Request, Resistance and the Rhetoric of Choice

UK Women’s Experiences of Expressing Nonnormative Choice in a Complex and Fearful Maternity System

Background

Informed choice is a central tenet of a woman-centred, human rights based respectful care framework. Enshrined in the UK through iterations of strategic healthcare policy and legal precedent. Tacit assumption of expected compliance with recommended interventions across the childbearing continuum exists, associated with social, cultural, and institutional norms. International evidence exists that both explores narrow phenomena-based experiences and decision making for ‘out with’ guideline care or rejection of social and cultural norms (i.e., freebirth, induction of labour, home birth against medical advice, maternal request caesarean section) and clinicians facilitating out of guideline care. UK women’s voices remain largely absent in the literature in relation to understanding broader scope nonnormative choices. Furthermore, a lack of knowledge exists encompassing experiences of making nonnormative choices and associated interactions with a fearful and complex maternity care system under the influence of a challenging socio-political environment. This poster presents the initial and emerging narrative findings of a wider study aiming to explore these experiences.

Aims

- Explore experiences of women making non-normative choices in pregnancy and childbirth.
- Explore why and how participants constructed choices and how the navigated maternity systems to achieve them.
- Develop a theoretical understanding of the conditions and mechanism affecting the experiences.
- Expose the underlying social processes that therefore underpin decision making and assertion of choice.

Preliminary Findings

Choices made reflect a nuanced combination of psychologically and physiologically protective measures to preserve a highly individualised reproductive identity.

Many viewed choice as a ‘illusory’ as they either were not offered a choice or when they declined or withheld consent, clinicians did not have the knowledge or tools to be able to facilitate the choice being exerted:

"...there was no language of choice, and there was no sense that there was anything to do with kind of self-determination or feeling positive that there could be a physiological outcome"

(Justina)

Most interactions with the system were negative with a range of reactions from clinicians, designed to coerce, dismiss challenging choices and gain compliance.

Some of these interactions included confrontation and overt violence:

"...the doctor came over and she demanded access to my vagina...I refused to comply with coached pushing and the doctor said, ‘...we need to deliver this baby, you’re in serious danger...’ and I said if there was an emergency I consent to a caesarean, if there is not I would like an epidural”

(Imogen)

Nonnormative mode of birth choices rarely made in isolation, rather with a build up of micro-choices during the pregnancy which, when not respected, influenced future withdrawal from the system.

There was evidence of positive and facilitative interactions with clinicians and the system, however these were few. Most reflected that positive interactions came about resultant of continuity of carer and shared philosophies.

Methods

- Constructivist Grounded Theory
- Data were collected from October 2021 to September 2022
- Recruitment via social media including Facebook, Twitter and Instagram shared by gatekeepers in closed and restricted groups to which the researcher had no access.
- Interviews conducted via MS Teams and Telephone lasting between 45-90min

Participants

- n=13 (Purposive theoretically sampled)
- Birthed within or alongside the ‘system’ within last 5 years
- Wales, Scotland, England and Northern Ireland
- Socio-economically diverse
- Mixture of Cultural and Ethnic backgrounds

Discussion

These data represent initial and emerging narrative findings within the context of a wider study aiming to theorise social and psychological processes associated with nonnormative choice making. Despite the rhetoric of informed choice and individualised care, the extent to which nonnormative choice can be exerted within the UK and how these episodes of care are experienced is influenced by complex biopsychosocial and institutional factors, leading to widespread variation from facilitative to obstructive encounters with the system. It is hoped that these findings will, alongside existing understandings of individually separate and distinct phenomena will inform future development of policy and improve guidance to support clinicians to support similar choices in the future.

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References