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The experiences of women, midwives and obstetricians when women decline recommended maternity care: A feminist thematic analysis

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ABSTRACT

Background: pregnant women, like all competent adults, have the right to refuse medical treatment, although concerns about maternal and fetal safety can make doing so problematic. Empirical research about refusal of recommended maternity care has mostly described the attitudes of clinicians, with women's perspectives notably absent.

Design: feminist thematic analysis of in-depth, semi-structured interviews with women's (n=9), midwives' (n=12) and obstetricians' (n=9) about their experiences of refusal of recommended maternity care.

Findings: three major interrelated themes were identified. "Valuing the woman's journey", encapsulated care experiences that women valued and clinicians espoused, while "The clinician's line in the sand" reflected the bounded nature of support for maternal autonomy. When women's birth intentions were perceived by clinicians to transgress their line in the sand, a range of strategies were reportedly used to convince the woman to accept recommended care. These strategies formed a pattern of "Escalating intrusion".

Key conclusions and implications for practice: declining recommended care situated women at the intersection of two powerful normative discourses: medical dominance and the patriarchal institution of motherhood. Significant pressures on women's autonomy resulted from an apparent gap between clinicians' espoused and reported practices. Implications for policy and practice include a need for specific guidance for clinicians providing care in situations of maternal refusal, the potential value of an independent third-party for advice and advocacy, and the development of models that support reflexive practice amongst clinicians.

Introduction

The right to refuse medical treatment, held by all competent adults and unaltered by pregnancy status, is a central tenet of respectful maternity care (White Ribbon Alliance, 2011). It is well established in case law, midwifery (International Confederation of Midwives, 2008) and obstetric ethical guidance (FIGO Committee for the Study of Ethical Aspects of Human Reproduction and Women's Health, 2012), and health policy (Department of Health, 1993). However, research about refusal of recommended maternity care has focused on the attitudes of obstetricians (Cuttini et al., 2006; Samuels et al., 2007; Chigbu et al., 2009), and to a lesser extent, midwives (Danerek et al., 2011). These studies have often examined the use of court orders to authorise caesarean sections (CS) on non-consenting women, or been conducted in situations where dissenting women were refused care.

Although court intervention to authorise treatment on competent non-consenting pregnant women is almost unheard of in Australia, choice in maternity care remains illusory (Pilley Edwards, 2004), and willing and unwilling compliance with recommended care is commonplace (Thompson and Miller, 2014). When women resist the norm, safety concerns can lead to conflict, as clinicians can feel their own autonomy is challenged, or that the woman's preferred care is beyond their expertise (Perry et al., 2002). Ethical turmoil and clinicians' medico-legal concerns are well documented (Thompson, 2013; Biscoe and Kidson-Gerber, 2015). Inflexible maternity care that fails to meet women's needs has also contributed to rising rates of planned home-birth without skilled attendant (Dahlen et al., 2011; Ireland et al., 2011).

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Only a few studies have engaged women who had (Chigbu and Iloabachie, 2007; Ireland et al., 2011), or intended to (Enabudoso et al., 2011), decline recommended care in hospital settings. These studies shed light on women's reasons for declining recommended care, but not on their experiences of doing so. This silence around women's experiences perpetuates their marginalisation (Rich, 1995).

Reclaiming women's bodily autonomy is a longstanding focus of feminism (Rich, 1995), although largely centred on access to abortion and contraception (Weitz, 2003). Rich (1995, p13) distinguished between the experience of mothering as "the potential relationship of any woman to her powers of reproduction and to children" and motherhood as "the *institution* which aims at ensuring that potential, and all women, shall remain under male control." This distinction, between the experience of mothering as woman-centred and potentially empowering, and the "unequivocally oppressive" (O'Reilly et al., 2005, p9) patriarchal institution of motherhood, enabled feminism to reclaim mothering while securing women "a life, purpose and identity outside and beyond motherhood" (O'Reilly, 2007, p.802).

Woman's enculturation into the institution of motherhood begins long before childbirth, with the ideal woman defined by her status as a mother (Malacrida and Boulton, 2012). As the perception that the fetus has separate rights to the woman has grown (Pollitt, 2003), the expectation of self-sacrificial motherhood has extended into pregnancy (Bristow, 2016) and even pre-conception (Clark-Flory, 2016). Although woman-centred care has become a cornerstone of progressive health care policy, there has been a shift in obstetric concern towards the fetus such that "there seems to be a point at which the value of foetal life begins to outweigh, perhaps not so much the life of the mother, but perhaps her right to self determination, her plans and her choices" (Cahill, 2001, p. 340).

