach, meaning that respondents' accounts of the process of decision making, before birth and after, are elicited during the interviews and considered as a whole, taking into consideration social, moral and organisational contexts. Study rigour will be enhanced through maintaining good records and providing a clear account of how the project was undertaken. Interpretative rigour will be strengthened through

careful supervision of the primary data analysis, ensuring that findings are shared with a wide reference group, that interpretations of issues or events during interviews are clarified with respondents, and through sharing primary texts with colleagues to assess inter-rater reliability. Converting findings, observations and interpretations into conclusions will be an iterative process involving colleagues, professionals and study respondents, and this will contribute to the evaluative rigour of the study (Liamputtong and Ezzy 2005). Funding for service users' time/expenses to contribute to occasional meetings for data interpretation has been included in the project costs.

Dissemination

A dissemination strategy will be operational throughout the project, and will include development of a study contact group (to include representatives of consumer groups and maternity service users) as well as relationships with academic collaborators. The study will be written up for submission as a PhD thesis, and findings will be prepared for conference presentations and for publication in peer reviewed journals, and a study report and summary will be prepared. The project will also be disseminated to the NHS using new collaborations such as NIHR PSSQ as well as through established networks. A lay summary will be written in conjunction with service users, for maternity service users and consumer representative groups, and project findings will be shared across a consumer network through conference presentations, web publications and magazine articles. The dissemination strategy will be designed to facilitate communication with policy makers, practitioners and consumer groups throughout the study.

Project Plan	Year 1			Year 2			Year 3		
	Oct 08 - Sept 09			Oct 09 - Sept 10			Oct 10 - Sept 11		
Project									
Literature review									
Ethics and RG approvals									
Initial interviews									
Postnatal interviews									
Writing up, dissemination									
PhD and training									
Formal PhD research training									
PhD supervision (monthly)									
ESRC courses									
N Vivo Intermediate									
QUARU master classes									
EPPI Evidence Synthesis 1									
EPPI Evidence Synthesis 2									
NCSR Integrating Res Methods									
Health Economics									

Appendix B Letters of approval from NHS research ethics committee

The first document, dated 23rd April 2009, is the letter confirming that the study has received ethical approval. The second letter, dated 8th February 2010 confirms that the substantial amendment was approved.

The study information sheets and consent form are in Appendix C.

NHS
National Research Ethics Service

23 April 2009

Ms Kirstie Coxon
NIHR Research Training Fellow and Research Associate
Florence Nightingale School of Nursing and Midwifery/Division of Health and Social Care Research
Waterloo Bridge Wing, Kings College
150 Stamford Street
London
SE1 9NH

Dear Ms Coxon

Full title of study: **A prospective, qualitative study of risk and uncertainty in relation to intended place of birth.**
REC reference number: **09/H0808/45**

The Research Ethics Committee reviewed the above application at the meeting held on 15 April 2009. Thank you for attending to discuss the study.

Ethical opinion

Thank you for attending the meeting and confirming:

- All the interviews will be undertaken by the CI. It should not be too much of a burden as the sites chosen are in the locality of her home and her place of work.
- It is hard to clarify a sample size as saturation is required to gain meaningful results. It will probably be around 60 .

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Ethical review of research sites

The Committee agreed that all sites in this study should be exempt from site-specific assessment (SSA). There is no need to submit the Site-Specific Information Form to any Research Ethics Committee. The favourable opinion for the study applies to all sites involved in the research.

Conditions of the favourable opinion. The following points were raised and need to be addressed:

- The PIS needs to state that this project is being undertaken as part of a PhD.
- Conformation that the insurance excess will not fall on the participant is required.

Now that you have completed the application process please visit the National Research Ethics 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
- 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.

09/H0808/45	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project

Yours sincerely

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: *Professor Anne Marie Rafferty*
KCH

NHS
National Research Ethics Service

08 February 2010

Ms Kirstie Coxon
King's College London
Division of Health & Social Care Research
7th Floor Capital House
42 Weston Street
London SE1 3QD

Dear Ms Coxon

Study title:	**A prospective, qualitative study of risk and uncertainty in relation to intended place of birth.**
REC reference:	**09/H0808/45**
Amendment number:	**1**
Amendment date:	**11 January 2010**

The above amendment was reviewed 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
Participant Information Sheet: Information sheet for women	3	10 January 2010
Participant Information Sheet: Information sheet for women	3	08 January 2010
Protocol	2	01 January 2010
Notice of Substantial Amendment (non-CTIMPs)	1	11 January 2010
Covering Letter		

R&D approval

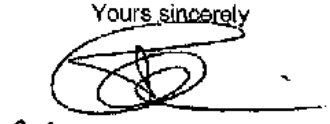
All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research.

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.

09/H0808/45:	Please quote this number on all correspondence

Yours sincerely



p.p.

E-mail

Copy to: *Professor Anne Marie Rafferty – KCL*
Research Office – KCL

Appendix C Information sheets and consent form

[Version 3 10.01.2010, NHS Logos removed]

The 'Birth Place Decisions' study information sheet for women

I would like to invite you to take part in a study about how women and their partners make decisions about where to give birth. This study is taking place between September 2009 and March 2011.

I am a researcher based at King's College London and am carrying out this study, which is funded by the National Institute of Health Research (Department of Health).

The purpose of the study is to explore how women and their partners make decisions about where to give birth. I am also interested in finding out about the influence of other factors, such as the TV or papers, your friends or relatives, health professionals or your own experiences. By doing this study, I hope to improve understanding of the process of making a decision about where to give birth. I understand that you may not have made a decision about this yet, and that even if you have, your decision may change at a later stage of your pregnancy. I hope the knowledge gained by this study will help health professionals to communicate well with mothers and their partners about where to give birth.

I would like to hear your views on subjects such as:

- Whether you have decided where to give birth, and what sorts of things affect this decision.

- What you think about the various options that are available, such as giving birth in a hospital, a midwife led unit ('Birth Centre'), or at home
- Whether you feel you have been given a choice of where to give birth
- Whether the decision about where to give birth changes at all, and if so, why this happens
- After you have given birth, I would like to talk to you about your experience during this labour, and how this might affect where you give birth in future pregnancies.
- Other issues around deciding where to give birth that you consider important

Below are some questions and answers about this research. If you have any other questions, please don't hesitate to contact one of the team listed at the end of this information sheet.

