A Narrative Inquiry into the Experience of Decision-Making about Place of Birth.

By

Susan Lynn Prendergast

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Abstract

Birth decisions have a significant impact on the physical health of a woman and her child as well as to a woman's mental and emotional health. Healthy low-risk women who birth with a physician in a hospital have statistically significantly higher odds of having interventions like augmentation and epidural. Labour interventions statistically significantly increase the risk that women will require an assisted or surgical birth. Interventions during birth, and surgical birth, significantly increase a woman's risk for infection, difficulty breastfeeding, incontinence, and mental health problems during the postpartum period. Despite this, the majority of women in Canada choose to birth in hospital. The purpose of this project was to bring forward the experience of decision-making about place of birth. *Narrative Inquiry*, as developed by Clandinin & Connelly, is the methodological approach that underpins this work. It was chosen because it utilizes story shared in conversation as the foundation for co-created research text. Through the process of completing this project, common threads emerged. Participants brought forward story about the influence of the childbirth culture; about experience as influence; and finally, about the influence of others to their decision-making about place of birth. These threads are suggested as integral commitments for birth care providers, as well as health system design professionals, to ensure that health and experiential outcomes for pregnant and birthing women are positive or even, transformational.

Preface

This thesis is an original work by Susan Lynn Prendergast. The research project, of which this thesis is a part, received research ethics approval from the University of Alberta Research Ethics Board, Project Name “Decision-Making about Place of Birth”, No. Pro 00076332, October 27, 2017.

Dedication

This thesis is dedicated to my husband, without whom I would not have started, or finished, this project. Your unrelenting support of my passions and pursuits along with your willingness to do whatever is needed at home, has made it possible for me to continue on this journey and for this, I thank you.

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Reader's Guide

This dissertation was undertaken to bring forward the stories of women as they make decisions about place of birth. It's a project that is very close to my heart; I have walked alongside hundreds of women as they weigh this decision, and my role has been varied. I've been the trusted friend, the newly chosen provider, the supportive professional in the mess left by physician, and the woman making the decision for herself. All of these experiences have impacted me and influenced me to become the person, partner, healthcare provider, and mother that I am. And just like every other woman who is pregnant and navigating the healthcare system in Canada, my decisions about my own child's birth, and the path that I took to make that decision, was influenced by my life experiences, my goals and dreams for the birth of my child, the socio-cultural-political environment of the time, and by people. It is this process and experience of uncovering the influences of multiplicity in one's life, of past, present, and future, that I hope to illuminate.

I begin this dissertation by telling my story (chapter one). My narrative beginnings are the impetus and personal justification for this research and as with all *Narrative Inquiry* work, is integral to situating the research (Clandinin, 2013). I then move forward by positioning the project in the socio-political, and practical justifications (chapter one). The socio-political justifications are rooted in the reality that women's experiences of pregnancy and birth often develop from a place of vulnerability. The practical justifications unfold from the need to better understand what and who influences women as they make decisions about place of birth, so that birth care providers can better support, educate, and walk alongside women.

The methodology [*Narrative Inquiry* developed by Clandinin & Connelly (2000)] as well as the methods utilized to bring this work forward, are described in chapters two and three. From

there, the narrative accounts of four women, as they made decisions about place of birth, are shared (chapter four). Each narrative account is presented similarly; the stories and memories that each woman chose to bring forward, have been written reflectively and co-created with my reflections interspersed.

Coming to the decision to write the narrative accounts in this way caused me significant worry. I was very concerned that my thoughts, opinions, and wonderings would influence or change the threads, pattern, and final product of this work. Working through this, considering and reconsidering the purpose of bringing these stories forward, laid alongside the powerful meaning making that occurred in the field, I have come to understand the value of co-creation of research text. As such, each narrative account is presented in a separate section to represent each woman's unique and individual experience.

The threads that were revealed through the process of unraveling the field texts and weaving the co-created research texts, provide the foundation for chapter five. The dissertation ends with a discussion about how this work might impact nursing (chapters six and seven).

There are significant tensions in this work; the most prominent of which is that of the presence of power in relationships between provider and woman. This power, and the struggle that I felt by naming it as such, is at times palpable. I feel the need to recognize this and to highlight it, rather than apologize for it. My standpoint[1] as a woman, a mother who has given birth in the hospital versus where I had chosen, and a health care provider who is forced to navigate power relationships to stay employed, is obvious. But my standpoint also offers me a

[1] I acknowledge that the concept of standpoint can be understood in multiple ways. I have been highly influenced by the writings of Nancy Hartsock and Sandra Harding specific to feminist standpoint theory whereby it is understood that knowledge is socially situated; marginalized groups are situated in ways that make it possible for them to be aware of and ask questions compared to those who are not marginalized; and finally, that research that is focused on power relations should begin with the marginalized (Bowell, T., 2020).

unique perspective from which to consider, reflect, and talk about decision-making with women. I hope that this tension does not overshadow the experiences of the strong women who have shared their time and their story

Chapter One: Justifications for this Research

Personal Justifications (Narrative Beginnings)

Abandoned

We arrived at the radiology center excited to find out whether we were pregnant with one or two babies. We had had our invitro fertilization (IVF) transfer of two blastocysts done 10 weeks prior and I had been feeling fairly well – some mild nausea and a bit of bloating but the positive blood test results had told us that the process had been successful. This had been our first round of IVF, but I had only produced three viable ova. Luckily, all three had fertilized and although three were very few, they were more than zero! If this first attempt at transfer hadn't worked, we only had one blastocyst left. Nevertheless, I was confident that our pregnancy would give us our baby (or babies if we were lucky) – finally after all of these years. I lay on the exam table feeling anxious and excited. The technician was allowing me to watch the ultrasound as I had told her I was a family nurse practitioner (NP). As she brushed the wand across my stomach so gently, I could visualize my uterus. It took me a few seconds to recognize that there was nothing in it – there was no grey sac holding my precious babies. There was just blackness representing the empty space of my womb. In my mind I was saying over and over again "but I'm pregnant – I can feel it – they must be there". And then I saw him. His heart was happily beating away in his tiny little body. He was there – alive. I started to celebrate but then noticed the radiologist glance at me with this frantic look…it felt like time stood still. I knew in my heart before I could fully comprehend logically that my baby was in the wrong place. When the wand moved again, the screen showed my uterus and then slowly, the fallopian tube and then there he was. I heard a loud cry and realized that I had screamed out. "NO"! I sat up covering my face with my hands as I broke down with the knowledge that I was going to have to kill my baby to

survive this pregnancy. I was sobbing. I could hear the technologist mutter about going to get my husband as she shuffled out. Seconds later my husband rushed in unknowing to the grief that he would suffer as a result. I fell into his arms as the radiologist explained to him that our pregnancy was ectopic. There are several minutes in that room that I cannot recall – probably because I was completely overwhelmed with thoughts of what was going to happen next. I know that the staff felt bad for us – their faces and postures reflecting their knowledge of what we had been through and what we had yet to face. And then my husband and I were alone in the room where we had received the news that our dream had become a nightmare. We didn't speak. I slowly dressed and I could feel him close to me – his energy hovering as though he was afraid to touch me. I turned to him and looked into his face to hear him say, "we'll try again". As we walked in the long dimly lit hallway that would lead us to our next destination, I recall feeling as though I was in a tunnel going down into the earth. The ceiling was low, and the walls were dark. The hallway seemed to go on forever. Thinking back on it today, I don't remember anything else except the deep sense of foreboding. I knew with every step down that passage, that the months ahead would be the most difficult in my life. Our dreams for our family were about to end, and there was nothing either of us could do.

We arrived at the hospital and were brought into a hospital room. I was given the bed beside the window. It was a beautiful day and the sun was streaming in on the bed casting a warm light inviting me to rest. I stood. I couldn't sit. If I sat on that bed it would make the entire nightmare real. Eventually, the nurse returned and in the fewest words possible, was successful in getting me ready for surgery. I must have succumbed to the bed because the next thing I knew I was being wheeled down the hallway toward the operating room (OR). We went down to the basement level in the elevator. The porter was an older woman who didn't say much, and I recall

thinking that the silence of this experience was going to kill me. I lay there willing myself not to cry.

I was left in the hallway waiting for someone. Again, I was told nothing – the porter just wheeled me alongside the wall, put on the brake and walked away. I waited for what seemed like hours.

I was crying uncontrollably by the time the nurse came to my side. She held my hand, introduced herself as Jane, and said "I'm so sorry that this is happening to you". "I understand that you've been trying for a baby for several years and your baby is ectopic – is this right"? I sobbed and said yes, that I was going to lose my baby today. Jane held my hand and wiped my tears as I cried. She stayed with me until it was time to go into the OR and she was the last person that I saw before I was put under.

I remember being aware that I had woken from surgery when I was back in the hospital room beside the window. It was nighttime and the lights were dimmed in the room. The curtain was drawn to separate me from the woman in the next bed. I was so sore, and I remembered with a jolt that my baby was gone.

The entire night and into the wee hours of the next morning, I saw a nurse once. Once. I rang the bell for medication several times and no one came. At one point, I rang the bell hoping that the nurse would come and help the woman next to me. She was crying all night and she was getting telephone calls where she would explain over and over to the people on the other end of the line that she couldn't have any more children. I wondered what had happened to her. Did she have a hysterectomy following a postpartum hemorrhage? Did she have cancer? I felt so badly for her, but I wished that she would just stop talking. She wasn't the only one suffering.

The next morning, I called my husband and told him that I was discharging myself. I had had enough of my neighbour's tears and I needed to be at home. I rang again for the nurse, but no one came.

My husband arrived within the hour. He had to help me with my catheter – it hadn't drained all night because it was kinked. That explained the severe pain. I had already discontinued my IV myself, so I changed, and we were at the nurse's station signing discharge papers 10 minutes later.

I didn't return to my much-loved career for a long time after my experience losing my baby. I had worked before that day, as a family nurse practitioner supporting and walking alongside women and their families as they prepared for and became parents. I just couldn't do it anymore after that. I also felt very wronged. I hated nursing and knew that if I went back to practice, my anger would eventually affect my relationships with my peers. I was devastated by the fact that nursing had let me down in the most basic of ways. As a patient I had been treated horribly when my entire career I had given the best of myself every day to ensure that my patients would feel supported, cared for, attended to, educated, and even loved. I had held dying babies in my arms because their parents couldn't do so, only to carry the images of their little bodies with me for the rest of my life. I had worked through breaks and dinners and held my pee for hours upon hours, to ensure that my nursing peers were not left with the burden of my patients to care for on top of their own. I had done all of that because that's what nursing meant to me. Nursing was about walking alongside, being in relation with my patients. It was more than a job and it was certainly more than a place to hang out in the judgment of others, behaving as though everyone and everything was a burden so that I could take home a pay cheque. I had truly

cared and given of myself, and I knew that I couldn't go back to doing that after how I had been treated in the hospital over those two days.

It's been 12 years since we lost our baby and those nurses abandoned me. I am still angry about it. Many of the decisions that I've made about my career and my personal life have been in direct consequence to my experience at my local hospital. I've become an educator who is known by her students to "stand on her personal soap box to espouse the benefits of relational nursing practice in women's health" (student feedback 2013). I'm the woman who went on to choose a midwife and home birth, even though I was told I was high risk. I am the woman who directed the hospital birth that I so did *not* want, loudly and aggressively to ensure that I would remain in control of my experience. I am the nurse practitioner that women seek out for health care support because I listen, care and partner with them in their efforts to be well when others won't take the time.

I will never allow myself to be the nurse that abandoned her patient. And I do everything I can to ensure that my students see the power that they will hold as nurses. But I also do everything I can to ensure that my patients, friends, and family understand that they can decide to play an integral role in their experiences with the healthcare system.

Choosing a Birth at Home

The first few months of my second (and last) pregnancy something felt very off – that is the only way that I can describe it. We were beyond excited to be pregnant and thankfully this time our baby had implanted normally. There was of course, a lot of trepidation in the first few weeks because of our experience last time but also, because this precious little person would be our last chance at having a child – he was the last blastocyst. The fact that we'd even become pregnant was a miracle, as this last blastocyst had been frozen for over a year.

The feeling that something was off had more to do however, with the care we were receiving. My husband and I had been persuaded to select a physician to care for us during our pregnancy even though in my heart, I had wanted to move back to New Zealand and the care of a midwife. I had trained as a midwife in New Zealand and wholeheartedly trusted the system and my peers there. In Edmonton, pregnancy care providers were known to rush through appointments and be less than relational with their clients. This was exactly what we were experiencing, and we had thought we had chosen wisely!

Having worked alongside our chosen care provider for more than three years, I had been confident that she would be the right fit for us. It's different when you're the patient though…the 10-minute appointments are insufficient and the waiting in the waiting area for more than two hours to see her was ridiculous. The worse part was the fact that she had her hand on the doorknob of the clinic room for the majority of our appointment, almost as though she was waiting for the opportunity to make her escape.

My husband was the one to finally name our issue – we needed a midwife. We went against the advice of our fertility physician by choosing a midwife and planning a home birth. Yet, our midwife had no reservation about our potential for a successful vaginal birth at home and so far, our pregnancy had been healthy and normal. Besides my age, I was the perfect candidate for a home birth. Our physician, however, felt that because we had struggled for so long to get pregnant and because of our experience with our last pregnancy, that we were unwise to "push our luck". I couldn't believe that he chose those words especially considering our experience. How could he think that we would want to birth in a hospital after being completely ignored during our loss? How could he think that I had any trust in my nurse peers to support my husband and me after our last experience?

Our midwife was amazing. She supported us and walked alongside us every step of the way – exactly as I would have had our roles been reversed. Our midwife became our partner and our friend. I truly trusted her and knew that whatever transpired, she would have my back.

We had gone through a lot in our life as a couple with our struggles with infertility and our loss amongst others. Our midwife gave us her time, her attention, and her love. She supported us in identifying the things that we needed to address in our marriage and our lifestyle before we brought our baby home. She supported me in identifying the sources of my anxiety so that I was approaching our son's birth with confidence and love rather than fear and doubt. Our relationship with our midwife was so very important to our experience and to our success in bringing our son earthside.

There were other reasons for our choice to birth with a midwife at home. My husband and I believe in the ability of the human body to nurture and heal itself. As we were spending years trying to get pregnant, my husband was always the one that questioned what we had to do to my body to achieve our goal. He worried about me during our fertility treatments and would have given up if I had of said I didn't want to do it any longer. My husband was also the person who encouraged me to chase my dream of becoming a midwife. He gave up his job in Canada to move with me to New Zealand so that I could study in the most midwifery-friendly country in the world. He often acted as my *birthing woman* as I studied and practiced my new skills. I once asked him what he thought about not continuing with our physician provider and he said that he "could catch our baby – he'd practiced enough"!

There are so many reasons that midwifery was the right choice for us. Even though as a nurse in my early career I had cared for the sickest and smallest babies born in the hospital, I had also been the birth care professional who had been privileged to catch dozens of other babies

born healthy at home. As a couple we have found peace in a more organic purpose; living as minimalist and health focused as our urban lifestyle allowed. As individuals, both my husband and I have questioned the world around us, and we continue to do so as a couple. I truly believe in the body's ability to give birth and I feel strongly that midwives should be involved in every woman's pregnancy and birth regardless of risk.

This is our story – but it is only a small part of how we came to the decision we did. Both my husband and I came to our pregnancy with a lifetime of experiences that have influenced how we think, reflect, live, and make decisions.