Although medical control of childbirth was (and is) promoted as being about the safety of women and babies, it was (and is) a gender-based oppression (Cahill, 2001; Diaz-Tello, 2016). The medicalisation of childbirth was predicated on the incompetence and unreliability of women, whether to birth babies or to provide care to birthing women, and led to the ascendancy of obstetrics over midwifery (Murphy-Lawless, 1998; Cahill, 2001; Fahy, 2007). Women's autonomy in childbirth has been further eroded by a culture that focusses on the short-term and trivialises women's experiences (Wendland, 2007).

In August 2010, a large tertiary hospital in Brisbane, Australia, implemented the Maternity Care Plan (MCP) policy to guide communication and documentation when women declined recommended care. The policy directs a consultant obstetrician to meet with such women during the antenatal period to discuss and document their intentions in an MCP, which is then circulated to all obstetricians and to midwifery managers. The policy recognises the woman's rights to refuse recommended care and assures them of ongoing access to care at the hospital, Our earlier studies of the MCP process found that it was used narrowly and inconsistently, and generally not created until late pregnancy, meaning most maternity care did not occur in the context of an MCP (Jenkinson et al., 2015). Also, while we found that the MCP process provided a symbol of respect for maternal autonomy, the larger forces of patriarchy and medical hegemony remained largely unchallenged (Jenkinson et al., 2016). Such findings highlighted the opportunity for a feminist analysis of the experiences of women, midwives and obstetricians when women decline recommended maternity care.

Methods

In-depth semi-structured interviews with women, midwives and obstetricians provided data for a feminist thematic analysis of interview transcripts. The study that was led by a steering committee involving the three authors, as well as obstetric and midwifery leaders from the study site. Interviews were facilitated by the first author, on some occasions jointly with the second author or another academic advisor (as part of the first author's doctoral studies). The first author is not a clinician, but has worked extensively as a maternity consumer representative and advocate in Australia. The other authors are both midwives, working in both academic and clinical contexts. The study was approved by hospital and university ethical review committees.

Table 1
Open-ended prompts for interviews.

Clinicians	Women
• What aspects of recommended care do women sometimes refuse? • How common do you think it is? Is that changing? • Why do you think they refuse? • What are your reactions or concerns when women decline recommended care?	• Tell me about your recent maternity care. • What aspects of recommended care did you prefer to avoid? Why was that important to you? • Who did you express your birth intentions to? What happened after that?

Participant selection and recruitment

The database of MCPs was used to identify potential women participants (n=52). These women's charts were audited for consent to be contacted about research, and consenting women (n=16) were invited to participate, by letter. Midwives and doctors who had provided care in the context of MCPs and obstetricians who had authored MCPs were recruited via email invitation from hospital managers and information sessions provided by researchers.

Data collection

Interviews followed feminist principles (Oakley, 1981) and were guided by open-ended prompts about refusal of recommended care (see Table 1). Transcription and preliminary analysis occurred concurrently with interviewing, and all individuals who expressed interest in the study were interviewed. Data saturation was observed in each participant group. Most interviews were individual and face-to-face. Three interviews occurred in small groups, involving 2 midwives, 2 obstetricians and 4 obstetric registrars respectively. Two interviews occurred via telephone at participant request. Interview times and locations (hospital, participant's home or community location) were nominated by participants.

Data analysis

Interviews were audio recorded, transcribed verbatim and anonymised before uploading to NVivo (QSR International, 2012) for thematic analysis guided by Braun and Clarke's six step approach (Braun and Clarke, 2006). The first and second author jointly read a selection of transcripts to create an initial coding scheme, which the first author used to code remaining transcripts, with adaptations made to accommodate new ideas. Coding proceeded iteratively, grouping related comments into themes. Further reading within themes and whole transcripts included searches for disconfirming data, and enabled themes to be clarified, with some sub-divided and others merged until stable themes were tentatively labelled and defined. All three authors independently reviewed data within each theme. Minor adaptations were made by consensus, until stable themes were agreed by all.

This study's overall goal was to informing change in maternity services, and it was therefore strategic to adapt Braun and Clarke's (2006) approach describe above by conducting two iterations of the qualitative analysis. The first iteration took a descriptive approach (reported elsewhere, see Jenkinson et al., 2016) and focussed on participants' experiences of the MCP process. That descriptive thematic analysis was not, however, intended to foreground the underlying values, attitudes and behaviours