1. Who has approved the study?

The [named] NHS Research Ethics Committee has reviewed the study and given it ethical approval (Study reference 09/H0808/45, dated 23.04.09). This approval extends to all the participating sites. Each of the hospitals involved has also given their local 'Research Governance' approval to the study.

2. Why have I been invited to take part?

All women who are registering for maternity care at [hospital name], and who match the study criteria (see Q4 below), are invited to take part. Your participation is entirely voluntary, but I do hope you can help me by taking part.

3. Why is the study being conducted?

This study is designed to provide information about the way that people make decisions about where to give birth, and to understand more about the influences that affect these decisions.

4. Can anybody take part in this study?

To be eligible to take part in this study:

- You should be at least five months (20 weeks) pregnant

- You should also have had your first antenatal 'booking' appointment before week 20 of your pregnancy (before you were five months pregnant).
- You should be aged 16 or older.

5. Will taking part be of any benefit to me?

I would really welcome the opportunity to interview you, but I do realise that interviews can be an inconvenience, and that you may have reservations about talking about your experiences to a researcher. In order to recompense you for your time and involvement in this study, a £20 voucher will be provided to you after the antenatal interview, and a second £20 voucher after the postnatal interview, so you would receive £40 in vouchers for taking part in two interviews of about an hour each.

Vouchers can be for a range of stores, including Tesco's, Sainsbury's, Boots, for mobile phone top up or 'i-tunes'. If you agree to take part in an interview, I will ask you what voucher you prefer when we arrange a date and time. Please be aware that I am not able to provide cash as an alternative.

6. What about my husband, partner or 'birth' partner?

For this interview study, I am interested in hearing from interview women *and also their partners*. If you agree to take part, and think your partner may also agree to participate, you can let me know when we arrange the interview. For the purposes of this study, a partner is the person (or people) that you say is your supporter and who helps you to make decisions about the birth. You do not have to identify a birth partner to take part, and your husband, partner or relative does not have to take part in the study, even if you agree to do so. They will be asked independently, and can agree or decline freely.

7. What would be involved in taking part?

This is an interview study, which involves two 'face to face' interviews and also one short telephone interview. If you agree, I will interview you and your partner (if they are participating) separately. This is purely so that both you and your

partner can discuss issues around place of birth openly, without concern about how your views may affect each other. The intention is not to find out whether you as a couple, or a pair, agree with each other. If you are at all uncomfortable with separate interviews, I will interview you both together. I will provide a separate information sheet for your partner if you are interested in taking part in this study.

8. When, and where, will the interviews take place?

The first interview will take place during the first eight months of your pregnancy and the last will be held within three months of when you give birth. The telephone interview (for women only) will take place in the last month of your pregnancy.

Each interview will be **confidential**, and the same researcher (Kirstie Coxon) will conduct all of the interviews. The interview will address the issues listed on the front page of this leaflet but it will be flexible, to allow you to talk about the issues around choosing where to give birth that are important to you.
The first interview will take about an hour, and will be held when you are between three and six months pregnant. The telephone interview will take about ten minutes, and will take place in the last month of your pregnancy. The final interview will also last about an hour, and will take place during the first three months after you have given birth.

Interviews will take place at a time and place that is convenient to you. This could be your at your home, but we can arrange alternative venues if for any reason you do not wish to be interviewed at home.

9. What if I change my mind?

You can withdraw from the study at any time without having to give an explanation, and without your maternity care being affected in any way.

10. Are there any disadvantages to taking part?

I recognise that helping with the study will take up some of your time. I will do my best to minimise any inconvenience to you by ensuring that you take part at the time and place that suits you best.

I do not expect anyone to suffer any harm or injury as a result of participating in the study, although the study does have insurance cover. The treatment and advice you receive will be the same whether you take part or not.

11. Will everything I say be confidential?

Yes. Nothing you say will be revealed to hospital staff, to other people close to you, or to **anyone** outside the research team in a way that could identify you. Tapes of interviews will be stored securely at King's College, London and made accessible only to research team members.

12. Are there any circumstances under which the researcher might breach my confidentiality?

The only possible circumstance where this might happen is if you were to divulge information that the researcher is duty bound to disclose, and this includes information relating to serious harm, neglect or abuse of a vulnerable person such as a child or elderly relative. In this circumstance, the researcher would also have a duty to inform you before any such disclosure takes place.

13. What will happen to the interview tapes and transcripts ('Typed up' interviews)?

The tapes will be destroyed at the end of the study. It will not be possible to identify you from the published results. A copy of the study data will be securely stored at King's College, London for seven years.

If you agree, the **anonymised** interview transcripts will be stored at the Economic and Social Data Service (ESDS) UK data archive at Essex University after the study ends, so that other researchers in the future are able to access these records. Agreeing to take part in the study does not mean that your data will be automatically archived; I will ask for your consent for this separately, and provide

further information to you if you would like this. (See also http://www.data-archive.ac.uk/about/about.asp).

14. What if I have any questions?

If you think of questions about the study, please feel free to contact the research team using the contact details at the end of this leaflet. We will be very happy to discuss your concerns and/or put you in touch with someone who will be able to help.

15. How and where will the results be published?

I plan to publish the findings in NHS trust websites and newsletters, in consumer, academic and professional journals, on consumer internet sites and at conferences to associations involved in improving maternity services. I will also send you a summary of the research findings at the conclusion of the study

16. What should I do if I want to take part?

If you are willing to be interviewed for this study, you can contact the researcher, Kirstie Coxon, directly at the email address below. If you do not have access to the internet, please return the 'contact details' sheet (from this pack) using the pre-paid envelope provided.

If you have discussed becoming involved with the researcher or with your midwife and provided your contact details, then I will contact you within about a week to discuss this and answer any further questions you may have before arranging a date for an interview.