With every pregnant woman that I meet, I wonder what it is in her life that has brought her to the decisions that she has made. What is it that influences women to make the decision to birth in one place over another? How do a woman's life experiences influence her beliefs about her body, about pregnancy and about birth, and what or whom do women turn to for information and support in achieving the birth that she desires? These wonderings are what have brought me to this project.

Socio-Political Justifications

The Critical Nature of Multiple Influences

The transition to motherhood has been pronounced as sacred (Sandelowski, 1995). It is a transition that is difficult to describe because of its complexity and embodied reality. The transition to motherhood starts for some women years before pregnancy is achieved. Children may role-play being a mother, and as these young children grow into adults, the ideas and thoughts developed during play contribute to their understanding of motherhood (Lowe, 2002; Munro et al., 2009). As with motherhood, understandings of birth cultivate from a person's life experiences of watching other mothers and children; of reflecting on their own and their

partner's family experiences; and of living with the attitudes and stories shared by family, friends, in the media, and by birth care professionals (Lowe, 2000; MacLellan, 2015; Maier, 2010; Munro et al., 2009). But the realities of birth and motherhood are often made more complex by the multiple and often unrecognized influences of culture, politics, power, and social inequalities that put many women in a situation of vulnerability (Maier, 2010; Rayment-Jones et al., 2015).

Reflecting on the social determinants of health (Mikkonen, & Raphael, 2010) and the concept of vulnerability (Briscoe, Lavender, & Mcgowan 2016), I suggest that the vulnerability that occurs during the birth continuum is a significant factor that influences decision-making and which must be addressed in clinical relationships, research, healthcare policy, and system design to ensure equitable access to care and positive health outcomes for women and their babies regardless of place of birth.

To bring forward the socio-political justifications for this research, I start by presenting what is known, as well as identifying the gaps specific to how women go about making decisions about *place* of birth. I chose to focus on place of birth decisions specifically, because of the significance that place of birth has to many women (Davis et al., 2011; Hutton et al., 2009; Janssen et al., 2009; Shaw, 2013). Also, place of birth is often the first decision a woman makes about her birth and it can have a significant impact on her pregnancy and birth experience (Davis et al., 2011; Ebert et al., 2014; Hodnett, 2002; Lowe, 2000; Lowe, 2002; Rayment-Jones et al., 2015).

What Do We Know?

Birth decisions have a significant impact on the physical health of a woman and her child as well as to a woman's mental and emotional health. Healthy low-risk women who birth with a

physician in a hospital have statistically significantly higher odds of having interventions like augmentation and epidural (Davis et al., 2011, 2011; Reitsma et al., 2020). Early admission to hospital and labour interventions statistically significantly increase the risk that women will require an assisted or surgical birth (Abasian Kasegari et al., 2019; Davis et al., 2011; Rota et al., 2018; Tracy et al., 2007). Interventions during birth and surgical birth significantly increase a woman's risk for infection, difficulty breastfeeding, incontinence, and mental health problems during the postpartum period (Henderson & Redshaw, 2013; Hobbs et al., 2016; Karlstrom et al., 2013; Soet, 2001; Souza et al., 2010a; Villar et al., 2007; Zaers et al., 2008).

In contrast, the current empiric literature establishes the innumerable benefits of physiologic birth to women, babies, families, and the health care system. A few of these benefits include lower rates of infant admission to the NICU (Fallah et al., 2011), higher breastfeeding rates (Thompson, Kildea, Barclay, & Kruske, 2011; Watt et al., 2012), lower rates of intervention (Davis et al., 2011; Reitsma et al., 2020), lower rates of postpartum depression (Bland, 2009; Zaers et al., 2008), and decreased costs to the system (Schroeder et al., 2012; Tracy & Tracy, 2003). Further, offering women choice in place of birth, has allowed researchers to highlight the importance of having control over decision-making as an important factor in why many women wish to move away from hospital-based birth (Bland, 2009; Cook & Loomis, 2012; Davis et al., 2011; Hutton et al., 2009).

Research exploring women's decision-making about place of birth has revealed that women make place of birth decisions (home versus hospital) in a pragmatic way; by weighing out the risks associated with birth and the positive and negative aspects of place of birth options (Gebrehiwot et al., 2012; Murray-Davis et al., 2012a; Viisainen, 2001) including ease of access, access to provider of choice, comfort and familiarity of the location, and access to pain relief

options (Grigg et al., 2015; Hollowell et al., 2016; Sluijs et al., 2015). Women consider the personal meaning of their cultural and familial traditions as well as their faith when making decisions about place of birth (Gebrehiwot et al., 2012).

Multiple other sources of influence are also described in the literature as having an impact on a woman's decision about where to have her baby. Family, friends, and healthcare professionals have been shown to have a significant bearing on a woman's perspective about what she wants from her birth (Carlton et al., 2005; Clark et al., 2015; Ebert et al., 2014; Fontein-Kuipers et al., 2017; Hinton et al., 2018; Lowe, 2002; Rayment-Jones et al., 2015; Simpson et al., 2010; Sluijs et al., 2015). Stories that others share through conversation, and particularly through the media about their experiences of birth are highly influential to women's knowledge about birth and her decisions (Hinton et al., 2018; MacLellan, 2015; Munro et al., 2009). Some authors have suggested that reality television and social media perpetuate the medicalization of childbirth and strongly affect a woman's ideas and values specific to birth (Luce et al., 2016).

The concept of safety (from death or harm) has become predominant in the birth literature as well as in the media in recent years (Hollowell et al., 2016; McCauley et al., 2019; Regan & McElroy, 2013; Sluijs et al., 2015; Woog, 2017). Safety is often conceptualized as a dichotomy with medicalized hospital birth on one side, and home and physiologic birth on the other (Davis-Floyd, 1994; Ebert et al., 2014; Maier, 2010; Shaw, 2013). Medicalized birth is publicized as safe because it provides access to emergency and specialized care for both the woman and her baby. In contrast, a birth centre or home birth is touted as safe in that it offers women more control over decisions resulting in her being able to avoid unwanted and unneeded interventions (Grigg et al., 2014a; Grigg et al., 2015). The debate about this dichotomy is constant with one side of the dichotomy portrayed as safer. The debate is rarely about options,

but about one side winning over the other and being championed as the 'best' option. As women make decisions about place of birth, they can become entangled in the strongly held opinions of others who have also been influenced by this dichotomy; often leaving women feeling judged by the decisions that they come to (Ebert et al., 2014; Hodnett, 2002; Holten & de Miranda, 2016; Maier, 2010).

Care provider attitude about birth is demonstrated in the literature as having an impact on women's decision-making about place of birth (Clark et al., 2015; Cook & Loomis, 2012; Ebert et al., 2014; Hodnett, 2002; Holten & de Miranda, 2016; Rayment-Jones et al., 2015). Care provider attitude has been shown to manifest in the type of information provided (or withheld) during prenatal appointments and in the type of relationship that is established with women (Cook & Loomis, 2012; Ebert et al., 2014; Rayment-Jones et al., 2015). It can also result in a distinct bias in the provider to offering birth support in only one place (hospital or home) and even more concerning, in the manner with which power is shared (or managed) over decisions during a pregnancy (Carlton et al., 2005; Ebert et al., 2014).

Even though there is a paucity of literature about the impact of relational aspects to women's decision-making, the few studies that have explored this concept have demonstrated the significant difference that continuity of care provider and advocacy can have on experiences and outcomes (Clark et al., 2015; Hollowell et al., 2016; Kroll-Desrosiers et al., 2016; Longworth et al., 2001; Rayment-Jones et al., 2015). When women feel that they can trust their provider and feel safe, outcomes are more often positive (Carlton et al., 2005; Ebert et al., 2014; Hodnett, 2002; Maier, 2010). The need to feel safe to be oneself, and to honestly disclose personal contextual circumstances with one's birth care provider is highly appreciated by women (Ebert et al., 2014). Feeling listened to, feeling valued by the care provider as responsible and

knowledgeable about one's own needs and experiences, and being able to trust one's care provider to follow through with one's wishes, are a few of the key factors that have been emphasized as important to a woman's sense of power to make decisions about birth (Briscoe et al., 2016; Carlton et al., 2005; Cook & Loomis, 2012; Ebert et al., 2014; Maier, 2010).

Whether through social or professional interaction, people influence women as they make decisions about where to have their baby. Pragmatics can influence a woman's decision-making about place of birth as can her ideas about birth. Her personal values, which are always developing and evolving as she lives her life, will influence her decisions (Coxon et al., 2017; Hinton et al., 2018; Murray-Davis et al., 2012a; Viisainen, 2001). But a woman's contextual circumstances and her cognitive, emotional, and psychological capacity to make and be confident in the decision also play a role in this process (Grigg et al., 2015; Noseworthy et al., 2013a). Consequently, as a woman navigates the birth continuum, she is vulnerable to a complex interplay of influences both from within and external to herself.

Vulnerability

The idea that pregnancy and birth is a time of vulnerability is not new. Several countries have identified vulnerability as a key consideration in maternity care system design to reduce maternal mortality and improve women's wellbeing (National Maternity Review, 2016). If women are less vulnerable to risk (physical, psychological, social), outcomes of pregnancy and birth will be better for families and the system.

Recently there has been more clarity around the concept of vulnerability specific to the birth continuum. Through concept analysis, Briscoe et al., (2016) have developed a middle-range theory that is rooted in a belief that: "women are vulnerable when they experience 'threat' from a physical, psychological or social perspective, where 'barriers' and 'reparative' conditions

influence level of vulnerability" (p. 2338). This definition comprehensively captures the multiplicity of influences that women navigate as they make decisions about place of birth and on through the pregnancy and birth continuum.

Defined in this way, we are forced to recognize that vulnerability across the pregnancy and birth continuum is rooted in multiple complex factors including threat (that results from physical, psychological and sociological risk), barriers (lack of accessibility and healthcare professional attitude) and repair (rooted in healthy positive relationships and health care provider skill) (Briscoe et al., 2016). Although it is beyond the scope of this project to examine each of these factors in-depth, I feel it is important to recognize that *sociological risk* is the consequence of the interplay across multiple factors termed social determinants[2]. For many women, their social determinants put them into a situation of inequity related to pregnancy and birth because it influences their access to, and use of, healthcare services. Inequities act as barriers to learning and knowing about options for place of birth. Inequities can also create barriers to understanding written information about pregnancy and birth, understanding one's rights in decision-making, being able to access support, and so on. When considered in this manner, it becomes evident how a woman's sociological risk can influence her decision-making across the pregnancy and birth continuum by putting her into a situation of potential harm. I must also acknowledge however, that threat can be mitigated by reappraisal, self-determination, increased support and increased control (Ritchie, 2004). Hence vulnerability should not be confused as incapacity.

Vulnerability is not experienced as a result of one factor. Women are vulnerable across the birth continuum because they come to this continuum having lived a life. Each woman

[2] The social determinants of health are; income and income distribution, education, unemployment and job security, employment and working conditions, early childhood development, food insecurity, housing, social exclusion, social safety network, health services, Aboriginal status, gender, race and disability (Mikkonen & Raphael, 2010).

carries with her, the stories that she has lived with about birth, framed by her personal experiences living her life in a social, cultural, and physical environment. Each woman comes to this continuum, and to making decisions about place of birth, as a woman. Her gendered self, influences how she perceives and interprets the options available to her (Martin, 2003). As well, her experiences of living as gendered, also influences how she reacts and responds to the barriers placed in front of her. Some feminist researchers have suggested that internalized identities of gender constrain women to conform to socially and culturally defined behaviors and ways of being; that women 'do gender' (West & Zimmerman, 1987). As such, some women are socialized to being relational, selfless, caring, polite, nice, and kind at times, at the expense of their hopes and goals (Martin, 2003). This is especially true during pregnancy and birth where decisions are being made that have the potential to affect outcomes not only for the woman but her baby and family.

Decision-making is a socially constructed concept that reflects both cultural and social norms (Pilley Edwards, 2004). Options are made available to women within a socio-cultural-political frame. Options carry value – there are socio-cultural-political determined benefits and risks associated with each option. When a woman chooses the option that is favored, a 'good' choice is made. This is in contrast to the 'bad' choice that comes from deciding in favor of the alternative. For women making decisions about place of birth, the risk of being blamed for poor outcomes that result from making the 'bad' decision is often at the forefront of her mind (Coxon et al., 2014a). Considered in this way, most, if not all women come to place of birth decisions (and all birth decisions in fact), vulnerable to influence. For those women who are navigating the pregnancy and birth continuum in a situation of threat, the degree of vulnerability is amplified.

One's degree of vulnerability across the pregnancy and birth continuum can also be influenced by the birth culture. The current birth culture is rooted and functions in a hierarchical and patriarchal medical system that treats pregnancy and childbirth as medical events where interventions and treatments are touted as a way to control for possible negative outcomes (Council, 2013; Davis-Floyd, 1994). The medicalized birth culture makes the system complex and barrier ridden for those women who are wanting more personal control or, to birth away from this influence. As an example, alternative place of birth options are not made available, are not accessible, or birth care providers other than physicians are not funded despite out of hospital birth with non-physician providers having demonstrated similar outcomes for healthy women experiencing a healthy pregnancy (Council, 2013; Davis et al., 2011; Hutton et al., 2009; Janssen et al., 2009; Murray-Davis et al., 2012a; Reitsma et al., 2020). Unfortunately, funding models for birth care providers still favor the medical model, making it difficult and sometimes impossible for women to access alternatives. Through the process of providing biased funding, and supporting patriarchal healthcare systems, politicians and policymakers put women in situations of vulnerability.

What are the Gaps?

Through their work, Brisco et al. (2016) have been able to highlight the inconsistencies in the literature specific to definitions of vulnerability that have influenced the research. They have identified that "complexity in women's daily lives is often hidden in research" (p. 2338). I believe that decision-making about place of birth is highly complex, is often multi-factorial, and may be complicated for some women by multiple competing influences.

Coxon et al., (2017) as well as Yuill et al., (2020), each offer a conceptual model that highlights the complexities, uncertainties, and I would argue, opportunities that influence women

as they make decisions about place of birth. Although it is beyond the scope of this project to intentionally apply these models to the current study, it is important to acknowledge that considering the extant and emerging literature as a whole has provided me with the opportunity to turn my gaze toward a better understanding of the experience of decision-making about place of birth.

Practical Justifications - Why this Study?

As demonstrated, the literature is only beginning to reveal how women go about making decisions about place of birth or, about how life experiences influence decision-making. When women are living the experience of decision-making do they feel strong, confident and secure or, do they feel vulnerable? How do the physical changes of a woman's pregnant body and the interactions that she has with her environment and the people around her influence her experience? How do women go about thinking on the upcoming birth of their child? To whom do they turn for advice? Which stories do they consider as they ponder their options? How do they finally come to decide where, with whom and how they will make this sacred transition? What limitations or barriers do women experience personally, socially and culturally to making decisions about birth? Questions such as these inform my research puzzle. These questions are important, as the story that they bring forward may allow women, researchers, and birth care providers to understand more fully, the role of individual experience, values, and circumstances to decisions about place of birth. These sorts of questions may reveal specific influences, concerns, needs, and barriers that women encounter and navigate as they approach this sacred transition. The stories that they bring forward will certainly help us, as clinicians, researchers and policy makers to appreciate, understand and respond more appropriately to the women in our community and perhaps more positively influence outcomes for these families.

I believe that a multitude of factors influence women's decision-making about place of birth including the woman's life experiences (that are socially and culturally considered), her knowledge about each option, access to the resources that will allow her access to options, her vulnerabilities, and by her cognitive, emotional and psychological capacity to make a choice. This research puzzle was therefore focused on a complex and very personal process and requires a methodological approach that brings forth the stories of life, and how the woman's life experiences have brought her to where she is today.

