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Tensions and conflicts in 'choice': Womens' experiences of freebirthing in the UK

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ABSTRACT

Background: the concept of choice is a central tenet of modern maternity care. However, in reality women's choice of birth is constrained by a paucity of resources and dominant medical and risk adverse discourses. In this paper we add to this debate through highlighting the tensions and conflicts that women faced when enacting a freebirthing choice.

Methods: secondary analysis of data collected to explore why women choose to freebirth in the UK was undertaken. Ten women were recruited from diverse areas of the UK via invitations on freebirthing websites. Women provided a narrative and/or participated in an in-depth interview. A thematic analysis approach was used.

Findings: we present three key themes. First 'violation of rights' highlights the conflicts women faced from maternity care systems who were unaware of women's legal rights to freebirth, conflating this choice with issues of child protection. 'Tactical planning' describes some of the strategies women used in their attempts to achieve the birth they desired and to circumnavigate any interference or reprisals. The third theme, 'unfit to be a mother' describes distressing accounts of women who were reported to social services.

Conclusion and implications for practice: women who choose to freebirth face opposition and conflict from maternity providers, and often negative and distressing repercussions through statutory referrals. These insights raise important implications for raising awareness among health professionals about women's legal rights. They also emphasise a need to develop guidelines and care pathways that accurately and sensitively support the midwives professional scope of practice and women's choices for birth.

Introduction

A central tenet of modern maternity care in developed countries is that of 'choice' (World Health Organisation, 2005; International Confederation of Midwives, 2014). This concept arose through the 1990s from an interaction between political, feminist and consumerist cultural shifts, which have become firmly embedded within the rhetoric of modern healthcare (Beckett, 2005; McAra-Couper et al., 2011). The concept of choice explicitly asserts that women have the right to make autonomous decisions about their maternity care thereby creating a move away from the passive woman under 'expert' decision makers to a partnership model in which women's needs and preferences are central to decision making (Midwifery, 2020, 2010; The Royal College of Midwives, 2012; International Confederation of Midwives, 2014). It also includes the right to decline care even in life threatening situations (McAra-Couper et al., 2011; Birthrights, 2013c). In many countries the concept of 'choice' has been formalised through: legislating women's rights to autonomy (United Nations, H.R. 1999, Birthrights, 2013c); governmental policy (US Department of Health and Human Service, 1997; DH, 2010; Goldbord, 2010; Public Legal Education and Information Service of New Brunswick, 2015) and evidence based healthcare guidelines (World Health Organisation, 2005; World Health Organisation, 2014; NICE, 2014).

In the UK, since the 1990s a particular focus of policy (DH, 1993; DH, 2007; DH, 2010) and guidelines (Maternity Care Working Party, 2007; RCOG, 2013; NICE, 2014) has been to offer more choice and access to various birth settings (i.e. home, hospital, birth centres). Evidence highlights that for healthy women, out of hospital birth is safe and associated with positive outcomes

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such as increased vaginal birth rates, reduced medical interventions and increased maternal satisfaction (Brocklehurst et al., 2011; Burns et al., 2012; NICE, 2014). However, the UK 2014/15 birth statistics (Health and Social Care Information Centre, 2015) demonstrate that 87% of women birth in hospitals, 11% in birth centres and only 2% at home, depicting current norms and an inequity of service provision. Findings from the NCT (2009), the Birthplace study (Brocklehurst et al., 2011; McCourt et al., 2011). Royal College of Midwives (RCM, 2011) and the Maternity Services review (NHS England., 2016) describe various factors that contribute to the inequity of homebirth provision and birth centre availability across the UK. These include local trust resourcing, staffing levels, organisational structures, on call demands, midwives lack of confidence, lack of management support and negative attitudes by the obstetric team. Within this context, critics argue that 'choice' is socially constructed, politically constrained and often inequitable (Beckett, 2005; McAra-Couper et al., 2011; Budgeon, 2015). It is suggested that the combination of dominant medical and risk averse discourses, within a technocratic culture of maternity care super-values certain choices over others, creating hegemonic birth practices (Kitzinger, 2005; Walsh, 2009; McAra-Couper et al., 2011).