Thank you very much for reading this information and for considering taking part in this study

Researcher:

Kirstie Coxon
Research Associate & NIHR Research Training Fellow (M Phil/PhD student)
King's College
London
kirstie.coxon@kcl.ac.uk

Tel: 07986 911814, or 0207 848 6604

Supervisors:

Professor Jane Sandall
King's College London
Tel. 0207 848 6604
jane.sandall@kcl.ac.uk

Professor Naomi Fulop
King's College London
Tel. 0207848 7152
naomi.fulop@kcl.ac.uk

Local Clinical Collaborator:

[Director of midwifery at relevant NHS trust)

The normal NHS complaints mechanism is available to you if you wish to complain about any aspect of the way you are approached or treated during the course of this study. Formal complaints may be addressed to Professor Anne Marie Rafferty, Head of Florence Nightingale School of Nursing and Midwifery, King's College London, tel. 020-7848-3561.

Should you require independent advice, you may wish to contact the Maternity Services Liaison Committee at [name of] hospital]. You can also contact the National Childbirth Trust through their website www.nctpregnancyandbabycare.com, or you may wish to look up the INVOLVE website www.invo.org.uk.

Information sheet for partners

[NHS logos removed, V3 dated 08.01.2010]

The 'Birth Place Decisions' study: information sheet for partners

I would like to invite you to take part in a study of how women and their partners make decisions about where to give birth. This study is taking place in [name of NHS trust] hospitals between September 2009 and March 2011.
You have been given information about this study because your wife, partner, relative or friend is considering taking part in the study, and where possible, I would like to involve 'birth' partners too. I am keen to involve birth partners in this study, because the views and experiences and influence of men (and other birth partners such as relatives or friends) are poorly understood, although there is evidence to show that you have an important influence on decisions about place of birth.

The purpose of this study is to explore how women and their partners make decisions about where to give birth. I am also interested in finding out about the influence of other factors, such as TV, papers, magazines, your friends, relatives or health professionals or your own previous experiences. By doing this study, I hope to improve understanding of the process of making a decision about where to give birth. I understand that you and your partner may not have made a decision about this yet, and that even if you have, your decision may change at a later stage of your pregnancy. I hope the knowledge gained by this study will help maternity services to communicate well with mothers and their partners about where to give birth.

I would like to hear your views on subjects such as:

- Whether you and your partner have decided where to give birth, and what sorts of things affect this decision
- What you think about the various options that are available, such as giving birth in a hospital, a midwife led unit ('birth centre), or at home
- Whether you feel you and your partner have been given a choice of where to give birth, and what sort of influence you think you are able to have in this issue
- Whether the decision about where to give birth changes at all, and if so, why this happens
- After your partner has given birth, I would like to talk to you about your experience during her labour, and how this might affect you in a future pregnancy
- Other issues around deciding where to give birth that you consider important

Below are some questions and answers about the research. If you have any other questions, please don't hesitate to contact one of the team listed at the end of this leaflet

1. Who has approved the study?

The [named] NHS Research Ethics Committee has reviewed the study and given it ethics approval (REC reference no 09/H0808/45, dated 23.04.09). This approval extends to all the participating sites. Each of the hospitals involved has also given their local 'Research Governance' approval to the study.

2. Why have I been invited to take part?

You have been given this information about the study because your partner is thinking about taking part. Although she has indicated that she may be willing to participate, whether or not you take part is entirely your decision. If you do not wish to participate, your partner can still be included.

3. Why is the study being conducted?

This study is designed to provide information about the way that people make decisions about where to give birth, and to understand more about the influences that affect these decisions. I am also doing the study as part of my PhD.

4. Can anybody take part in this study?

Husbands, partners, boyfriends, friends, relatives or other 'birth' partners of pregnant women are invited to take part in this study. For the purposes of this study, a 'birth' partner is the person the pregnant woman indicates is their partner, or the main person who helps her make decisions about the birth. Where possible, I would like to include a partner for each pregnant woman who takes part.

5. What would be involved in taking part?

This is an interview study, which involves two 'face to face' interviews (and also one short telephone interview for the women only). If you agree, I will interview you and your partner separately. This is purely so that both you and your partner can discuss issues around place of birth openly, without concern about how your views may affect each other. The intention is not to find out whether you as a couple, or a pair, agree with each other. If you are at all uncomfortable with separate interviews, I will interview you both together.

6. When, and where, will the interviews take place?

The first interview will take place during the first 32 weeks (eight months) of your partner's pregnancy and the second interview will be held within three months of the baby's birth.

Each interview will be **confidential**, and the same researcher (Kirstie Coxon) will conduct all of the interviews. The interviews will address the issues listed on page 1 of this leaflet, but they will also be flexible, to allow you to talk about the issues around choosing where to give birth that are important to you.

Each interview will take about an hour. Interviews will take place at a time and place that is convenient to you. This could be your at your home, but if for any reason you do not wish to be interviewed at home, we can arrange an alternative place that is more suitable for you.

7. What if I change my mind?

You can withdraw from the study at any time without having to give an explanation, and without your partner's maternity care being affected in any way.

8. Will taking part be of any benefit to me?

Perhaps not directly, but I hope you will find it helpful and interesting to explore your views and experiences, and I also hope that the study findings will help to improve the maternity service for women and their partners in the future.

9. Are there any disadvantages to taking part?

I recognise that helping with the study will take up some of your time. I will do my best to minimise any inconvenience to you by ensuring that you take part at a time and place that suits you best.

I do not expect anyone to suffer any harm or injury as a result of participating in the study, although the study does have insurance cover. The treatment and advice your partner receives will be the same whether you take part or not.

10. Will everything I say be confidential?

Yes. Nothing you say will be revealed to hospital staff, to other people close to you, or to anyone outside the research team in a way that could identify you. Tapes of interviews will be stored securely at Kings College, London and made accessible only to research team members.

11. Are there any circumstances under which the researcher might breach my confidentiality?

The only possible circumstance where this might happen is if you were to divulge information that the researcher is duty bound to disclose, and this includes information relating to serious harm, neglect or abuse of a vulnerable person such as a child or elderly relative. In this circumstance, the researcher would also have a duty to inform you before any such disclosure takes place.

12. What will happen to the interview tapes and transcripts ('typed up' interviews)?

The tapes will be destroyed at the end of the study. It will not be possible to identify you from the published results. A copy of the study data will be securely stored at Kings College, London for seven years.