Because of the lack of clarity in the literature, in our understanding of place of birth decision-making as a process, and the complexity of decision-making about place of birth, I have taken a different approach to explore this phenomenon. I believe that understanding the multiple influences on women's experience of decision-making requires a methodology that has the potential to create a new sense of meaning for women and researchers. This methodology should make visible the life experiences, stories, and dreams of women as they move toward a particular birth option as well as the strengths, vulnerabilities, barriers and supports that are meaningful to their decision-making journey. As such, I chose to utilize *Narrative Inquiry*, as created by Clandinin & Connelly (2000). This methodology has allowed me to research alongside women as they make decisions about place of birth, and to bring forward life experiences that have played a part in their decision-making.

Chapter Two: Narrative Inquiry

Narrative Inquiry as Methodology

Narrative Inquiry is both a methodology and a phenomenon (Clandinin & Connelly, 2000). It is an approach to research that allows the researcher and co-participants to bring forward experiences from their past, whilst living the moment. It is a way in which co-participants can reflexively consider the impact of past events and stories and knowledge on their experiences today. It is also a way in which the researcher can uncover, understand, and create new meaning about experience for the purposes of better supporting, improving or changing systems, processes or environments.

I chose *Narrative Inquiry* as the methodological approach for this project because I believe that story and narrative are an effective way to bring forth the "present of the past, the present of the present and the present of the future" (Crites, 1971, p. 301) so that it may be understood and considered by another. Only the narrative form of experience "…contains the tensions, the surprises, the disappointments and reversals and achievements of actual, temporal experience" (Crites, 1971, p. 306) and it is through story, that people "make sense of their existence" (Caine et al., 2013, p. 576).

The ontological commitment of the *Narrative Inquirer* to enter into ordinary experience (Dewey, 1934) alongside and with co-participants, shapes each stage and the entire process of a *Narrative Inquiry*. And the relationship between researcher and co-participant becomes the foundation for and from which the *Narrative Inquiry* unfolds (Caine, Estefan & Clandinin, 2013, p. 576). In the pages that follow, I will bring forward the philosophical underpinnings of *Narrative Inquiry* but as well, the key features of *Narrative Inquiry* and the multiple meaningful considerations specific to this project. I will then report about the steps taken (methods) to

rigorously co-create this narrative inquiry alongside women as they made decisions about place of birth.

Philosophical Underpinnings of Narrative Inquiry

Experience and Pragmatism

Narrative inquiry allows the researcher to study experience. Clandinin & Connelly's *Narrative Inquiry* argues for a Deweyan view of experience. This pragmatic view is rooted in three commonplaces (principles) including temporality, continuity and interaction (Downey & Clandinin, 2010). This view of experience is what allows the narrative inquirer and co-participants to make meaning of experiences today and across a life.

Experience influences experience. Whatever experiences are in one's past, influence the way in which one interprets experiences today (Dewey, 1938). This is the case with everything in life including decision-making about place of birth. Every woman comes to their childbearing years having been influenced by their past experiences which are lived in a social environment filled with others who also live with experience. The complexity of these multiple intertwined, and sometimes unrecognized influences is what women sift through as they make decisions about place of birth.

But it is more than sifting through individual experiences. Like each experience singly, one's "life itself is something temporal that unfolds in time and whose phases are surveyed prospectively and retrospectively from within an ever-changing present" (Carr, 1991, p. 75). I suggest that living life as pregnant, is a time when women (and their loved ones) view their life in new ways. They consider their past experiences through a different lens. A lens which is intimately wrapped around another, in particular, the child. Reflecting on one's own life and finding coherence, value, purpose, meaning and making crucial decisions whilst in that space can

be heavy, daunting work. But this work is made even more complex because decision-making during pregnancy involves other people and places. This decision-making occurs in context and alongside and with others.

Experiences occur in a time and place, to an individual who is influenced by their environment as well as their past and present. As the environment changes, or as the place changes, so does the individual's experience and comprehension of that experience. Experiences, thoughts, decisions, and actions are all lived under the influence of the past, present and future. *Temporality* of experience is one of the key Deweyan principles from which Clandinin and Connelly's *Narrative Inquiry* has been developed.

Dewey's principle of *continuity* further enhances our thinking about experiences across a life. Situations that occur, and that individuals experience, are constantly changing. There is movement from one moment and situation to the next, and this movement is continuous. "Different situations succeed on another" (Dewey, 1938, p. 384), and continuity describes the fluid movement of parts of each situation being "carried over from the earlier to the later" (ibid). This process goes on as life goes on, and we take parts of our past into the present and future with us.

Finally, Dewey's principle of *interaction* enriches our understanding of how each experience is influenced by what has happened before and also, by what is happening now. As an individual continues to move through life, reflecting and thinking and learning about the past, experiences change us. As we interact with our experiences, we are influenced and our thoughts, reflections, and even memories are changed. A person's interactions throughout their life bear on what occurs today and, how it is experienced today. Further, the experiences of today influence what will happen in the future (Dewey, 1938).

It is for the purpose of attempting to understand the phenomenon of life through storied experiences, events and actions that *Narrative Inquiry* is undertaken. "Narrative inquirers start with experiences as expressed in lived and told stories" (Clandinin & Connelly, 2000, p. 40), and consider these stories in a pragmatic way; as temporal, interactive and continuous.

The Power of Story

> People shape their daily lives by stories of who they and others are and as they interpret their past in terms of these stories. Story, in the current idiom, is a portal through which a person enters the world and by which their experience of the world is interpreted and made personally meaningful. Narrative inquiry, the study of experience as story, then, is first and foremost a way of thinking about experience (Connelly & Clandinin, 2006, p. 375).

Story is the vehicle through which experiences in one's past are brought forward to the present. When women talk to each other and they tell their birth story, they talk of the interventions available in the hospital that can offer freedom from the pain of childbirth; they talk about their ability to avoid labour (with elective Caesarean Section), and they talk about the care they received from their birth care provider. Women also tell stories about birth at home and how it can give women back control over their experience; that it allowed them to experience the magic and meaning of physiologic birth (Klein et al., 2006). The stories that women hear, see, and embody "shape, in the most profound way, the inner story of experience" (Crites, 1971, p. 304). Stories impact people's views and thinking, they push us to consider our own experiences through a lens that has been coloured by the stories of others. These stories are socially embedded; reflective of the context or landscape within which they occurred, are told and considered (Caine et al., 2013; Crites, 1971; Huber et al., 2006). Stories and experience are

things that you carry with you the rest of your life, to reflect on, learn from, and with which futures are imagined.

The stories that other people share about their experiences influence us but, they can also change us. As I recall the stories of decision-making about birth told throughout my career by women, I recall stories of fear and trauma but also of intense love; these stories have influenced my perspective and my understanding about decision-making both personally and professionally. As I continue to listen to others' stories and think about my own experiences laid alongside the experiences of others, my perspectives, thoughts, ideas, and understandings change. My interactions with others' stories change my experience.

Change is a constant in everyone's life. As each moment passes and events occur, we are no longer the same as we were the moment before. Through our interactions with others and our thinking about the past, living the present, and pondering the future we are changed (Bateson, 1994; Coles, 1985; Geertz, 1995). Understanding how experience influences individual growth, change and decision-making is what this particular methodology allows the *Narrative Inquirer* to bring forward.

Interpretive Frame

Each of us is the author and principal character of our life story (Carr, 1991). We choose which life experiences we share with others; we have the ability to reflect, consider and determine action based on experiences in the past and present; and we have opportunities to make decisions about our future. But there are boundaries or limitations set or that frame experience and story. In fact, all experiences occur amongst other people and, in a particular place. It is the influence of others (sociality) and of one's environment (place) that often goes unrecognized. *Narrative Inquiry* is rooted in pragmatism but as well, it requires the "narrative

inquirer attend to a three-dimensional narrative inquiry space in which experience is understood as comprising temporality, sociality and place" (Smith, Estefan & Caine, 2018, p. 513). Within this space, each story lived and told and relived, is situated and understood within the larger cultural, social, familial and institutional narratives.

It was with a commitment to considering experience as rooted in the past, always changing and interacting but as well, influenced by others and by place, that this *Narrative Inquiry* was undertaken. Like other projects that have utilized this methodology (Dewart et al., 2020; Kubota et al., 2019) this unique approach to research has provided us, as co-participants, the opportunity to tell our story as a way to bring about understanding of the experience of decision-making about place of birth. Further this methodology allows us to live, relive, tell and retell experiences while in the present; considering the meaning of experiences from our past and examining their influence and the power that that reflexivity can provide.

Relationship

Understanding experience requires time, trust, and relationship. As a listener of stories and *Narrative Inquirer*, I cannot truly understand what a participant's experience is about because it is theirs alone. As such, our living and reliving together over time, and in-relation, allowed us to co-create meaning and understanding (Caine et al., 2013). It was only through a steadfast commitment to the relationship and to the methodology and method of *Narrative Inquiry* that I came to more fully understand how each woman's "present of things past, present of things present and present of things future" (Crites, 1971, p. 301) has influenced her decision-making. And further, how the transactional space within which she interacts and lives her life alongside others, has brought her to the present.

Creating understanding in the midst of the relationship between researcher and co-participant requires us to be playful with story. As I listen to the other tell a story, I need to hear the words, process the meaning, see the story taking place in my mind, feel the sensations, smell the scents, and so on. A story requires the listener to put together what happened. Because there are no two people who have had the same experience (each person's experiences are embodied alongside a lifetime of other experiences), I can never expect to fully and completely understand another's experience. The story that I hear is filtered through my very personal and unique memories and relies on my personal and unique imagination. But with *Narrative Inquiry*, the story is imagined, discussed, reflected upon, revisited and co-created in relation. Our understanding of how experiences influence our present and our future "…does not come instantaneously, or quickly, or by engaging in clever analysis. Instead, our understanding deepens as we retell and relive our lived stories over time, place and social contexts" (Cain et al., 2003, p. 581). By telling and retelling together and in relation, we are, in a sense, framing and reframing the meanings of the experience then and now in the changing contexts of life.

Caine & Steeves (2009) describe the process of creating an "in-between space" that offers the promise of imagining together whilst also being, growing, changing and playfully remembering as allowing us to create understanding about experience. This in-between space created by researcher and co-participant, although bound by relational ethics and complex lives, is what allows the *Narrative Inquirer* to explore and understand lived experiences through narratives and stories (Caine & Steeves, 2009, p. 9).

The process of doing *Narrative Inquiry* research has grown out of a commitment to not only the philosophical view of pragmatism or the interpretive frame of temporality, sociality and

place but as well, on several ontological commitments. These commitments have been named by Clandinin & Caine (2013) as qualitative touchstones.

Doing Narrative Inquiry

Touchstones

Qualitative touchstones, as described by Clandinin & Caine (2013), were utilized during this project as a way to test or mark, the quality of this work. The twelve qualitative touchstones were also a guide or roadmap for me as researcher, to ensure that I remained wakeful as I lived narrative inquiry research alongside the co-participants as they made decisions about place of birth. In the section that follows, I describe my commitment to the qualitative touchstones.

1.Relational Responsibilities. *Narrative Inquiry* research requires co-participants (researcher and participants) to share narrative inquiry spaces (in-between spaces) that are "always marked by ethics and attitudes of openness, mutual vulnerability, reciprocity and care" (Clandinin & Caine, 2013, p. 169). These spaces allow for and foster relationships. Relationship is essential to how participants come to know each other and to understand each other (Craig & Huber, 2007). It is in these spaces and within the relationship that women reveal and bring forward the stories of their life. "Relationship is the key to what it is that narrative inquirers do" (Clandinin & Connelly, 2000). It is the foundation from which *Narrative Inquirers* can "attend to lived, relived, told, and retold stories of experience … and to craft our always negotiated research texts" (Caine et al., 2013, p. 576). Hence, it is our responsibility as *Inquirers*, to honour the woman and the relationship upon which we rely.

A strong *Narrative Inquiry* requires one to be wakeful to relationships with participants. Relationships are vulnerable to multiple influences both within and outside the control of those involved. They require time, patience, and genuine engagement and they don't always work. So

for the *Narrative Inquirer*, Clandinin and Connelly advocate that "... they try to come to their inquiries and to the persistent tensions and concerns that emerge from a relational point of view…in much the same way that we consult our consciences about the responsibilities we have in a friendship…" (Clandinin & Connelly, 2000).

Remaining wakeful to relationships with participants in a *Narrative Inquiry* space requires one to commit to relational ethics (Austin, 2006; Austin, Bergum & Nuttgen, 2004) (Bergum, 1994). The thread of relational ethics should weave through the entire research endeavor; from negotiating how participants will come together in the narrative inquiry space, to how the final research texts are made public. There should never be a moment when commitment to the woman and relationship is not at the forefront of the *Inquirer's* mind. This may come at the expense of the 'good' story (Caine et al., 2013, p. 583); it may come at the expense of the project; but it is essential to the trusting relationship that will facilitate storied experiences to be shared and narrative to be co-created.

Relational ethics also requires of the *Narrative Inquirer* to be wakeful to what the research process has the potential to do to participants. By this, I mean that asking questions, sharing perspectives, and considering stories together "might call forth or shift attention in new and unsettling ways" (Caine et al., 2013, p. 578). As we listen to the stories of the other, "we catch resonant threads that call up our own internal journey" (Downey & Clandinin, 2010, p. 392). Resonant remembering[3] has the potential to bring forth memory that is unpleasant, difficult, and risky to a participant (inquirer or informant) and it is to this, that the inquirer must be wakeful.

[3] Resonant remembering is a term used by Clandinin (2009) to describe her own memories that resonate from stories brought forward by others.

Women come to pregnancy with a lifetime of experiences that will influence her decisions about place of birth. How these experiences influence a woman to make a choice about her place of birth is what I hoped to understand through my *Narrative Inquiry* research. The process of looking backward and forward, reflecting, and pondering over and over until time and thinking eventually move a woman to a decision is important to understand. It is through a commitment to relationships with participants that I have had the opportunity to comprehend it more fully. It is within this relational space, where I was listening and sharing with a woman about life experience and future possibilities, that stories of a life have been shared, and field texts evolved and developed into co-created research text. Hence, being responsible about and wakeful to relationships with participants added to the rigour and validity of this narrative inquiry.

2.In the Midst. The relationships that we negotiate and enter into as co-participants occur in the midst of lives being lived. Both the researcher and the participant are carrying out and going on with their personal and professional lives; "lives that are enacted within institutional, social, cultural and political narratives" (Clandinin & Caine, 2013, p. 170). These narratives influence how and what stories are shared but also, the ways in which stories and reflections are considered and shaped over time. It is with understanding that we are meeting in the midst, that relationships are negotiated, attended to, entered and exited from.

3.Negotiation of Relationships. Entering into relationship with a co-participant must be negotiated just like the purpose, intent and ongoing process of the research needs to be negotiated. And as the relationship develops over time and whilst researcher and co-participants are in the midst, this relationship will change. Though our intent "is to enter the relationships with participants as researchers, participants come to know and see us as people in relation with

them" (Clandinin & Caine, 2013, p. 170). At times we may be called upon to live out professional responsibilities or to share practical knowledge or social positioning. This reality brings forth the reminder that co-participant relationships must always be guided by relational and professional ethics.

As I spent more time and was in-relation with participants, living and reliving, telling and re-telling our stories, we changed. This continuous negotiating of the relationship whilst living research in the midst of our own and our shared lives provided each of us as co-participants with the space to explore and playfully imagine experiences but as well, grow and change. The relational space also provided us with the opportunity to consider and begin to create relational, social and political change simply by doing this work together.