A birth choice that sits outside of the 'norm' (i.e. a hospital birth) is freebirthing, sometimes referred to as unassisted birth (blinded for review). Freebirthing is characterised as an active decision to birth without trained health professionals present but where maternity care is readily available (Nursing and Midwifery Council, 2013). Concerns surrounding safety for mother and infant (Nursing and Midwifery Council, 2013), misconceptions about its legality (Birthrights, 2013d) as well as safeguarding for the fetus (Birthrights, 2013b); make it a controversial birth choice. Its subversive nature not only challenges hegemonic birth practices of both the medical and midwifery model of birth (Dahlen et al., 2011; Jackson et al., 2012; Edwards and Kirkham, 2013; Feeley et al., 2015), it also brings the rhetoric of choice under scrutiny.

Literature concerning the phenomenon of freebirthing has primarily focused upon why women choose to freebirth. A meta-synthesis (blinded for review) of qualitative studies undertaken in USA (Freeze, 2008; Brown, 2009; Miller, 2009) and Australia (Jackson et al., 2012) identified common motivations to freebirth including: a rejection of the medical and midwifery model of birth, a previous distressing/traumatic birth experience, obstructions to homebirth provision and a lack of trust in maternity services. Due to a lack of insights into this phenomenon from a UK perspective, we undertook a study to explore why UK women chose to freebirth. While similar issues to those reported in the meta-synthesis were identified (blinded for review), what also emerged was the tensions and conflicts that women experienced when enacting their freebirthing 'choice'. In this paper we report on a secondary analysis of the interview data to provide new insights into how a maternity system that offers a rhetoric of choice is experienced as coercive, fearful and imbued with negative reprisals.

Methods

Design

For the original study, a hermeneutic (interpretative) phenomenological approach was used based on Heideggerian and Gadamerian philosophical hermeneutics (Koch, 1995). Hermeneutic phenomenology is an approach that interprets the phenomena in question, with the premise that all description is already an interpretation and that every form of human awareness is interpretative (van Manen, 2011; van Manen, 2014). Fundamental to this approach is that hermeneutical phenomenology does not seek new knowledge rather it seeks to uncover and express an understanding of the experience as it is lived (Koch, 1995; Smith et al., 2010).

The purpose of a secondary analysis is to answer different research questions of the same data (Long-Sutehall, Sque et al., 2010), which may illuminate a new perspective or a different conceptual focus to the original research (Heaton, 1998). It is a widely used approach in both quantitative and qualitative research (Long-Sutehall et al., 2010). The original research sought to explore the phenomenon with a broad research aim: 'Making sense of childbirth choices; the views of women who have freebirthed'. The two types of data collected – an unstructured written narrative and follow up interview - generated rich and complex data. In the first paper published from this study we focused on answering the research question 'Why do some women choose to freebirth in the UK?' (blinded for review). For the secondary analysis, we focused on untold aspects of the participant experiences to emphasise the conflicts and tensions they faced when enacting their freebirth choice.

Sample

A purposive and snowballing sampling method was used to recruit women to the study during September 2014. Known freebirthing websites were approached and consent was obtained to advertise the study. Women who had freebirthed in the UK, were over at 18 years old and were English speaking were invited to participate. All participants were provided with an information sheet, password protected email consent form, and consent gained via email and verbally. Recruitment ended when no further participants came forward.

Data collection

Data collection comprised of two methods, an unstructured written narrative by the participants and/or a telephone interview carried out by the first author. Both methods involved participants being asked to describe their views, experiences and motivations of choosing to freebirth.

Participants

Participant characteristics have been published elsewhere (Feeley, Thomson, 2016). To summarise, 10 participants were recruited into the study; nine completed an unstructured narrative and 10 participated in an interview. The majority were Caucasian, the age range was 25–42 years, all were either married/living with a partner and all had higher education qualifications; six held degrees, with seven women continuing their education at the time of interview. Seven participants were in employment when the study was undertaken. Geographically, the women lived in different locations, thus their local maternity service trust differed for each woman. Collectively, the participants had experienced 15 successful freebirths during 2006–2014, with no adverse perinatal outcomes.

Ethics

Ethical approval was obtained from one of the ethics subcommittees at the second author's institution, and an amendment was approved in January 2015 (project number: STEMH 208). In order to ensure anonymity, a pseudonym has been used when reporting participant quotes.