If you agree, the anonymised interview transcripts will be stored at the Economic and Social Data Service (ESDS) UK data archive at Essex University after the study ends, so that other researchers in the future are able to access these records. Agreeing to take part in the study does not mean that your data will be automatically archived; I will ask for your consent for this separately, and provide further information to you if you would like this (http://www.data-archive.ac.uk/about/about.asp).

13. What if I have any concerns?

If you think of questions about the study, please feel free to contact me or my supervisors using the contact details at the end of this leaflet. We will be very happy to discuss your concerns and/or put you in touch with someone who will be able to help.

14. How and where will the results be published?

I plan to publish the findings in NHS trust websites and newsletters, in consumer, academic and professional journals, on consumer internet sites and at conferences to associations involved in improving maternity services. I will also send you a summary of the research findings at the conclusion of the study

15. What should I do if I want to take part?

If you are willing to be interviewed for this study, please tell your partner that she may give your contact details to me, and I will then contact you to discuss this and to answer any further questions you may have about the study, before arrangement a date for an interview.

You can also contact me directly at the email address and phone numbers below. If you do not have access to the internet, you can also return the attached contact details sheet using the stamped addressed envelope provided.

Thank you very much for reading this information and for considering taking part in this study

Researcher:

Kirstie Coxon
Research Associate & NIHR Research Training Fellow (M Phil/PhD student)
Kings College
London
kirstie.1.coxon@kcl.ac.uk
Tel or text: 07986 911814 or Tel 0207 848 6604 (switchboard)
Supervisors:

Professor Jane Sandall
King's College, London
Tel. 0207 848 6604
jane.sandall@kcl.ac.uk

Professor Naomi Fulop
King's College London
Tel. 020-7848 7152
naomi.fulop@kcl.ac.uk

Clinical Link: [Head of midwifery at NHS trust name and contact details here]

The normal NHS complaints mechanism is available to you if you wish to complain about any aspect of the way you are approached or treated during the course of this study. Formal complaints may be addressed to Professor Anne Marie Rafferty, Head of Florence Nightingale School of Nursing and Midwifery, King's College London, tel. 020-7848-3561.

Should you require independent advice, you may wish to contact the Maternity Services Liaison Committee through your local hospital. You can also contact the National Childbirth Trust through their website www.nctpregnancyandbabycare.com, or you may wish to look up the INVOLVE website www.invo.org.uk.

Consent form

[NHS logos removed, V3 08.01.2010]

The 'Birth Place Decisions' study

Chief Investigator: Kirstie Coxon

Please Initial Box

- I have read and understand the information sheet (Version 3) for the above research study. ☐
- I have had the opportunity to ask questions about the research study. ☐
- I understand the purpose of the study and how I will be involved. ☐
- I understand that my interview will be audio-taped and transcribed, but that no identifying information will be kept with the tape or transcription and that only members of the research team will listen to and read them. ☐
- I understand that all information collected in the research study will be held in confidence and that, if presented or published any identifying personal details will be removed. ☐
- I confirm that I will be taking part in this research study of my own free will. ☐
- I agree to take part in the above study ☐

_____	_____	_____
Name of Participant	Date	Signature
Researcher	Date	Signature

Consent form Sheet 2

'Birth Place Decisions' study

Consent to archiving of anonymised data after the study ends

Chief Investigator: Kirstie Coxon **Please Initial Box**

- I am willing for transcripts of interviews to be placed in a data archive at the Economic and Social Data Service, at the University of Essex. I understand that all transcripts that are archived (stored) in this way will be anonymised, which means that any identifying personal data will have been removed before archiving takes place. ☐

- I have been provided with information about the purpose of data archiving (storage) ☐

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	
Researcher	Date	Signature

Appendix D Interview Schedules

Schedule A: Antenatal Interviews

Section 1 Narrative question

As you know, I'm researching how people decide where to give birth, and in a minute, I'm going to ask you to tell me the story of your pregnancy, and where you think you may give birth at this point in time.

Please include all those events and experiences that were important for you, personally. I'll listen, I won't interrupt.

I'll just take some notes in case I have any questions for after you've finished.

Please take your time – please begin wherever you like...

So, can you please tell me the story of your pregnancy...

Section 2 Following the unguided narrative: reminders for narrative prompts

Ask questions in the same order as the interviewee related the events

Image Feeling Thought	Time Situation Phase Example Period	Occasion Incident Moment Event Day

You said.....do you remember (any more detail) about ...

Section 3 Following narrative account

Check for:

- Current feelings about different places of birth; hospital, midwife led unit, home
- Previous experiences of hospital, including visiting family and friends
- Details of booking appointment – whether/how choices are presented to women

- Influences on making a decision about where to give birth – people, anecdotes, debates, in papers/TV or between families and friends, with health professionals
- Experiences in this and any previous pregnancies, and how these affect current choice
- Social and health issues; risks, safety of woman and baby.
- Imagining different birth environments
- Benefits and risks of different possible birth environments
- When/at what point was decision made (if made at this stage)
- Drivers for making a decision – what are these, when are they experienced, do they fit with women's experience of pregnancy?

If interviewed with translator present

Can you tell me

1. Where you think you will give birth
2. Why you think you might give birth there (or in those possible places) (what sorts of things have led to that?)
3. Can you describe for me your role in this decision? – can you tell me how it came about now?
4. How you feel about this – whose decision is (was) it, did you think you have a choice?
5. Did you talk to anybody about where you plan to give birth? If so, who?

Birth Place Decisions Attribute Sheet

(gather information at end of first antenatal interview)

Name:

Age:

Date of antenatal interview:

Site:

Recruitment:

Booked: (GP surgery or midwife)

EDD:

Pregnancy details

Parity

Previous pregnancies

Number

Place of birth- previous pregnancies

For each previous pregnancy, were there any problems during pregnancy, labour or birth?

Prompt: health problems, other existing medical conditions, needed to go to hospital, needed to see consultant, have monitoring, or extra tests.

Any problems during labour or birth?

Mode of birth and type of birth?

Were there any problems at birth or immediately after?

<u>This pregnancy</u>

How many weeks pregnant are you now (at antenatal Interview)?

How many weeks pregnant were you when you had a booking appointment?

Who did you have your first (booking) appointment with?

Do you remember whether place of birth was discussed?

At the moment, do you have any problems with your health or your pregnancy that you are aware of?