4.Narrative Beginnings. My own stories of experience act as personal justification for this project. "Because narrative inquiry is an ongoing reflexive and reflective methodology" (Clandinin & Caine, 2013, p. 171), I am required to continually inquire into my own experiences as the *Narrative Inquiry* unfolds. This process of reflexive and reflective inquiry is used to help readers and audiences understand the research puzzle but as well, the findings of the research (ibid).

5.Negotiating Entry to the Field. There are two separate and different starting points for entering the field (engaging in the relational inquiry space); listening to participant stories told through conversations or living alongside participants. I chose to undertake this *Narrative Inquiry* and entered the field through the use of conversation. Moving in and out of the lives of women as they lived their pregnancies and were making decisions about their birth required negotiating entry and exit from the field repetitively throughout the process of the inquiry. However, it also offered us as co-participants, the opportunity to exit our relationship and

consider and reflect upon our conversations. Re-entering the field and the relationship with that time in between allowed us to bring those reflections back to our conversation for further analysis.

The time spent in the field, in places, and in-relation called forth stories. The social, cultural, familial and institutional narratives that we are each embedded in but also, experienced together in relation, acted as beginning points for living and telling stories. These narratives also forced us to attend to the ways in which individual narratives are influenced by people, place, time and environment. By entering and exiting the field over and over, across the relationships, I was able to write field texts, interim and final research texts reflective of time alongside, but also separate, from the co-participants.

6.Moving from the Field to Field Texts. Field texts (known in other methodologies as data) were composed from conversations, reflections and participant observations. As relational spaces were negotiated and as we became part of events together, a variety of field texts that demonstrated diversity in topic were collected. Field texts took form as notes but also, as reflections and wonderings. Over time and across a variety of conversations in different places at different points in each participants' pregnancy journey, these field texts began to take the shape of interim texts.

7.Moving from Field Text to Interim and Final Research Text. When story is shared in conversation, going back and forth about the experience enhances one's understanding. The process of telling and retelling but as well, living and reliving story in-relation, and across time, deepens and widens one's understanding. The multiple field texts that are created and recreated lead to interim and final research text.

Through this process of telling, living with and retelling, numerous and varied influences work on the stories, and the field texts. As well, the stories and field texts were intentionally considered and attended to in the three-dimensional inquire space of temporality, sociality and place. Over time and in-relation, whilst both in and outside the field, meaning making occurred and the interim texts were created.

Interim texts were "the beginning place of attending to the research puzzle, and a place to begin to make meaning of the field texts" (Clandinin & Caine, 2013, p. 172). Interim texts were shared with participants as they developed, and meanings were revealed through conversation.

The final research texts were written whilst attending to the personal, socio-political and practical justifications. Writing the final research texts and specifically, the narrative accounts, was the most difficult part of the research process. I felt a great deal of pressure in my responsibility to reflect the truth of each co-participant whilst also attending to the multiple viewpoints, perspectives and narratives that we were living, had experienced, and would continue to navigate.

A narrative inquirer's "representations arise from experience and must return to that experience for their validation"(Clandinin & Rosiek, 2007, p. 39). As such, the representations must be co-created and I, therefore, relied upon co-participants' contemplation over time, and from multiple perspectives, for representations to come together. "Stories do not fall from the sky, nor can they simply be plucked from a research transcript. *Narrative Inquirers* understand "data as field texts that are to be experienced as they are lived and told as narrative compositions" (Caine et al., 2013, p. 579).

The movement of field text to interim and final research texts is what brought stories and experiences to life. The process was guided by the relationships I had negotiated with each participant and as well, through a rigorous commitment to the methodology and to experience.

8.Representing Narratives from the Three-Dimensional Space. Attending to the interim research texts from all three dimensions of the narrative inquiry space allowed the complexity of the experience of decision-making about place of birth to become visible. In fact, the process of considering and thinking about stories and text from each viewpoint made the fabric of experience become very detailed. I was unable, for a long time, to see the threads that contributed to the intricate patterns of the patchwork that was created through the process of completing this project, and I found myself stifled with the manner in which the dimensions and narrative influences were knotted together.

Over time and in-relation with the co-participants as well as my relational response community (described later), I was able to unravel and separate the threads sufficiently enough to identify the dominant threads. But I am reminded every time I revisit the narrative accounts, the threads, and my own reflexive contemplations, that the final research texts are never meant to be final answers (Clandinin & Caine, 2013). I did not come to this research with a particular question but a drive to understand. Hence, this project was more about stimulating readers into thinking, telling and retelling their own stories about decision-making and, to guide my action toward creating growth and change personally, professionally and even systemically.

***9.Relational Response Communities*.** Seeing with clarity how stories of experience are being interpreted and shaped throughout the research endeavour is essential to a strong (and hence valid) *Narrative Inquiry*. Being able to see with clarity is difficult, because the researcher always comes to the narrative inquiry space with their own life story, and with the justifications

for the research at the forefront of their mind. Relational response communities ["ongoing places where researchers can give accounts of their developing work over time" (Clandinin & Connelly, 2000, p. 73)] enhance rigor and validity as they act to remind those living in the midst of *Narrative Inquiry* research of their influence, impact, interpretation and perspective. Relational response communities, especially if "composed of interdisciplinary, intergenerational, cross-cultural, academic and non-academic members" (Clandinin & Caine, 2013, p. 173), can act to challenge those living in the midst of narrative inquiry research to consider the other and their experience in multiple different ways as well, to be responsible and responsive to their unfolding inquiry (Clandinin & Caine, 2013). "It is through a response community that narrative inquirers are often reminded to engage in [the] interplay and iterative process, to inquire into, and to revisit field texts, to address issues of personal, practical, and social significance, and to inquire into new research puzzles" (Clandinin & Caine, 2013, p. 174). Committing to my relational response community as well as remaining wakeful to relationships with the participants and their stor*ies* has directly influenced the validity of the work.

10.Justifications. I have already put forward the justifications for this work, but I feel it important to highlight that identifying and clarifying justifications is considered a touchstone of *Narrative Inquiry*. The process of imaging the justifications at the outset of an inquiry and then revisiting these justifications throughout the inquiry, ensures that the need or goal of the researcher does not supersede that of the relationships, the methodology, or development of disciplinary knowledge. Further, ensuring the research is justified in multiple ways helps to ensure that new methodological, personal, socio-political, and disciplinary ways of knowing are explored.

***11.Attentive* to Audience.** Attending to the unfolding interim and final research texts from both participant and scholarly/public viewpoints is another touchstone of *Narrative Inquiry*. It is this touchstone that I found most difficult to navigate as I found myself balancing two sides of the narrative - one side as birth care provider and advocate, and the other as researcher and academic. It was in this 'balancing' space that I struggled most with how to represent my own personal and professional stories and wonderings for the purposes of completing the inquiry whilst also remaining committed to the emotional safety of the participants and to our relationships.

While research texts are negotiated between researcher and participants, researchers also owe responsibility to the scholarly community and must compose research texts that answer the questions of "so what?" or "who cares?". It is this dilemma of being committed to two outcomes that I struggled with most.

12.Commitment to Understanding Lives in Motion. Undertaking a *Narrative Inquiry* requires the researcher to enter the research in the midst of the life of the participants and in the midst of one's own life. As our lives continue to unfold and the research unfolds as well, it becomes clear that there is never a final story. This is made very clear when one considers *Narrative Inquiry* as a methodology rooted in Deweyan pragmatism, ontologically rooted in the understanding of experience as occurring in the three-dimensional space of temporality, sociality and place.

Stories are shared, texts are created, and time moves forward. As already established, the sharing and creating that has occurred then influences and changes us; from our changed perspectives then, the stories we tell in the future will be different and reflective of our most recent experiences. Understanding that we are representing stories shared as lives are in motion

is an essential understanding; it allows the researcher to move forward with our work but also, "continuously inquire into the fabric, pattern, and threads of experience as people continue to become" (Clandinin & Caine, 2013, p. 176).

This project is a written representation of experience. Its co-creation relied upon the relationship within which experience was originally shared but also, on the ongoing relationship within which the representation developed. It required the co-participants to consider experience in the three-dimensional space of temporality, place, and sociality in order that new understandings could be brought forward. It also required the guidance and challenges provided by the qualitative touchstones.

> "To think about quality in narrative inquiry is to think about multiple commitments. The most significant commitments and obligations are methodological and relational commitments. As with other methodologies, it is important to show commitment to a methodology, which involves extensive reading, engagement with other scholars and, in narrative inquiry, it also involves an extensive commitment to writing as a way to inquire" (Clandinin & Caine, 2013, p. 178).

Narrative Inquiry as a methodological approach to examining particular phenomena has the potential to bring forward the truth about that phenomena. The truth will not be wholly generalizable but "narrative inquirers embrace the power of the particular for understanding experience and using findings from research to inform themselves in specific places at specific times" (Pinnegar & Daynes, 2007). For understanding women's experience of decision-making about birth, *Narrative Inquiry* was the best way to reveal and bring forward the complexities of the muddling (as described by Dewey, 1902 in Downey & Clandinin, 2010) that occurs as one

moves toward decision, and it has provided a meaningful process to more deeply understand how one's life experiences influence decision. The stories of a life in the midst that have resulted from remaining wakeful to relationships with participants and their story, has allowed co-creation of a narrative representation of how particular women have come to decisions about place of birth. A commitment to the twelve touchstones has brought both rigour and strength to this very worthy endeavour.

Chapter Three: The Methods

Narrative Inquiry as a research methodology and approach to bringing forward the experiences of co-participants, is unique in its openness and flexibility. It creates a space for conversation between co-participants (researcher and participant) to explore stories and experiences. There is no prescribed method of recording beyond that which is comfortable for co-participants; there is no required number or type of 'interview' but rather, allows the relationship between researcher and participant to unfold and determine the path of interaction, sharing, reflecting and recording.

The twelve qualitative touchstones of *Narrative Inquiry* (described previously) are essential commitments that fashion the direction and rigour of *Narrative Inquiry* as a method. These touchstones and commitments were central to the co-creation of this project.

Meeting Women who are Pregnant

Recruitment

Purposeful recruitment was utilized for this project as it was thought the best way to engage women who have chosen different places for their birth (hospital, home, birth centre) and women who are willing to commit to the *Narrative Inquiry* process.

Recruitment posters were placed at public locations that pregnant women frequent, including the West Primary Care Network (PCN) physician's offices, Edmonton Southside PCN physicians' offices and the Lucina Birth Centre. An online recruitment poster was also utilized on my personal and professional *Facebook* pages as well as on the Lucina Birth Centre's webpage.

Participants

Four[4] women who were pregnant (in their first trimester at the start of the project) and experiencing a healthy pregnancy volunteered as co-participants in this project. All of the co-participants are Caucasian and between the ages of 32 and 45 years of age. Three women were primiparous whilst one was planning for her first birth in Canada. Finally, all women involved in co-creating this project have previously completed a master's level education and were employed as professionals earning >$100,000.00 annually.

I feel it is important to note, that I received multiple inquiries from women who were interested in being involved in this study, but each had recently given birth. When I asked as to why they were hoping to be involved even when the recruitment poster stated that participants needed to be currently pregnant, all expressed a need to tell the story of their birth. They talked about how their experiences having a birth in hospital will influence decisions for any future pregnancies. This is very important as it affirms for me that having a lived experience of pregnancy and birth can have a significant impact on women and their decision-making about place of birth.

Turning Toward Participants

Each woman who participated in the co-creation of this work is unique and has lived her unique life. As such, the path toward getting to know each participant was guided by the unique needs of each participant. For most conversations, I met in a neutral location so that we could enjoy a relaxing drink together. I spoke with Lisa and Michelle (pseudonyms) via social media in between our formal conversations as both women wished to keep me informed of their thoughts, reflections and pregnancy milestones. My relationship with Jennifer (pseudonym) was more

[4] Narrative Inquiry as developed by Clandinin and Connelly advocates for only a few participants in order for the researcher and each co-participant to develop relationship over time and through sharing experiences. This methodology generally utilizes three or four participants but relationships that grow over long periods of time.

formal in that our conversations were limited to face to face. In contrast, I was welcomed into Sarah's home and was fortunate to meet her partner and Luca (pseudonym).

The relationships that developed with each co-participant were different and determined the frequency with which we talked as well as how and where. For example, I spoke with Michelle and Sarah at least weekly over the course of their entire pregnancies; conversations were not always focused on their pregnancy or about their decision-making but certainly allowed our relationships to extend beyond the *Narrative Inquiry*.

I chose to remain in conversation with only one participant at a time in order to allow myself the opportunity to truly focus on each woman's stories and experiences. Because of this decision, the conversations took more than 24 months to complete.

Co-Creation of this Work

The process of co-creating the narratives and narrative threads was both challenging and exciting. As participants' stories and reflections were shared and were laid alongside my own experiences, understanding was uncovered, and new questions and reflections were revealed. The stories and reflections shared in conversation were at times, recorded. In fact, the first conversation with each participant was recorded and transcribed whilst subsequent conversations with participants involved creation of field notes.

The creation of field text for any *Narrative Inquiry* is an iterative and interpretive process whereby text, grounded in the field experiences of telling, retelling, and reflecting, is created. Creation of field text for this project was done by both participant and researcher and involved several kinds of field text including conversation and reflection, notes taken in the field, and journaling. The opportunity to journal was provided to each participant but none decided to contribute in that manner; hence, journaling was done solely by the researcher as a way to

consider, unwind and unravel the stories, experiences, and influences. Stories, experiences and influences were considered intentionally from multiple perspectives and reconsidered continuously to ensure that my stance, experiences and biases were not overshadowing the realities brought forward by the participants.

Completing this *Narrative Inquiry* research alongside women as they made decisions about place of birth, has allowed me to bring forth stories of lives lived. As co-participants told stories of their past and present, the complex weaving of influences was revealed. Each co-participant told me how the lives of others have brought them to their understanding of what birth is and could be; how the beliefs of the people closest to them have made their initial thoughts about birth clearer or, foggier; and how the responsibilities of becoming a mother to their baby nudged them along a particular path.

As we, the co-participants, told our stories, we also spent time reflecting on them together, and on our own. Over time, and in relation, we came to a fuller understanding of how the past, the present, and the expectations for the future, as well as the meaning that decisions have to us, as women, but also, to others outside of us, has influenced what we have chosen. It was through relational reflection on experience in a metaphorical three-dimensional space (thinking about experience as both personal and social, as part of one's life both present and past, and also as continuous across time along a changing landscape influenced by context) that the co-created stories emerged.

The process of moving from field text to final research text was difficult because of the fact that the medicalized childbirth culture permeated every story and experience that was brought forward by the co-participants of this project. This dominant narrative was so strong that I found it challenging to unravel the multiple threads of influence. However, over time, in

relation with each participant and, with the support of my relational response community, the research texts (narratives and narrative threads) were shaped.

Relational Ethics & Responsibilities

The twelve qualitative touchstones that Clandinin & Caine reference for the purpose of "testing the excellence or genuineness" (2016, p.169) of a *Narrative Inquiry* remained at the forefront of my mind during this work. I have described all of the touchstones previously as each touchstone is embedded into, and an integral component of a rigorous and strong *Narrative Inquiry*. However, one of the most important touchstones for me to highlight is the commitment to the women, their stories and experiences, and to our relationships.

At every stage of this project, I was cognizant and mindful that conversations and experiences shared with each participant could result in change. My commitment in this relationship was not to influence but to understand influences. Hence, I found myself constantly questioning and reflecting on my responses to the women, their stories and our time together. I turned to the women as well as those in my response community for guidance and re-centering when I found myself leaning toward my biases.

Relational Response Communities

My relational response community (various individuals whom I relied upon to reflect on this work) was an integral part of the process of completing this project. The informal members of this community included two of my PhD cohort peers, three clinical/birth colleagues, and my co-supervisors. At the outset of this project, my response committee gathered more formally; there were four of us at the outset that met regularly. Three of us had completed a graduate course together that focused on *Narrative Inquiry;* this smaller cohort was particularly helpful in providing the opportunity to talk passionately about our work whilst also being energized to keep

moving forward. At other times, my birth colleagues offered me their grounded perspectives and reminders to consider all experiences outside of what is most visible; to consider the silent and unrecognized experiences that can influence.

At all times, discussion and reflection about this project and the co-participants was done confidentially with no identifying information shared. Discussion with my relational response community, although planned and intentional, was also restricted to generalities. As the narrative threads emerged from this project, our discussions turned to philosophical and socio-political considerations which was crucial to my being able to think about, and with, the stories pragmatically and from the three-dimensions of temporality, sociality and place.

Once work began on the co-creation of the final research text for this project, we met less frequently and less formally (e.g., during a walk together we talked about our work). It was during this stage of the research that my co-supervisors became essential to the outcome as we considered and reflected on the narratives and emerging threads from the three-dimensional space and in commitment to the underpinnings of the methodology laid alongside the experiences of the participants.

Through commitment to the methodology, to relationships with each of the co-participants of this project, and by turning toward my response community, I believe that this work is strong and meaningful. Through this work I have made visible, the multiple influences that women consider whilst navigating the pregnancy and birth continuum as well as the responsibilities that birth care providers, researchers and health care policy makers hold. In the pages that follow, I will bring forward the co-created narrative accounts of each of the participants, the common threads that were revealed, as well as the contributions that I believe can be realized as a result of this work.

Chapter Four: Narrative Accounts

I imagine for many women, the process of making a decision about where to birth is straightforward – it may not even be a process at all. Perhaps these women haven't thought of any other place than their chosen one. The picture of their birth, the picture that they've cultivated over their lifetime, is present and similar every time they imagine it. They close their eyes and envision themselves pregnant, then labouring, then accepting their baby into their arms in a hospital bed, or in a tub, or outdoors. They see those people most important to them supporting them during their labour or rushing to their side after their baby has arrived. They are joyful, and their dreams have come true.

For other women however, the process of decision-making about place of birth is difficult; they ponder and think to find a balance between their needs and hopes alongside the risks that places pose. They consider and are influenced by their partner, their family and friends as well as their care providers. And the final decision is one of satisficing. There are so many factors to consider that the decision is one that is considered 'good enough' or, the best decision for right now.

For some women, the picture of their birth is influenced by multiple factors over a lifetime; their play as a child, their experiences of other women's births and babies, media, movies and television, knowledge gained through learning, their friends and strangers' stories and their loved ones' opinions and perspectives (which are also influenced by multiple factors over a lifetime) (Cook & Loomis, 2012; Hollander et al., 2020; Murray-Davis et al., 2012b). And over time as women become pregnant and are pregnant, all of these experiences together influence her decision about where her birth will occur.

But how do women come to these decisions? Why is it straightforward for some and for others a challenge? And what experiences influence women toward one decision over another?

The pages that follow are stories brought forward by four women as they made decisions about place of birth. These stories are co-created as they were shared in conversation with myself as researcher; my contribution to the emerging stories occurred whilst each participant was remembering and wondering. Our remembering and wondering together has influenced what has been put to paper.

I have also offered personal reflections. These reflections are presented though a lens of my own life experiences; a life that has been lived partially as a birth care professional who has walked on both sides of the childbirth culture (medical and organic). The influence of my childhood, my family and friends, my own birth experience along with my professional experiences working alongside many women and families as well as living with the literature continues to change me; and it affects how I interpret and what I think about others' decisions. My hope is that each co-participant's story laid alongside my reflections will bring forward remembering and wondering for the reader.

Michelle

To my unborn child,
what I wish to give you in times to come,
happiness, and wisdom,
a life filled with fun,
to explore all adventures of your curious mind,
to become knowledgeable of what you'll find,
as I await your arrival and the presence of newborn cries,

I picture how you'll look when I open up my eyes.
I feel your movements every time I wake each day,
letting mommy know that you're okay,
obstacles I hope you'll overcome,
education I know you'll get done,
I stay up late reading to you,
talking to my stomach,
a feeling I never knew,
hungry all the time
'No doubt you're a son of mine',
You make me feel happy even when I'm sad,
because the formation of another life makes me glad.
Proud of you I am,
I already know how you'll be,
a smart 'lil' man for mommy to see,
no worries from me a mom to be,
to a special baby boy I can't wait to see.

Rhonda O. Jones

I am meeting Michelle on a warm (for Alberta) February afternoon at a coffee shop; I'm quite excited to see her as I've only spoken with her via social media over the past few years and am so looking forward to catching up with her. Michelle and I know each other as professional colleagues; we have never actually worked together but we are both healthcare providers and have spent quite a bit of time over the years together in classes and at conferences.

As Michelle enters the coffee shop for our first conversation, and approaches the table that I've taken, she appears somewhat apprehensive. She is avoiding looking me in the eye and I find myself wondering if she is worried about our planned conversation or whether something else is on her mind. After a warm hug hello and as we sit down, I admit to Michelle that I feel so much excitement for her. Michelle has achieved a pregnancy after multiple losses and 'failed attempts' at getting pregnant. I too used IVF to achieve my pregnancies and can still remember the raw emotion and heaviness that I carried around with me the first few months of my pregnancy with my now 11-year-old son.

Michelle is a 45-year-old single woman who has adopted and transferred the embryo of a couple whom she does not know. She is currently in her first trimester after having miscarried four times over the past 6 years. Michelle admits to me that she is grieving the losses of her previous pregnancies and that she was really struggling with this grief. "But now that [she] has seen this baby via ultrasound [she] is feeling a bit more settled and confident that she will finally meet her baby".

When asked whether her experience of becoming pregnant has influenced her decision to birth where she has planned, Michelle pauses for a few seconds before admitting that it probably has, but she "wasn't really given a choice about where to birth in the first place". "In fact, I was anxious to tell you that I'm having my baby at hospital B with an obstetrician - I have experienced firsthand what you've talked about for so many years about birth being so medicalized". Michelle goes on to tell me that during her first prenatal appointment, her family physician asked her "*which obstetrician she wanted to care for her during her pregnancy and birth"*. Her family physician called her "*high risk because of her age"*.

Michelle is a healthy, fit, independent woman. She believes that she is "healthier than most 20-year-olds who are pregnant and that [she] is disappointed that [her] age is such a huge factor in her care". "I'm not saying that I would have necessarily chosen a midwife or a home birth but because of my age, they are telling me that I will be induced at 38 weeks and of course,

need to birth in a hospital. I'm not sure that I want that". Michelle remembers from her education that "induction can change the course of a labour, and I really want to avoid a C-section". [5]

[6]Whilst I was unsettled about hearing that Michelle would be induced at 38weeks, I felt my responsibility in this moment was to remain unbiased to stay committed to doing no harm to this woman who has volunteered to bring forward her story. It was not my place to question Michelle's providers' advice or, to encourage her to challenge him and hence put her in a position whereby she started to question herself. I stayed quiet and allowed Michelle to tell me more.

"I remember like it was just yesterday, what I learned in graduate school; that the baby's lungs clear of the fluid that they will no longer need outside of the womb, several weeks before the natural onset of labour. I remember that. And so, when my doctor started talking about inducing me, I started to panic a little – like, what do you mean you're going to induce me? Why? Isn't that putting my baby at risk? But I didn't say anything to him because he quickly moved on to something else and I got lost in the conversation. After I left the appointment and since then, I've been struggling with how I'm going to move forward with this plan – it doesn't feel right to me, but I don't know how I'm going to have this conversation".

As I listen to Michelle tell her story of her encounter with her family doctor, I can see this appointment unfolding in my mind; it is something I too have experienced, and it was the reason that my partner and I decided to work with a midwife for our pregnancy. Our appointments were rushed, my partner was not given time to ask questions or to understand. Our physician stood at the door of the office we were occupying, with her hand on the doorknob as though trying to make a hasty escape.

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[5] In the physiologic birth literature, the concept of the *Cascade of Intervention* is foundational (Hall, Lauren, 2019; Rossignol et al., 2013). It's rooted in an understanding that interrupting the natural onset and/or progression of labour with interventions like induction and augmentation (amongst others) increases the likelihood that further interventions will be required. The more intervention, the more likely an operative birth will occur. For those women who wish to avoid an operative birth, the goal is to not intervene. In Michelle's situation then, inducing her at 38 weeks theoretically increases the risk of her requiring further intervention and requiring an operative birth.

[6] I have altered the font to reflect change from participant (Times New Roman) to my own reflections (Calibri).

Knowing the healthcare system as I do, I find myself wondering if this running roughshod through information sharing and leaving women (and patients) behind and not providing them with opportunities to talk through, question, understand what the provider is saying, is a tactic that is used intentionally by providers? Is this a way that providers can tick off the box on their assessment form that 'confirms' that information was provided and then when women (and patients in general) then don't say 'no', consent is implied? Or is this approach to patient care something that happens to some providers after years of doing the same job, sharing the same information, and seeing the same outcomes?

I've been so fortunate to be able to walk alongside thousands of women as they navigate their pregnancy, labour, birth, and transition to motherhood. And although it took me time to understand the need to do this, I always go slow. I explain, I give time and intentionally plan how to introduce questions and information. I have come to understand that I have to assume that women know nothing – and this is meant in the most loving way. I cannot expect women to know all of the variables that come into play during pregnancy and birth that can impact one's health or experience. It is my job to bring women to that understanding, their understanding.

Perhaps the difference between how I walk alongside women and how some other providers do, is that I am choosing with the intention, to offer every woman the opportunity to understand what they want for their pregnancy and birth and how to get it. I share as much as I possibly can with every woman; nothing is held back. I might have to revisit topics multiple times due to an individual's priorities, but I am intentional in discussing whatever is needed from a physical, emotional, social, and philosophical perspective.

I'll admit it frustrates me that many healthcare providers rush through medical appointments. The system is designed to make tight timeliness a positive thing. The fee for service method of payment by which the Canadian medical system is structured makes a short 10-minute appointment the goal. But what can one do within a 10-minute appointment? And when a woman (or any patient for that matter) has a need beyond that which can be addressed

in that 10-minute appointment, how does that need get attended to? I'll be frank in answering this rhetorical question…it doesn't.

In a situation like the one which Michelle has described, whereby appointments are short, and information is given rather than explored, women are left to learn on their own. Whether carrying out a review of the literature oneself or reading blogs and more digestible sources of knowledge, women interpret information based on their own experience and knowledge. All people read and think about what is offered to them, through a lens of personal history; certain stories or scientific findings resonate with them based on what they have learned, lived, or heard before.

But what makes self-directed learning even more complex is that the vast majority of sources are biased. Even randomized control trials, considered the gold standard of scientific research, are biased (Yang et al., 2010). They are designed and planned based on a wish to understand phenomena. And although there are steps taken to minimize bias and to best bring forward findings and knowledge that is bias-free, interpretation of results can be influenced by a researcher's history, the specific participant profiles and lack of realistic comparatives (ibid). Hence when we, the providers who do that same work, read the findings, the findings often act to confirm an already held understanding or belief.

Information that is shared by providers can also be biased. In the hospital birth care environment, physicians and nurses with expertise in how to manage high risks labours are employed. These professionals are necessary to be able to offer women and their newborns expert medical interventions when something goes wrong in a labour or birth. Over time, with years of experience working in this environment, physicians and nurses report that their viewpoint and understanding about the risks associated with labour and birth is swayed toward the negative; they see many problems and emergencies that they lose sight of what a healthy and physiological birth can be (Coddington et al., 2020). And many birth care providers, like any other health care professional who works in an acute care environment, will admit that their approach to supporting women (and patients in general) is one of risk aversion (Vedam et al.,

2009, 2012). When sharing information about labour and birth, these specialist professionals then talk from a perspective of what, in their expert acute management perspective, can be safely offered versus the full array of options available.

It is my experience that healthcare professionals offer information or options which are deeply rooted in their experience. If a health professional's experience has shown them that birth is risky, they will offer options to women that minimize risk. In contrast, if their experience is that birth is natural and safe, they will offer options that are less grounded in harm reduction.

The perspective and opinion about birth that the healthcare provider holds, has the potential to influence what information and options women are given. I wonder if Michelle's family physician had a different opinion about risk and birth, if Michelle might have been planning a different sort of birth? At a minimum, I believe Michelle would have been offered alternatives to induction at 38 weeks.

Michelle and I talk several times over her first and second trimesters as she took more time to consider and reflect on her desire for her birth. Michelle admits to me that she has always been reluctant to go "against the grain" when it comes to this pregnancy because she worked so hard to achieve it. Michelle talks about the fact that perhaps "there were unforeseen risks that, in her limited pregnancy and birth care experience, she didn't know about". But she also states that she wasn't willing to put the work into fighting her physician's decision. She is "fine with having an obstetrician and birthing at her choice of hospital so [she] can hand over the decision-making and worrying to her provider".

As a healthcare provider herself, she "is the decision-maker for her patients all day long and it is exhausting". Working in acute care, and in an environment where the patients she is responsible for are acutely ill, she is the person who guides the planning as well as the person who determines the care team's actions. Michelle admits that "this is a heavy burden to carry every day and at times [she] feels worn down by the responsibility". "I feel as though the responsibilities I have in my professional life have really affected the energy I could put into this pregnancy. As well, over the course of the past few years, I have worked so hard and had to

make so many decisions about getting pregnant that now that I've gotten to this stage, I need to be able to finally pass the decision-making off to someone else". Michelle admits that she is looking forward to being "looked after instead of doing the looking after".

Michelle hasn't had any thoughts around what her labour or birth will look like. She "imagines that [she] will go into hospital pregnant and then come home with her baby" and she "knows that [she] will be able to get through whatever transpires between arriving and leaving the hospital". She "is confident in [her] provider". "Maybe I'm being naïve, but I'm just so tired of having to think about everything so much".

As a single person, Michelle reflects that she "finds herself at times wishing that she had someone to lean on in making decisions". She "is worried about making a wrong decision and having a negative outcome" and has not had "that intimate support from a partner as she's been going through the process of getting pregnant". For Michelle, the idea of parenting alone is not overwhelming; she felt more alone trying to get pregnant and grieving her losses without anyone that understood by her side.

In an attempt to safely unpack and understand what Michelle might mean by "making a wrong decision", I asked her to tell me a little more about her comment. I wondered what it was that she was contemplating that might be seen as 'wrong'; her answer surprised me.

Michelle believes that home birth and being supported by a midwife would have been a "beautiful option for [her] if [she] wasn't who [she] is". Michelle admits that she feels that she would be harshly judged by her peers and have to face this judgment daily if something went wrong during her birth and her baby was harmed. "I would rather hand over responsibility to someone else and not carry that with me. I don't know how I'd go back to work having to explain to the people that I work with that I made a decision that leads to my baby dying. At least this way in the end, I'll know that I did whatever I could to keep my baby safe".