At the moment, where do you think you will give birth to this baby?

Demographic information

1. Marital status
   - ☐ Single (never married)
   - ☐ Married (first marriage)
   - ☐ Remarried
   - ☐ Separated (but still legally married)
   - ☐ Divorced
   - ☐ Widowed
   - ☐ Civil partnership
   - ☐ Living together
   - ☐ In a relationship, but live apart

2. Country of birth
   - ☐ UK

     Elsewhere

     If elsewhere, write in name of country

     _____

3. Language – what is your first language?

   _____

   If not English, what is your first language?:

   _____

   _____

   What language do you speak at home?

   _____

   _____

4. What is your ethnic group?

White

- ☐ British
- ☐ Irish
- ☐ Other white background – please write in

  _____

- ☐ Mixed
  - ☐ White and Black Caribbean
  - ☐ White and Black African
  - ☐ White and Asian
  - ☐ Any other mixed background – please write in

    _____
- ☐ Asian or Asian British
  - ☐ Indian
  - ☐ Pakistani
  - ☐ Any other Asian background – please write in

    _____
- ☐ Black or Black British
  - ☐ Caribbean
  - ☐ African
  - ☐ Any other black background – please write in_____

Chinese or other ethnic group

- ☐ Chinese

Any other – please write in _____

5. What is your religion?
   - _ None
   - Christian (including Church of England, Catholic, Protestant and all other Christian denominations)
   - Buddhist
   - _ Hindu
   - Jewish
   - Muslim
   - _ Sikh
   - Any other religion, please write in

     _____

6. Employment status
   - _ Employed
   - _ Self employed
   - Unemployed
   - Studying
   - _ On maternity leave
   - Looking after others at home
   - If combination please give details:_____

     _____

     _____

7. (if employed)
   What is (was) the full title of your main job?

8. Describe what you do (did) in your main job:

9. Which of these qualifications do you have?
   - _ O levels/CSEs/GSCEs
   - _ A levels/AS levels
   - _ First degree (BA, BSc)
   - _ Higher degree (MA, PhD, Postgraduate certificates/diplomas

_ NVQ levels 1, 2 or 3
_ Other qualifications (e.g. City and Guilds, BTEC)
_ No qualifications

Schedule B: End of pregnancy follow up

(women participants only)

Name	
Date of follow up	
How many weeks pregnant now At antenatal interview, birth place preference was:	
Has anything changed since then?	
Now, at antenatal follow up interview, where do you think you will give birth?	
Have you developed any health problems since our first interview?	
Have you had any change to your midwife since we last talked?	
If preference has changed, what are the reasons for this?	

Schedule C Postnatal interviews

(with women and partners)

Section 1

Invite a narrative account of the events leading to the birth, and the birth itself, and any changes of place or transfer that happened in the antenatal period, during labour or in the postnatal period.

Section 2

How has the experience of this pregnancy influenced what decision you might make in a subsequent pregnancy- or, what would you advise a friend or family member in the same situation?

Section 3

Have your perceptions of risk, safety and making decisions about where to give birth changed? If so, can you describe how?

Where would you plan to give birth in a future pregnancy?

Appendix E Individual attributes

Name	Age	Parity[1]	NS-SEC[2]	Relationship	Ethnicity	UK born	English speaking	Graduate
Vita	36	Second+ baby	Managerial (2)	Married	White, other	No	Yes	Yes
Michael	40	Second+ baby	Managerial (4.1)	Married	White, British	Yes	Yes	Yes
Cecile	42	Second+ baby	Managerial (4.1)	Married	White, other	No	Yes, 2nd language	Yes
Annette	36	First baby	Managerial (4.1)	Cohabiting	White, British	Yes	Yes	Yes
Eric	41	First baby	Managerial (2)	Cohabiting	White, other	No	Yes (accent)	Yes
Jane	35	First baby	Managerial (4.1)	Married	White, British	Yes	Yes	Yes
Laura	38	First baby	Managerial (2)	Married	White, British	Yes	Yes	Yes
Naomi	31	First baby	Managerial (4.3)	Married	White, British	Yes	Yes	Yes
Paul	34	First baby	Managerial (3.1)	Married	White, British	Yes	Yes	Yes
Arabella	33	Second+ baby	Managerial (4.1)	Married	Wh/bl Carib	No	Yes	Yes
Sarah	34	First baby	Managerial (3.1)	Married	White, British	Yes	Yes	Yes
Florence	33	Second+ baby	Managerial (4.1)	Married	White, British	Yes	Yes	Yes
Maria	27	Second+ baby	Managerial (4.1)	Cohabiting	Black British	Yes	Yes	Yes

[1] Second+ indicates second or subsequent baby

[2] Using the National Statistics Socio-Economic Classification (Rose et al 2005). Based on education and employment status, taking into account size of organisation and position. Many participants' jobs fit the 'Managerial and professional occupations' domains, hence the range within the level is also provided (i.e. between managerial domains 2 and 4.1).

Name	Age	Parity	NS-SEC	Relationship	Ethnicity	UK born	English speaking	Graduate
Nia	29	Second+ Baby	FT student (L15)	Married	Black British	Yes	Yes, 2nd language	Yes
Alexandria	28	Second+ Baby	Not working outside home	Married	Bl African/ Carib	No	Yes	Yes
Samantha	26	First baby	Managerial (4.1)	Married	White, British	Yes	Yes	Yes
Jazz	27	Second+ Baby	Not working outside home	Married	Asian	Yes	Yes	No
Kath	38	First baby	Managerial (4.1)	Cohabiting	White, other	No	Yes	Yes
Carl	48	First baby	Managerial (4.1)	Cohabiting	White, other	No	Yes, 2nd language	Yes
Hannah	30	Second+ Baby	Not working outside home	Married	White, other	No	Yes, 2nd language	No
Debbie	33	First baby	Managerial (4.1)	Married	White, British	Yes	Yes	No
Dan	39	First baby	Managerial (4.1)	Married	White, British	Yes	Yes	Yes
Holly	28	Second+ Baby	Managerial (3.1)	Married	White, British	Yes	Yes	Yes
Hilary	34	First baby	Managerial (4.1)	Cohabiting	White, British	Yes	Yes	Yes
Salah	34	First baby	Managerial (4.1)	Cohabiting	Other	No	Yes	Yes
Serena	38	First baby	Intermedi-ate (7.1)	Married	White, British	Yes	Yes	No
Ella	34	Second+ baby	Managerial (4.1)	Married	White, other	No	Yes,2nd language	Yes
Homer	34	Second+ baby	Managerial (3.1)	Married	White, other	No	Yes, 2nd language	Yes