Michelle acknowledges that her experiences working in a "very paternalistic environment and in a role that is framed by, and functions within, a paternalistic viewpoint of patient and provider" has significantly influenced her journey to becoming pregnant. She's "been a part of

the system to this point as [a] provider, and now feels as though [she's] a cog in the wheel just like any other patient". She did what she had to get what she wanted. She "went into the hospital to get pregnant and came out pregnant. And [she] will go in to have her baby and will come out with her baby." She rhetorically asks; "Do I really want to challenge that by choosing a midwife or a home birth or questioning what I'm told"?

As I consider our conversations, I continue to come back to this one comment. The idea that this highly educated, engaged, health care professional feels as though she can't question her care provider, and feels as though she needs to do "what she is told", is disturbing. How can we, as women, still be here? Hanging on the word of the physician – and in the case of Michelle, a male physician? It's times like this, hearing these words, that I realize the power that the patriarchy still holds over women. Why does the physician have to be held as the authority especially around a natural, physiologic process like birth? Why do women and people continue to concede to the guidance of the figurehead of this patriarchal system?

As we talk about the healthcare system in Alberta and how we [as Nurse Practitioners (NPs)] are forced to function within it as professionals, Michelle talks about how struggling to become pregnant and becoming so embedded in the system as a patient must influence women to choose hospital birth over other alternatives. "Women work so hard to get pregnant and there's so much pressure to make the 'right' decision – how could a woman then risk a home birth"?

Being embedded in the birthing literature in the manner that I am, I am aware of the statistics around outcomes for women who birth with a midwife at home or, with a physician in a hospital. Healthy women who are experiencing a healthy pregnancy are found to have more positive outcomes, with less intervention, and are more pleased with their birth experience than women who birth in hospitals (Council, 2013; Davis et al., 2011; Difilippo, 2015; Freeman et al., 2006; Reitsma et al., 2020). I believe that the idea of one being 'safer' in hospital comes about because lifesaving interventions are available more readily. But why is it that women believe they would need those interventions in the first place?

Since the mid 1900's, women have been told that birthing in hospital rather than at home, can improve the chances of survival of both mother and baby. And for many years, due to the poor health of women, this was likely the case. In contemporary times, however, when women of childbearing age are generally healthier and pregnancy care is organized to support the development of healthy babies, women less often require life-saving interventions. Birthing at home reduces the likelihood of interventions, especially those that are unnecessary (Council, 2013; Davis et al., 2011; Hutton et al., 2009; Reitsma et al., 2020; Stapleton et al., 2013).

It has been proposed that moving birth from home to hospital culturally, even though initially beneficial to women and babies, has broken down women's trust in their ability to birth (Davis-Floyd, 2002; R. E. Davis-Floyd, 1994; Flores, 2018). The likelihood of one needing help has come to outweigh the belief that one will not – hence, the high numbers of hospital births even in areas of the world where hospitals are found to have worse outcomes. As well, in some countries, a birth that occurs in a hospital is viewed as a mark of social rank whereby if one can have a Caesarean Section, one is assumed to be wealthy and deserving of social respect (Liamputtong, 2005; Nyongesa et al., 2018).

Whatever the reason for Michelle believing that she is safer to birth in hospital than outside, this is her belief. In the big scheme of things, her having the ability to have the birth that she wants, or needs, is the ultimate goal.

Michelle denies that she has experienced any issues in accessing support or, with her care. "I've been able to access supports in an intentional way because of who I am within the system. For others that don't have the knowledge and the experience of working in the system however, I can imagine that they might experience significant barriers to accessing what they really do need. To be able to know who to access or even to know what their options are to achieve the outcome that they want, would be very difficult". Even Michelle, with all her knowledge and insider access, felt that she was unable to ask, question, request, or challenge her care provider.

Unfortunately, Michelle and I were not able to spend as much time as we had hoped before her 38th week; she decided to put her house up for sale and moved closer to the city before her induction date. But before her move, we met one last time, and Michelle told me that she "is really worried about being induced. [She] isn't confident that it's a good idea but [her] obstetrician is pretty adamant that its safer than waiting". When I asked what she thought the physician meant, Michelle admits that "[she] never asked – I've just gone along with what he wants. But as the day is getting closer, I'm really worried that I've made the wrong decision in not speaking up".

Knowing Michelle for as long as I have and getting to know her a little better over these past few months, I chose to respond by bringing forward the idea that we all make decisions that are right for us at the moment based on information that we have at the time. And as we move forward in time, and learn more, and reflect, each moment is an opportunity to choose a path. Michelle admits that she's "just looking forward to being able to hold [her] baby and experience being a Mom – something that [she's] wanted all [her] life and had to struggle to achieve". My hope for Michelle is that she can experience this joy, with confidence that she made decisions that were right for her at the moment and not feel the need to look back and wonder.

Lisa

I once saw a mother with eyes filled with laughter.
And many little shadows came following after.
Wherever she moved they were always right there,
Holding onto her skirt, hanging onto her chair.
Before her, behind her, they were everywhere!
"Don't you ever get weary as day after day,
So many tagalongs getting in your way?"
She smiled a big smile as she shook her head-
And I'll always remember the words that she said...
"It's good to have shadows to run when you run,
That laugh when you're happy, and hum when you hum...
For you only have shadows when your life's filled with Sun!!!

Anonymous

Every time I pull up to the curb to park my car outside of Lisa's home, I find myself thinking that her babies are so fortunate that they will be coming home to this lovely neighbourhood. It's been a snowy and very cold winter, but there is warm air rising from the homes and there are holiday decorations displayed making the houses even more welcoming. Lisa's sidewalk and path are shoveled of the heavy snow as are her neighbours' walks; the evenings are dark but the beautiful white moon casts its glow on the snow, making it sparkle. I always arrive with anticipation of our conversation and looking forward to learning more about Lisa and her life.

Today, upon pressing the doorbell to Lisa's home, I hear her telephone ring and her brisk "hello?" as she approaches the door. She pulls the door open with a broad smile and welcomes me inside as she gently says goodbye to her Mom on the other end of the telephone line. Lisa takes my coat and as she gets comfortable in her chair, she asks me to sit. This has become our routine as we have gotten to know each other over these months leading up to the birth of her babies.

Lisa's home is inviting; overstuffed furniture, fluffy rug, warm lighting and carefully displayed pictures and mementos. Lisa tells me that her cat may appear at any moment; "he is super curious about people – I can't wait to bring the babies home to see how they all get along".

Through our conversations over these past few months, I have learned that Lisa is a 38-year-old health care professional. She is a recently single woman (divorced over a year ago) and pregnant with twins that were conceived via intrauterine insemination (IUI) with donor sperm. Lisa is planning a hospital birth.

When Lisa achieved this pregnancy, she did so under the care of a specialist. A specialist was required because Lisa has a condition called *idiopathic thrombocytopenia* (ITP). ITP is an immune related clotting disorder that puts individuals living with this disease, at risk of significant bleeding. Because infertility is common with ITP, Lisa's obstetrician facilitated her being able to access the fertility clinic when she began talking about wanting to become pregnant.

"Going through [a] fertility clinic, they do a lot of tests" and over the course of several months, Lisa was diagnosed with another condition, non-classic congenital hyperplasia[1]. Lisa believes that these two diagnoses are what make her pregnancy "high risk".

As a result of Lisa's medical diagnoses, her experience of getting pregnant was long and "very medicalized". Lisa admits that "the poking and prodding to get pregnant becomes normal when going through fertility treatments". For Lisa, her experience of getting pregnant heavily influenced her decision-making about her birth – she was "so used to the processes and the matter-of-factness, that having her baby in [a] hospital just seemed to be part of it all".

Thinking about my journey to becoming pregnant and having to resort to fertility treatments, I recall resenting the medicalized nature of the process and couldn't wait until I was pregnant so that I could turn away from it all. I remember talking with my husband about the commitment to the regimented hormone injections, timed intercourse, and pregnancy testing let alone travelling to and from medical appointments was exhausting; that I was looking forward to being a healthy woman who was pregnant instead of a pincushion. I find it interesting that Lisa, and many other women that I know, continue with medicalized pregnancies and births. I wonder if pregnancy achieved with fertility treatments influences women and couples to view pregnancy like any other medical 'problem' - so you just go along with whatever the physicians say because you can't deal with the problem without them? Because you had to work so hard to get pregnant, you just continue going along with the medical approach because it's brought you this far?

Because I knew what prevented us from getting pregnant didn't put our pregnancy at risk, I was able to trust my body in being pregnant and giving birth. But for some women, I wonder if they lose trust in their body? I wonder if that lack of trust continues to drive them forward with a *risk mindse*t rather than confidence. And is it that risk mindset that tips the scales toward birth in a hospital?

Lisa recalls that she was never given a choice about where she was going to have her babies. And she admits that she doesn't have a clear understanding of what her options are for her birth and feels that "there is a lack of education in the system about where and how and with whom, women can birth". There is also a "lack of educational materials like brochures and no real discussion about it" (options). "It's almost like you're not even told that you have a choice. And so, I just kind of went along with it".

As Lisa talks about the place in which she plans to birth her babies, Lisa is clear that she was not given any options. "My obstetrician delivers at Hospital A, so apparently I'm having my babies at Hospital A". Lisa's place of birth was determined for her because of whom she had supporting her pregnancy and birth. Her birth care provider (obstetrician) was also determined for her because of her perceived medical risk. In fact, however, being pregnant and living with ITP does not necessarily preclude her from making a decision about her place of birth (Eslick & McLintock, 2020).

In this sort of a situation whereby there are medical risks that could complicate a pregnancy, the choice for provider and location are not made visible in our city. Choice is simply just not offered. It might have been possible for Lisa to choose to birth at a birth centre or home, or to choose a different provider to be able to birth at a different hospital, but this "wasn't something that even crossed [Lisa's] mind". Lisa continually came back to the high-risk nature of her birth and the fact that she needed to go along with whatever her specialists advised. And Lisa wanted a birth in a hospital right from the start.

Lisa has "always wanted to be a mother [her] whole life". "I envisioned the ideal of course - you don't think about the reality of it. And I've never really thought about giving birth. It was never too much in-depth - it was just a distant thought". But she had always envisioned

having her children in hospital. "People, my friends, say to me *oh what's your birth plan?* and I say what's a birth plan? You just go to the hospital and you have your baby. Quite frankly…a birth plan is so neurotic! You can't plan this stuff…your baby is gonna do what its gonna do and I think women can be very traumatized when their birth doesn't go how they had planned. You have to be able to put your trust in the provider to do what's best for you and the baby and just roll with it. So, when people say *what's your birth plan* - I say epidural. There's two in there - I'm not doing that twice!"

Lisa has been told that her twins will be "delivered early". When questioned about this plan, Lisa's response was a matter of fact that "this is the practice in our city for twins". She has decided that "if twin A is head down, [she'll] go for it [vaginal birth] but, if Twin A is breech, then Caesarean Section (C/S). I have no control over that so I'm not going to worry about that - I don't need that stress".

The fact that Lisa's pregnancy has been labelled has almost forced her to approach her birth directed by the opinion of her specialists. Because she has been told she is high-risk, decisions have been made for her rooted in this label – perhaps without Lisa even realizing it. Her care was automatically shifted to an obstetrician; her place of birth was determined by her provider based on where that provider works; and the type of labour (induced "early") that she will experience was determined by the birthing environment within which we all function. I don't know though if Lisa would have chosen another way. In fact, I often found myself wondering if Lisa was slightly relieved by the fact that she was not given a choice about where or how she was having her babies because it relieved her of the responsibility for decision-making.

Lisa recalls having fairly good experiences with doctors and hospitals. She talks about how she loves her family physician whom she has had since she was 19 years of age. Lisa has "always had such great respect for her family physician", and she talks about the fact that she has had fantastic interactions with and worked alongside some other "very caring and wonderful physicians". Lisa believes that "physicians have the patients' best interests at heart". Rarely has she "seen where her peers would put their own needs or goals ahead of a patient's…trust in your medical professional is very important".

Family members' experiences and opinions have also made a significant impact on Lisa. Her sister (Nicole) is an obstetrician in eastern Canada and although they "don't have deep heart to heart conversations, [Lisa] feels very close to her". Lisa knows what Nicole would have said if she had told her that she was considering a home birth with a midwife. Nicole did doula training and was looking into midwifery but then chose medicine.

Lisa recalls several years ago that Nicole was very upset by a documentary that she had watched about midwifery and home birth. Nicole felt that the documentary (*The Business of Being Born* by Ricki Lake) was "extremely biased". "They (those in the movie) were making comments about how doctors will use oxytocin so that they can get more women in and out of the hospital faster and get paid more" and that "the documentary was without evidence". Lisa recalls that Nicole was very angry about this documentary and since that time her sister has a different opinion about midwives and home birthing.

As I think back to this conversation, one of our first, I was surprised to learn that Lisa's sister, who had at one time wanted to be a doula or midwife, would become so enraged about a documentary about birth in the way that Lisa says she did. Was the documentary somewhat one-sided? Yes. Did it bring forward some negative ideas about medicalized childbirth? Yes. But

the documentary was also created to serve a purpose - to allow those involved, to explore their birth experiences and uncover for the general public, contemporary birthing in the U.S. (Epstein, 2008).

As I write this reflection, I am left to wonder what happened to sway Lisa's sister's opinion so drastically. She was once contemplating a profession that supports woman-lead physiologic birth, but she chose the polar opposite profession. Why? What happened to push her toward medicine and obstetrics? And why react so strongly to a movie? Did something happen with a patient or was she simply defending herself and her chosen profession?

Regardless of how and why the fact that her sister would have had a negative reaction to her choosing to birth outside of the hospital did impact Lisa. Lisa came back to this memory several times during our conversations and it is very clear to me that her sister's opinion about birth resonated strongly with her.

People are influenced by those they admire. In some situations, this is a positive thing; good things can happen when friends and loved ones talk openly about their experiences. But in the case of Lisa and Nicole, I wonder if Nicole's opinion of midwifery, obstetrics, birth, women's bodies, and the medical system has placed a burden on Lisa. If things had been different for Lisa and she wasn't considered to be high risk, would she have felt free to consider a different type of birth?

The things that people say impact us. They may be small comments shared casually, they may be shared with significant emotion, and everything in between. Most of the time though, at least for me, I think about my conversations with those I respect and care about long after they have happened. And sometimes, if the conversation brought forward ideas that

differ from my own, I find myself wondering about and pondering the meaning of those conversations.

For Lisa, as for many women who are pregnant, the things that people have said, and the stories that people have shared, affected her. And there's no going back to change the past so that those conversations and stories can be altered. Women are left with what those stories have already done to them. But pregnancy can be an experience whereby a woman analyzes those stories and thinks through how they feel about them. I wish for Lisa, that she has the opportunity to do this.

Although Nicole's opinion of the documentary resonated with Lisa, Lisa feels that because she's had such great care from, and has such respect for her medical colleagues, is why the medical approach is appropriate for her. But there's more to Lisa's decision to birth at the hospital and along with the medical approach.

Lisa had decided that by the time she was 34 years of age she wanted to have babies. At 34, she was married, but she and her partner were unable to conceive together. Her partner wasn't willing to use donor sperm to achieve a pregnancy. Lisa felt that her partner's refusal to try to build a family would have been the end of their relationship eventually, so she chose to end the relationship and move forward on her own.

Using fertility specialists to get pregnant isn't a new thing for Lisa or her family. "Nicole is in a same-sex relationship and they had to use IVF. They used Nicole's egg fertilized by a donor sperm but carried in her partner's womb. They're now in the process of trying to have another baby".

Lisa's parents are used to their children using fertility to achieve a pregnancy so when Lisa told them that she was going to try to get pregnant they weren't surprised or concerned.

"[Her] parents always knew that being a mom was on [her] mind so when [she] told them that [she] was going to try to get pregnant they were supportive". "I have a really good relationship with my parents to the point that my Mom will say *that's too much information!* My parents know everything about me and everything that I've done…I might not tell them right away but eventually they get to hear it all".

Interestingly, Lisa and her sister were both born in a hospital in the UK but with a midwife. Lisa explains that "midwives support women in [the] hospital, in birth centers and at home; kind of like here in Canada". To her knowledge "birth wasn't discussed. [She] can't remember her mother talking about her birth experience or even any of her family members". For Lisa the "idea of having her baby in hospital has been a part of her for as long as she can remember, and probably reinforced by the fact that everyone else [she] knows and is close to has had their babies there". But Lisa "couldn't ever have considered another way of doing this (her birth)". "I wasn't given a choice and wouldn't have been able to make a different decision anyway. I'm too high risk for all of that".

Jennifer

Will the Earth rumble and crack?
Will the tides roll and crash?
Will time stop? Will fire freeze?
Will my heart skip a beat…or three?
Will my face go numb from smiling?
Will wars stop? Will walls come down?
Will the ovation last forever and ever?
Will all this, and more, occur
when I finally meet you?

Jared A. Washburn

Jennifer is barely eight weeks along and isn't visibly pregnant when we have our first of several conversations. Jennifer tells me that she is feeling quite nauseous; nauseous to the point that she struggles to get through her workday and "when the unit is busy it's been really difficult because [she] can't snack which makes the nausea worse". "I know that being nauseous is a good sign and that it will pass, but it's been pretty awful so far".

Jennifer is pregnant for the first time. She is married and has been for nine years. "We waited a long time to get pregnant because we wanted to be as settled as we could be before we had kids. Even though I just finished grad school a couple [of] years ago, and my husband is in school right now, it's the best time. I feel as though I can go on maternity leave and still manage my job when I return with the demands of a young child".

The idea of having a child together took a long time to come to terms with. "My partner is quite overwhelmed by the idea of having a child". And Jennifer is reluctant to ask him too

many questions about the birth or options that might get him thinking or overthinking. “He gets really stressed and needs to research everything and learn about all the possible outcomes before he will make a decision. And when he’s doing his process, he gets really worked up which stresses me out. And he’s a worrier”.

One of the things that Jennifer and her partner talked a lot about as they were trying to get pregnant is their friends’ birth experience. Jennifer tells the story of her close friend who recently had their baby in the hospital. The baby was born with multiple undiagnosed genetic anomalies and survived for a short period because of immediate access to NICU support. “Our friends really struggled with the turn of events after the birth. My husband was really upset by their story and he seems to really be focusing a lot on it now that we are pregnant. I’ll admit that it plays on my mind also now that we’re talking about where we’re going to have our baby”.

Jennifer and her partner have talked about how when they have kids themselves, they will want to birth in the hospital where there are a NICU and support services for Jennifer and their baby in case something goes wrong. With Jennifer’s healthcare expertise she talks at length about how she imagines things would have gone for her friend if they had had their baby at home. Jennifer feels that the hardest thing would be having to “live in the place where your baby died”.

As I think about the story that Jennifer has chosen to bring forward, I can imagine this birth. It’s a scene I’ve been a part of more times than I wish to recall. It’s a very chaotic birth whereby nurses and physicians are frantic to support the newborn with resuscitation, or intubation or whatever interventions are deemed necessary. At the same time, the woman and her support people are traumatized to have their baby whisked away from them not knowing what’s happening. Sometimes, in the best situations, the woman takes her baby home

afterward. In the worst of situations though, the baby dies, and everyone struggles with the significant loss.

When Jennifer brought forward this story of her friends, I found myself wondering; why is it that Jennifer is remembering this birth – the one with the worst possible outcome? Why does Jennifer, like so many other women I've talked with, focus on the awful things that might happen instead of the beautiful things that are more likely? I'm sure Jennifer has many other friends who have had beautiful births and yet, it's the tragic story that she and her husband continue to reflect upon and plan around.

Movies, television, and most recently social media have made witnessing birth much easier. There are television series like *The Midwives* that bring forward the stories of women and families as they navigate pregnancy and birth with nurse-midwives. In contrast, shows like *Birth Stories* are focused solely on labour and birth and tend to dramatize the suspense and risk of birth whilst failing to counter the horrifying with the beautiful births that take place far more often. When *Birth Stories* became available weekly on television, I watched parts of a few episodes and what I saw was rather disturbing to me; long labours in a hospital where women were supine and in obvious pain; and all very medicalized. For me, the series represented the social norm of the time. Women were *diagnosed* with pregnancy, their care was *managed* by a physician, and birth *occurred* in a hospital with a medical team. I believe the series, and others like it, impacted the current generation of pregnant and parenting women to understand birth as it was represented, as a purely medical event. I wonder if television and movies' one-sided representation is why this medicalized view of birth is so pervasive?

Social media also has an impact on women's knowledge about pregnancy, labour, and birth. (Witteman et al., 2016) have demonstrated that women's opinions about birth can be swayed by personal stories made available online. Women go to the internet and social media as a method of seeking health information and gaining knowledge (Wright et al., 2019). Therefore, social media and the internet can become a platform for experts and lay people to influence others.

It's not surprising that pregnancy and birthing have become synonymous with danger and risk when one considers the multiple similarly presented messages that women see on a daily or weekly basis on television, in movies and online. The average person spends two hours on social media daily (Thomson, 2017). There are hundreds of scientific and lay sources of information about pregnancy and birth that include stories and reflections; some are beautiful, and some are horrific. I wonder what makes a person then focus and remember one viewpoint or story or experience over another? Why do some people remember the horrible when there are so many other joyful reflections that could dominate?

Jennifer admits to me that she is very concerned about the space that she will labour and birth her baby in. "I want access to a sterile private room because I don't want to be around others who have babies who are addicted and withdrawing". Jennifer is very aware of the "high numbers of patients and women in hospital settings who are at high risk and have multiple social risks and she wishes to avoid these folks too". She doesn't want to have contact or to be influenced or around others who are struggling. Jennifer "deals with this every day in [her] job and it really bothers [her] emotionally so [she] doesn't want to be around it during her labour". As such, Jennifer has chosen to birth at Hospital C rather than Hospital B where she is employed and knows the population.

With great caution, I asked Jennifer if she had considered having her baby at home with a midwife especially considering her wishes to be isolated from others. Jennifer admits that she would have considered a midwife (instead of a physician), but only birth in a hospital because of her need for access to the NICU "and of course, pain relief". Jennifer doesn't feel as though she can cope with the pain. "I've talked to a lot of my friends who tell me about how awful their non-pain relieved birth was compared to their birth with an epidural. Some of my friends had their first [child] naturally but then for their second child got an epidural, and they talk about how much easier the second time was. I just don't think I'll be able to cope so I want to be in [a] hospital where I can get an epidural when I decide I need it".

When I think back to preparing for my own birth, I never had a single doubt about my ability to cope with the discomforts of labour. I learned through my midwifery education, to consider labour as exercise, and although I knew that the length of my labour might be extended, I didn't plan my labour around my need for intervention. In fact, I planned my labour around my need to stay away from interventions.

As a birth care professional and nursing professor, I've come to understand that for many people (women, nurses, nursing students, and other professionals) birth is considered as the time before birth and then the time after, and little consideration is given to what goes on during the in between. I think about labour as being a process and journey that connects the before and after. The journey is filled with moments of strength and rest alongside seconds of fear, joy, pain, pleasure, and everything in between. It's what happens during the journey, between the onset of labour and the birth, that can influence how the baby enters the world outside the womb. Although interventions during this time are necessary for some, most women can take this journey with little to no medical intervention. In fact, for healthy women

who are experiencing a healthy pregnancy, the safest place for her to labour and birth is at home, away from the medical setting and interventions that are not medically necessary. For Jennifer, the epidural that she wishes to have access to, and which is only available as an inpatient, will require her to labour in a hospital. I wonder if Jennifer had been provided with information and guidance about managing labour discomfort without an epidural, would her decision about place of birth be different?

Jennifer is content with her decision – she knows what she wants access to and has thought through how to avoid the things that she doesn't want to influence her labour. For Jennifer, and every woman who is contemplating her options and making decisions about place of birth, the place that will offer her what she wants and needs, is the place where she should be. The place where she will feel comfortable and confident in her decision is relative to her experience, her knowledge and her goals and that's really all that matters.

Jennifer's family physician was open to her choosing her care provider but only offered Jennifer an obstetrician. "She didn't offer me another family doctor or a midwife. I know that I will have access to an obstetrician at the hospital because someone always has to be available for emergencies, so I am open to having a family physician at my birth. I also know that I'll get more time with a family physician or midwife during my pregnancy appointments. But we haven't made a decision yet on a specific provider".

Jennifer didn't have her pregnancy confirmed by her family physician until after 8 weeks of gestation because she refused to purchase pregnancy tests thinking them a "waste of money". "Even if I did want a midwife, it might not have been possible because I was so far along in my pregnancy once I got to the doctor. I know a lot of people who have tried to get a midwife, but they can't because they didn't connect with one early enough". That inability to 'get' a midwife

acts as a barrier to many women being able to birth where they would choose. “They wait too long to get in touch with a midwife and no one is then available to take them on”.

Throughout her pregnancy, Jennifer and her partner decided to access the support of an obstetrician for their pregnancy and birth. Despite having the time and the connections to a variety of healthcare providers, Jennifer was unable to find a family doctor that could commit to them and their birth. Jennifer is “fine with it as [they] were able to get the obstetrician that they wanted and are going to be able to birth at their hospital of choice, but [they] know that they will have to do more work [themselves] to prepare because of the fact that they will have less time with [their] physician”. “Our obstetrician will only see us at 32 weeks along, so we will be receiving most of our care with our family doctor. This is fine, but we’d rather have had more time to get to know our obstetrician and for her to get to know us. In reality though, it’s the nurses who will be helping us at the birth – our obstetrician will show up once our baby is close to coming so it’s really not that important, I guess”.

The realization that birthing in hospital is about being supported by nurses whom you’ve never met before is disappointing for many women; many women do not understand that their physician won’t be there with them until the baby is ready to be birthed. As a result, women talk about their birth in the hospital as being positive or negative related to the nurses that are present (Barrett & Stark, 2010; Reed et al., 2017). Nurses that are kind and supportive and who nurse in a manner that is satisfactory to the patient can make even a traumatic birth, positive. This is in contrast to the nurse who is rough, rude, or not present enough in the patient’s opinion, who can make the most straightforward birth a negative or even traumatic experience (Reed et al., 2017). Unfortunately for many couples, this realization that the nurses are the professionals that matter in a hospital birth, does not come until after the birth. And couples

have no control over which nurses will be supporting them. One's nurse is dependent upon which day and which shift and who is working – there is no choice.

In nursing, we talk at length about the importance of informed choice. What does that really mean, and can we give this to patients? I believe that the system within which we work as nurses limits our ability to even provide choices let alone informed choice. We hope that patients come to us in the hospital setting with having done some type of learning. Often, however, we are required to provide them with full information about their choices, check-in with their understanding, and then support them in making on the spot decisions. The information that we are sharing, however, is influenced by the other professionals in the hospital where we work and often reflect the beliefs of the system, the facility, and the medical team (personal reflection from time spent working within the local health region). It is not always fulsome, and it can be biased (Johnson, 2021).

When a woman comes to the birth unit in labour, her care is managed by the nurse who has been assigned to her. In the best cases, the nurse will learn about the woman's wishes for her labour and birth and provide the woman with unbiased information about options. In the majority of situations, however, the nurse will follow unit and hospital protocols around what type of information is offered, what choices she presents, will place limits on the woman's activities and progress, and guide the woman to an outcome that is often determined by the unit's status that day, the nurse's responsibilities, and the lead obstetrician's preferences. There are so many factors that influence whether a woman is able to achieve the birth that she wants and many of these factors are beyond the control of the woman or her support people.

The stories of her friends' experiences of having their babies in the hospital have influenced Jennifer deeply but she also reflects on her own family's birth experiences. Jennifer's mother is "very laid back about everything. Even with her pregnancies, my mother trusted her body and that things would go well. She approached birth as a natural normal thing". Jennifer's mother laboured at home and presented to the hospital ready to birth unmedicated. But Jennifer feels that in no way is she anything like her mother. "I worry about things and about all the negative things can happen and I want to be in a place where I can get help if anything goes wrong".

As a long-time acute care health care provider, Jennifer's viewpoint is coloured by [her] professional experiences. "The normal to us [healthcare providers] is the abnormal. We see really awful things all the time and those awful things sit at the forefront of your mind…positive and normal experiences are understood but personal/professional experiences have more weight".

In addition, Jennifer admits that she didn't have great experiences watching people birth as an undergraduate student. "My experiences in undergrad in postpartum were completely overwhelming for me. What was going on, on the units, was very difficult for me; sad things were happening to young women and newborns; awful, horrible things at a time when people are healthy and young, and it should be such a happy time".

When I asked Jennifer to tell me more about what she remembers, she recounts a day in her clinical rotation as a student whereby she was participating in support of a woman in labour. "The woman had her baby but then hemorrhaged; there was so much blood and it was complete mayhem in the room. The dad was over in the corner holding his baby watching his wife

basically bleed to death. If it weren't for the fact that there were obstetricians and nurses and medications right there, she would have died right in front of me".

Jennifer also reflects on the experiences of her maternal grandmother who was a nurse in labour & birth. She remembers her grandmother telling her that she "had a tough time with the social and contextual parts of the job; when things went badly, and young women and families were affected, and their lives turned upside down". In Jennifer's current role, she witnesses the effects of losing loved ones regularly but "most of [her] patients are older adults who have lived a life; for women and families on the birth unit it's so different". Jennifer recalls that her grandmother chose to leave her career very early and Jennifer wonders "if leaving nursing early was influenced by her experiences in labour and birth".

Jennifer and I came back to talking about how both her mother and her grandmother, as important women in her life, have influenced her and her decision-making. Jennifer admits that she wishes she had asked her grandmother to tell her more about her career as a nurse when she had the chance – but she's been gone for a long time now. She died about 5 years ago so unless Jennifer asks her mother, there's no way to know what it was that influenced her to leave the birth unit.

I wonder how the stories told by Jennifer's grandmother would have influenced her and her decision-making about place of birth. I believe that hearing stories when one is not contemplating pregnancy or pregnant has a different impact then when preparing for one's own birth. I remember clearly the conversations I had with my mother and grandmothers as a young woman about how their pregnancies and births occurred, who was present, did they have pain relief, where did they have their babies – it was all important to me as an unmarried, novice nurse. As I aged and matured and lived my life, those stories took on a different

meaning. Pregnant for the first time, I was the same age as my grandmother was when she had her fifth baby. The birth culture was so different in the 1940s and 1950s then it was in the 2000s and I was offered so many options for my birth. My grandmother birthed at home with the assistance of the local lay midwife. My grandmother tells me that "women went to [the] hospital only when they were on their death bed in those days. Now it seems that women can't even manage the slightest twinge in labour and they're running for the hills". The hills being the hospital! Now in her 90's my grandmother has watched her children and grandchildren raise babies. My grandmother lost a grandchild (my cousin Sandra) during childbirth. And yet my grandmother still believes that "women are built for making and birthing babies. It's terribly sad and horrible when we lose our babies and what happened to Sandy was devastating but, even the doctors that were there with Sandy in the hospital couldn't help her".