Name	Age	Parity	NS-SEC	Relationship	Ethnicity	UK born	English speaking	Graduate
Alison	34	First baby	Managerial (4.1)	Married	White, British	Yes	Yes	Yes
James	35	First baby	Managerial (3.1)	Married	White, British	Yes	Yes	yes
Amanda	34	First baby	Intermedi-ate (7.2)	Cohabiting	White, British	Yes	Yes	No
Harry	33	First baby	Lower tech (11.1)	Cohabiting	White, British	Yes	Yes	No
Margaret	39	First baby	Managerial (4.1)	Cohabiting	White, British	Yes	Yes	Yes
Jia	19	First baby	FT student (L15)	Living apart	Asian	No	No	No
Adele	29	Second+ baby	Not working outside home	Cohabiting	White, British	No	Yes	Yes
Ronnie	23	Second+ baby	FT student (L15)	Single	Wh/Bl Carib	Yes	Yes	No
Iona	28	First baby	FT student (L15)	Married	White, British	Yes	Yes	No
Andy	31	First baby	Managerial (2)	Married	White, other	No	Yes	Yes
Marylin	31	First baby	Managerial (3.3)	Married	Chinese British	Yes	Yes	No
Jo	25	Second+ baby	Not working outside home	Married	White, British	Yes	Yes	No
Eddie	28	Second+ baby	FT student (L15)	Married	White, British	Yes	Yes	No
Melody	27	Second+ baby	Not working outside home	Married	White, British	Yes	Yes	No
Patsy	39	Second+ baby	Not working outside home	Single	White, British	Yes	Yes	No
Jan	60		Retired	Divorced	White, British	Yes	Yes	No

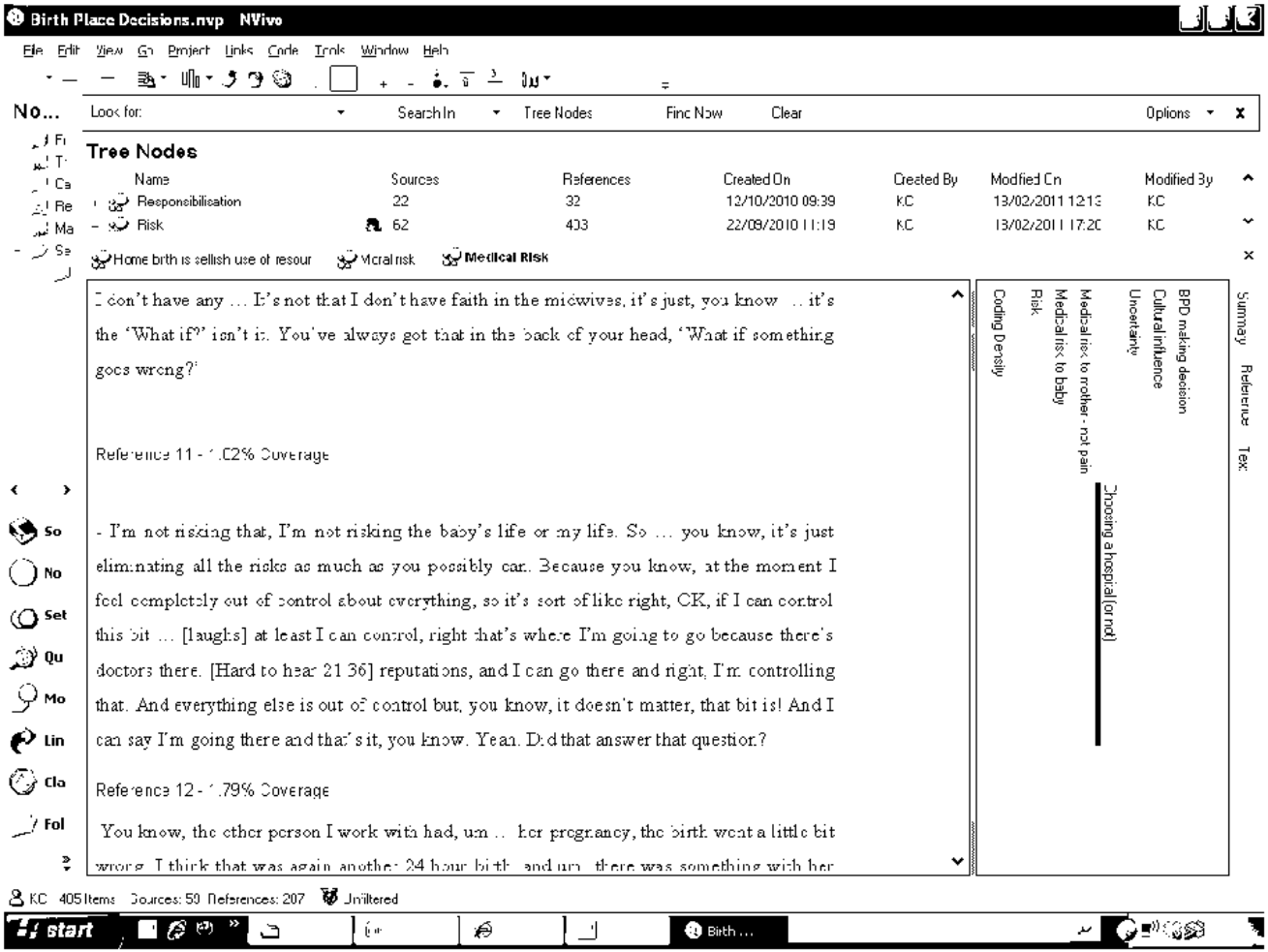
Name	Age	Parity	NS-SEC	Relationship	Ethnicity	UK born	English speaking	Graduate
Michelle	26	Second+ baby	Routine (13.4)	Single	White, British	Yes	Yes	No
Rhian	22	Second+ baby	Not working outside home	Single	White, British	Yes	Yes	No
Rosa	32	Second+ baby	Not working outside home	Cohabiting	White, British	Yes	Yes	Yes
Donald	34	Second+ baby	Managerial (4.1)	Cohabiting	White, British	Yes	Yes	Yes
Marta	26	Second+ baby	Not working outside home	Married	White, other	No	No	No
Adrianna	38	Second+ baby	Routine (13.4)	Married	White, other	No	No	No
Zofia	38	Second+ baby	Not working outside home	Married	White, other	No	No	No
Vanessa	29	First baby	Routine (13.4)	Married	White, other	No	No	Yes
Alex	28	First baby	Routine (13.4)	Married	White, other	No	No	Yes
Abi	32	Second+ baby	Intermediate (7.2)	Married	White, British	Yes	Yes	No
Donna	33	First baby	Intermediate (7.1)	Cohabiting	White, Other	No	Yes	No
Sebastian	27	First baby	Managerial (4.1)	Cohabiting	White, British	Yes	Yes	Yes

Appendix F Examples of thematic and structural narrative coding

This appendix contains examples of interview segments that have been thematically coded in N-Vivo (Part A). The first example is from an interview with Donald, who discusses his view that their home provides a safe sanctuary from the outside world, which contributes to his preference for home birth. The second example relates to coding of biomedical risks.

Part B provides an example of the structural analysis undertaken for the case study comparisons in Chapter 8.

Part A: N Vivo thematic coding


Birth Place Decisions.nvp NVivo
File Edit View Go Project Links Code Tools Window Help
Look for: Search In Tree Nodes Find Now Clear Options
Tree Nodes
Name Sources References Created On Created By Modified On Modified By
Responsibilisation 22 32 12/10/2010 09:39 KC 13/02/2011 12:13 KC
Risk 62 403 22/09/2010 11:19 KC 13/02/2011 17:20 KC
Home birth is selfish use of resour
Moral risk
Medical Risk
I don't have any ... It's not that I don't have faith in the midwives, it's just, you know ... it's the 'What if?' isn't it. You've always got that in the back of your head, 'What if something goes wrong?'
Reference 11 - 1.62% Coverage
- I'm not risking that, I'm not risking the baby's life or my life. So ... you know, it's just eliminating all the risks as much as you possibly can. Because you know, at the moment I feel completely out of control about everything, so it's sort of like right, OK, if I can control this bit ... [laughs] at least I can control, right that's where I'm going to go because there's doctors there. [Hard to hear 21:36] reputations, and I can go there and right, I'm controlling that. And everything else is out of control but, you know, it doesn't matter, that bit is! And I can say I'm going there and that's it, you know. Yeah. Did that answer that question?
Reference 12 - 1.79% Coverage
You know, the other person I work with had, um ... her pregnancy, the birth went a little bit
BPD making decision
Cultural influence
Uncertainty
Medical risk to mother - not pain
Medical risk to baby
Risk
Coding Density
Choosing a hospital [or not]
Summary
Reference
Tex
KC 405 Items Sources: 50 References: 207 Unfiltered
start
Birth ...

Part B Structural narrative analysis for comparative case studies

This document contains some early analysis which was used to develop the comparative structural analyses at the end of Chapter 8.
The structural analysis of Vita and Cecile's initial narratives was undertaken using an approach detailed by Riessman (2008, pp.93-100). The individual texts were prepared and 'parsed' (reduced) by searching for key elements which have a bearing on the overall narrative. The function of the separate episodes was analysed using Labov's terms for structural narrative analysis (from Riessman (2008) p.84). In the extract below, the following abbreviations are used:
AB – abstract (summary and or 'point' of story)
OR – orientation (detail: time, place, characters, and situation)
CA – complicating action, plot development, crisis, turning point
EV – evaluation (narrator steps back and comments on meaning/emotion: what this means to them 'soul' of story)
RE – resolution (Outcome of plot)
Coda – ending story, coming back to the present

The extract below is from a longer narrative which has been reduced to bring key sections to the fore. Each short extract is from the initial (unguided narrative section) of the antenatal interview. The line breaks represent natural breaks in the speech, and underlined words were emphasised by the speaker. The brackets indicate the length of pauses, where (.) is a short pause and (...) longer (up to three seconds). The structural analysis revealed how Vita relates the story of her previous caesarean (in Part 1) but doesn't dramatise this at all ('and then I had a C section'); this event is almost hidden in her narrative. However, she talks at much greater length about the events of this pregnancy, and trying to secure support for a home birth (see Part 2). Here, Vita highlights the emotional impact of being told that she can't have a home birth, and her own upset ('oh no! oh no!).

Vita (Initial antenatal interview)

Part 1

This pregnancy um (...)

Well I suppose obviously it relates to the previous pregnancy because of the experiences I had um during that (.) birth, and (.) we had um (.) tried for a home birth. AB

(I- *OK*).

And (..) because of [bleeding during labour], which happened relatively late CA

I had already dilated five centimetres when it happened, (I-OK)

I was on my way,

so it wasn't, you know, some super-early one that was very shocking, but still it was, obviously EV

I had to go to hospital, CA

and I had some signs of bleeding, CA

(louder) so I never got to even fill up the pool [laughs]. EV

And, we did have the home birth midwife come, OR

[midwife] came to the hospital, but [midwife] had to disappear off (*louder*),

and then I had a C section (.) (I-*OK*). CA

So I was accepting these things happen (*louder*), but (.) uuh you know

I've always thought that I would like to have things go differently if I had the chance to try again. EV

Part 2

And so when this baby came along I started thinking about it again, OR

I did (.) quite a bit of research (I-*uh-huh*) into (.) um trying to have vaginal birth after C section (I- *OK*) CA

which is what the hospital _sort of recommend now anyway_

and (.) the issue then became (.) do I (.) for me, do I have it at home, try to, do I go to hospital?

And (.) my very first experience with the midwife at the doctor's office (.) was quite negative, and she was sort of (...) OR

I mean she was very polite but she was basically saying CA

"No chance, (.) you'll never find anybody'(.) um 'you can contact the consultant if you like, but you'll be out of luck." CA

(I- *mm*)

And I was like, oh!' (laugh)

And quite So that (.) I got quite upset (.) and was emailing everybody saying, (*louder*) "Oh no, oh no!" and looking into private midwives and all the rest.

But since then, the consultants and other people I've spoken to have been (.) much more positive about it. (I-*OK*) RE

And the consultant said, 'oh well, you have to, well, you don't have to, but it's good to go to the VBAC clinic anyway and see what they think and so on'

[some text removed here]

So (.) that's _where I am. So many factors! [both laugh] It's like, _weighing everything up. RE – coda

Comparative analysis

Below is an extract from the analysis at a later stage, after I used the same approach to look at Rosa's interview, and started to make a comparison looking (here) at key thematic issues. By looking at each sequential interview in turn, I build up the longitudinal comparative analyses that are presented in Chapter 8.

	Vita Enclave (higher risk)	Rosa Isolate (higher risk)
Agency	I decided on home birth [The] first midwife said 'no chance'. But consultants and other people other people have been more positive.	They've told me I've got to go to hospital I don't have any choice

Appendix G Glossary of terms

Alongside Midwifery Unit (AMU)

NPEU Birthplace in England definition[1]: 'An NHS clinical location offering care to women with straightforward pregnancies during labour and birth in which midwives take primary professional responsibility for care. During labour and birth diagnostic and treatment medical services, including obstetric, neonatal and anaesthetic care are available, should they be needed, in the same building, or in a separate building on the same site. Transfer will normally be by trolley, bed or wheelchair'

Atypical antibodies

Often as a result of rhesus blood group incompatibility, maternal antibodies 'attack' the newborn's red blood cells, causing jaundice or in rare cases 'haemolytic disease of the newborn' (HDN).

Asphyxia

A condition caused by shortage of oxygen; in babies, used to describe lack of oxygen which if uncorrected will lead to death.

Booking or Booking clinic

Women are encouraged to book for antenatal care early in pregnancy, ideally before 12 completed weeks of pregnancy. The booking appointment is an initial consultation, usually with a midwife, that lasts about an hour. The booking includes referral for ongoing antenatal care.

[1] The definitions for AMU, FMU and OU were developed following consultation with the Evaluation of Midwifery Units research advisory group and other stakeholders, and these terms were subsequently adopted by the NPEU Birthplace in England programme of research. They are published online at https://www.npeu.ox.ac.uk/files/downloads/birthplace/Birthplace-Terms-Definitions-Report-290307.pdf accessed 25.9.11

Caseload practice

A model of service provision where antenatal, intrapartum and postnatal care are all normally provided with by a small group of midwives, so that women receive consistent care from known midwives. Such practices are relatively rare, but the model is established in some localities in the UK.

Elective Caesarean Section

When a decision is made to do a caesarean section before the onset of labour, and the surgery is pre-planned, rather than occurring in response to a clinical emergency.

Freestanding Midwifery Unit (FMU)

NPEU Birthplace in England definition: 'An NHS clinical location offering care to women with straightforward pregnancies during labour and birth in which midwives take primary professional responsibility for care. General Practitioners may also be involved in care. During labour and birth diagnostic and treatment medical services including obstetric, neonatal and anaesthetic care, are not immediately available but are located on a separate site should they be needed. Transfer will normally involve car or ambulance'.

Glucose tolerance test (GTT)

A blood test used to detect diabetes; in the context of pregnancy, the test is usually used in antenatal care to detect gestational (pregnancy-related) diabetes

Higher risk or 'complex' pregnancy

When women have, or develop, any of the risk indications listed in the intrapartum care guidelines which suggest planned birth at an obstetric unit is recommended.

Induction of labour

When labour is started artificially, through the administration of hormones to the cervix, or rupture of the membranes.

Low risk or 'straightforward' pregnancy

Women's pregnancies are classified as low risk or straightforward when they do *not* have any history of the medical or obstetric risk indications listed in the NICE intrapartum care guidelines (NCCWCH 2007) which suggest planned birth at an obstetric unit is indicated.

Maternity Services Liaison Committees

Each English NHS trust that provides maternity services has an MSLC, which is a forum for women who have used the services to meet with staff and managers and discuss their experiences of the trust, and raise any concerns about the care provided. The trust managers also present information about new service developments and invite comment and feedback.

Meconium

This term describes the dark green or brown substance which passes from the baby's bowel. Meconium staining of the amniotic fluid is associated with fetal distress, and is an indication for increased monitoring during labour (NCCWCH 2007).

Multiparous

This term denotes women who have given birth to one or more children.

Normal birth

The Maternity Care Working Party (MCWP 2007) consensus statement defines normal birth as: spontaneous labour (no induction) and vaginal birth without instrumental assistance, episiotomy or epidural, spinal or general anaesthesia.

NHS trust

A hospital, or group of hospitals, within the NHS which has self-governing status.

Primiparous

This term denotes women who are expecting their first baby.

Obstetric Unit

NPEU Birthplace in England definition: 'An NHS clinical location in which care is provided by a team, with obstetricians taking primary professional responsibility for women at high risk of complications during labour and birth. Midwives offer care to all women in an OU, whether or not they are considered at high or low risk, and take primary responsibility for women with straightforward pregnancies during labour and birth. Diagnostic and treatment medical services including obstetric, neonatal and anaesthetic care are available on site, 24 hours a day'.

Parity

Medical term denoting the number of live births a woman has had.

Perineal wound or trauma

Damage to the perineum (which includes the vagina, genitalia, and anal areas) received during birth, either spontaneously, or as a consequence of a surgical incision (episiotomy) to facilitate birth or assisted birth.

Post term pregnancy

Current NICE guidance (NCCWCH 2008) defines 'prolonged pregnancy' as a pregnancy that continues past 42 weeks. The guidelines recommend that women should be offered induction of labour between 41-42 weeks, to reduce the risks associated with prolonged pregnancy.

Retained placenta

A complication of the third stage of labour, where the placenta remains within the uterus and manual removal becomes necessary. Retained placenta is associated with bleeding and women with a history of retained placenta are thought to have an increased risk of postpartum haemorrhage (bleeding following birth) in subsequent pregnancies (NCCWCH 2007).

Third degree tear

Injury to the perineum following birth, which extends to and includes the anal sphincter.

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