The stories that Jennifer's grandmother shared about her own life as a woman, mother, and nurse in labour and birth cannot be retold now but are still having an impact. Jennifer has remembered snippets of things that her grandmother passed on casually to her and those snippets have stayed with her and were brought forward during our conversations as having meaning. And they have meaning in Jennifer's current context as a pregnant woman, who is a healthcare professional who remembers negative experiences in labour & birth. All of these factors and people and stories have somehow impacted Jennifer and brought her to today where she is deciding how and where to have her baby.

Jennifer seems reluctant to talk further about her mother and repeatedly brings forward the fact that they are completely different people. "My mother doesn't agree with anything I do; she keeps reminding me that I'm too worried about the negative stuff – but this is who I am. I

don't know how to not worry – I see terrible things all day long in my job and it's difficult to know anything differently".

I was always a worrier. My Mom used to call me a 'worry wort' growing up as I questioned her about 'what if' when things that were unknown to me were going to happen. I remember vividly, when my Mom was preparing to be admitted to hospital for the first of many times during her life, that I asked her question after question about how long she would be gone, and would I be able to visit her? I knew how much I would miss her and even at that young age I knew that things would be different at home with my Dad in charge! I was worried about what we would eat for supper because my Dad's cooking was a source of family jokes; eggs for supper every night was not appealing to a 12-year-old. Plus, my Mom was the centre of my world. She was my best friend and confidante and was the person in our family who allowed us as kids, to be emotional and loud and silly and angry. She accepted us for who we were and was always there with an embrace and gentle words.

My Mom stayed in the hospital for two months this first time. I missed her during those two months more than I could have ever anticipated. Life with my Dad was not as bad as I had expected but without my Mom around, I felt lost and scared. I remember several times during that span of time asking my Dad and my grandparents if my Mom would ever come home. In the early days their responses were grim; said without confidence. I knew that things were bad even though everyone was trying to hide that fact from me.

I remember at some point not too long after my Mom did come home, she told me that she had "died on the operating table and had to be brought back more than once". At that point in my life, I didn't understand what she meant, but it was something that stuck with me. I

created a picture in my mind of what dying on the operating table meant. I saw her lying on a silver table in a big room with no one else around. She was alone.

At that point in my life, I had no reference point for what an operating room looked like or what could have happened to her, so my mind came up with that picture – and it made the idea of surgery even harder for me to get my head around. I certainly didn't understand what my Mom went through, but I know that I was never the same once my Mom came home. I worried even more than I ever had and had a very difficult time being separated from my parents even for a sleepover at my beloved grandparents' house.

I know that my experiences of being emotionally connected to an ill parent significantly contributed to who I am today. I'm a health care provider but also, a woman who worries. It's very difficult for me to not think through every scenario related to my loved ones and analyze the risks of something happening and how I'd deal with it. I know that this is a result of the experiences in my past – not only my Mom's health struggles but other traumas. My worrying has caused me problems but, it also contributes to me being an excellent clinician.

Our past experiences and the person that each of us is today, influence how we consider situations, think through options and make decisions. Decision-making about place of birth is no different and for Jennifer, like every person, there are multiple experiences and events in her life that have brought her to be the person she is today. I found our conversations so interesting; Jennifer knows what she wants and what she needs and regardless of what has influenced her, she seems to have come to terms with what she needs for her birth.

"Most of my patients are older adults and they have lived their life so although their health status and decline is sad, at least there's that. I couldn't work in paeds or in emerg – it

would just be too hard to see all the horrible things all the time happening to kids and young people".

Jennifer has worked in her specialty area for her entire career and "can't imagine working anywhere else. I know everyone and I'm very comfortable - it's taken time, but my opinion and decision-making are respected on the unit now after only a short time in my new role".

We talked at length about how knowing everyone where she works, has influenced her to choose a different hospital for her birth. Jennifer "knows so many of the staff but also, a lot of the patients so [she] wouldn't want to have [her] baby at [her] hospital for fear of looking up to the end of [her] bed with [her] feet in stirrups to see a close colleague".

I asked Jennifer if she had ever considered a home birth, especially after coming to understand that she was concerned about running into professional colleagues or patients during her time in hospital. Jennifer feels that her need to have a "sterile environment, ability to have an epidural, and access to NICU pretty much make a home birth impossible. It's more important to me to have access to emergency support than to enjoy the birth. I can understand that some women feel that their birth experience is important but for me, it's about safety. And the hospital is the safest place in my opinion".

Sarah

Let's start speaking honestly about our births.

You're not a failure if your birth was disappointing.

You're not selfish for knowing you should have been treated with dignity and respect.

You're not melodramatic because you experienced your birth as a traumatic event.

It's time to broaden our definition of success to include how women are treated.

Kathi Velaii

Remembering Luca's Birth

Sarah and I talked with each other the first time, over the phone. She was so anxious to tell the story of her first birth that our earliest opportunity to meet in person seemed too far in the future. As a result, we had a two-hour conversation and then agreed to meet once she had decided upon a provider for her upcoming second birth.

Sarah's first birth took place overseas, and "it was a terrible experience". Sarah tells me that she "has had 4 years to think about everything that lead up to [her] son's birth and what happened, and [she] is still struggling. [She] is having a very hard time making a decision about where [she] should have this baby and who to trust".

Sarah grew up with her Mom who is a homeopath and a "big fan of everything natural. As a family, [they] used alternative healthcare more than the mainstream medical system. When [she] became pregnant with [her] son, [she] spoke with family and friends and did a lot of research about options for a care provider and found that obstetricians were considered the best option. [She] had heard about midwives, but they were not considered mainstream and none of [her] friends had used a midwife. Also, [her] Aunt, whom she loves and respects, is a gynecologist and she really pushed [Sarah] to use a physician".

Sarah reflects that "even though in [her] heart [she] wanted to give [herself] the best option for a natural birth and to believe in [herself] and [her] body and to trust [her] philosophy of life, [she] went to a physician to be extra safe". Thinking back on it now, Sarah says that "she doesn't know why [she] went but [she] really thinks it was fear…I wanted to be extra safe and to do things the right way".

"The physician that I was sent to, who was an obstetrician, told me that I was at risk, for what I don't know, and she instilled so much fear in me that things would not turn out well if I chose an alternative provider (midwife). Before that appointment, I was living my pregnancy in a happy bubble and I felt well and healthy. I didn't believe I had any need to be concerned about my pregnancy or labour. But then, all of my questions were challenged, and my decisions were questioned; I went home crying and continued to struggle with my decision to have an obstetrician at my birth in hospital for a long time. Eventually, I resolved myself to approach the birth with an attitude of 'ignorance is bliss'. I would go to the hospital like everyone else and just have the baby and accept the outcome".

The narrative that Sarah is bringing forward about being deemed at risk, is repetitive in women's stories. It's a narrative that reflects the medical model where birth is viewed as something to be managed and from a standpoint of deficit versus a position of health or strength. The fact that physicians are not providing enough information about risk and what is putting each of these women at risk, is so concerning to me. Was it something in Sarah's family history that is putting her at risk? Is it something in her health history that is worrying to the obstetrician? Or is it simply a scare tactic that this physician is using to ensure that Sarah follows her direction and advice?

When a relationship is being developed with a new patient, it seems counter-intuitive to me that a healthcare provider would use fearmongering as a basis for the relationship. Does making women afraid of pregnancy and labour help them live their pregnancy or to prepare for labour and birth in a more obstetrician-appropriate manner? Does labelling women and categorizing them negatively change the outcome? In Sarah's case, it sounds as though the initial meeting with this obstetrician caused Sarah a great deal of self-doubt and to do a lot of internal reflection. Sarah admits that she eventually came to terms with the conflict she was feeling between her own needs and goals and that of the obstetrician but, to what end?

Over the course of her first pregnancy, Sarah followed through with the typically scheduled medical appointments requested by her obstetrician. At 35weeks, Sarah recalls that her blood pressure was elevated, and she was sent to the hospital for "further checkup". Sarah ended up being admitted with pre-eclampsia and later that week had an emergency Caesarean Section (C/S). Her son Luca was born healthy, but he was monitored closely by the nurses because of being premature, whilst Sarah herself struggled to deal with the continued unsatisfactory treatment by her physician and the staff at the hospital.

Sarah recalls that she saw several different healthcare professionals over the course of her days in the hospital and yet there was never consistency – a new nurse every 8hrs with none coming back the next day. When her obstetrician came to see her in the mornings, to see how she was doing, the "obstetrician never remembered [her] baby's gender let alone his name – it was so disheartening that no one bothered to learn about [them] or what [they'd] gone through".

Eventually, Sarah was discharged home with Luca, and she forced herself to move forward with mothering. Sarah admits it was extremely difficult. She has spent a great deal of time trying to come to terms with how she felt as a new mother. Recently Sarah learned that she

suffered from postpartum depression, likely rooted from the trauma she experienced in the days leading up to and immediately after Luca's birth.

Sarah struggled with her pregnancy, labour and birth experience so much, that felt she needed to do something so "other women were made aware that they needed to fight for what they wanted during that precious time and to not be bullied into doing what some so-called expert advises". As a writer, Sarah tried to put pen to paper many times but so far, she has been unable to write about her experience.

Decision-Making for her 2nd Birth

How I clutched onto my firstborn for dear life.

This would be the last moment she'd be my only baby.

Forever.

And while I couldn't wait to welcome my new baby, my heart was breaking.

I felt completely shattered inside.

I didn't want to let go.

Ever.

Melissa Willets

When Sarah and her husband decided to start trying for another baby, they did so with much trepidation. Sarah admits that she struggled with whether she wanted to go through another pregnancy and birth. She and her husband wanted another baby, but Sarah carried so much fear. Now living in Canada and having learned that "there were more options including midwives and doulas, [she] decided to start researching [her] options before [they] conceived".

"I talked with a few of my Canadian friends because they had a midwife support them for their pregnancy and birth, and I was so curious about how they managed to birth at home. I had

watched a documentary about home birth at some point and I remember how peaceful the birth was, so different from Luca's birth. I wondered if this could actually be a possibility for me".

During her research about options for a birth care provider in her hometown, Sarah came across information about the local birth centre. The centre "is open daily for people to walk into for information and there were midwives and other practitioners onsite; so, I just went! I never expected to find what I did. I don't know what I expected but the centre was so much more. There's a feeling about the place; that you're walking into an embrace. It's a place where every woman is welcome and there's an energy of acceptance".

Sarah explains that when she drove up to the location the first time, she couldn't find it. "The centre is a rambling corner house and it's hidden by these huge evergreen trees. I almost didn't go in because I thought to myself this can't be it! But when I walked toward the front door, a woman was walking out with her baby in a carrier and she looked so happy. I remember thinking to myself that this was the right decision to come here".

When one walks into the centre, "there is no reception desk; it's like you're walking into someone's home. You take off your shoes and are welcome to walk around – it's sort of weird but it works. There is a sign directing guests to check in at the desk, so I approached the desk hoping to get permission to look around. The woman at the desk was very kind and she offered to give me a tour and tell me about the centre, so I agreed. It was almost surreal – I had nothing to compare the place to, so I just took it all in, trying to listen to and answer all of the woman's questions".

Sarah had read quite a bit about midwifery and midwifery practice in Canada before going to the centre, and she knew that she needed to explore this option for her 2nd birth. Birth

with a midwife can occur at home, at the birth centre or at a hospital in our city so for women who are unsure about the place in which they wish to birth, a midwife in an excellent option.

Sarah feels as though “there are so many choices and decisions to make during a pregnancy and the burden of making these decisions is very heavy”. “I don’t want to be mad at myself for choosing a hospital birth and giving up on having a different experience but, at the same time, I’m not sure that a home birth is really for me”.

Sarah and I discussed the practicalities of having a baby at home with a four-year-old in the house – a worry that she brought forward during one of our conversations. Sarah wondered if she could be in the house and birth freely, while worrying about not soiling furniture with all the products of birth. “As well, I’m not sure I’d want to leave the house while I was in labour – it’s such a difficult thing to decide”.

After her visit to the birth centre, Sarah decided that she would choose a midwife once she achieved a pregnancy. In the time between however, Sarah worked with a counsellor (Marissa – not her real name) who specializes in birth trauma, in order to allow her to deal differently with the grief and anger she felt following Luca’s birth. Sarah felt that her work with Marissa would “allow her to be pregnant and make decisions about this pregnancy and birth with an open mind”. It is through her work with Marissa that Sarah learned about this study and the opportunity that being involved in the study might offer her to talk about her experience, and perhaps help other women. “I’m having a hard time trusting medical people in general because of my experience with Luca. This is not the way that any woman should be preparing for a birth; burdened with all this negativity. Because of this, I am putting pressure on myself to make things right”.

Sarah's experience of finding a midwife that could take her was interesting in that, she was initially told it would be unlikely that she would be able to be supported through midwifery because all of the midwives in the city were full. Because however, Sarah was already connected with the birth centre and the birth trauma counsellor, and because of Sarah's need for a midwife who could support a VBAC, one of the more experienced midwives (Nicole – pseudonym) agreed to work with her.

Of course, once Sarah told her family about the new pregnancy and about her decision to work with a midwife, "opinions became quite clear. My in-laws and my own family are skeptical about some of my choices and I feel like I'm a victim caught between two philosophies of life. On the one side, with my parents, I'm supported to birth naturally whereas with my in-laws and my Aunt, they're really pressuring me to have the baby in hospital with a physician. I've made my decision to have a VBAC with a midwife, but at times I feel caught about where".

When I asked Sarah if there were others around her that could help her find a balance and a more objective viewpoint or opinion, Sarah told me about her neighbour who is an obstetrician (OB). Sarah and her neighbour "have talked at length about how here in our city, women have all options available to them; home, birth centre and hospital as well as obstetrician, family physician or midwife. My neighbour is confident that this birth will be different because it's my second, and that VBAC (vaginal birth after Caesarean section) is possible and fairly common. However, she seems reluctant to say that having a home birth as a VBAC is a safe decision".

Having a Caesarean section (C/S) delivery for one's first birth increases the likelihood of that woman having all other births via C/S (Chong et al., 2012; Vedam et al., 2012). The reason for this is related to the fact that the risks to the woman and her newborn for negative outcomes demonstrated in the literature show an increase with a trial of labour. This sort of

research evidence has influenced birth care providers to monitor for and intervene when labour becomes concerning leading to intervention and often, another C/S. Further, this sort of research evidence has influenced how birth care providers are allowed to support women to achieve a vaginal birth after a C/S and can limit access to this option (DeMeester, Lipworth, & Barrett, 2019).

The current Canadian guidelines specific to supporting a woman to have a trial of labour after a C/S are directive around careful selection of candidates. In Sarah's case, she experienced her C/S related to pre-eclampsia without a trial of labour. She therefore would have been considered a good candidate for a trial of labour as long as she was healthy before onset of contractions. The guidelines, however, do state that access to emergency surgical services is important to the safety of the woman and her newborn (DeMeester, Lipworth, & Barrett, 2019).

For Sarah, the decision about where to have her baby involves so many factors. Being a mother already, Sarah admits that she is afraid of dying; she has never thought about dying until this pregnancy, but Sarah explains that there is "this nagging thought that I need to be sure about what I'm doing so that I can be there for Luca. This thought is present a great deal of the time and I'm working through it trying to find a place for it; I know that it's because of my experience in hospital and my emergency C/S but knowing why it's there is different than dealing with it". Sarah and the counsellor continue to try to find ways for her to reconcile her previous birthing experience; having her "wonderful midwife is part of this process. With Nicole, I feel at peace and confident. I know that I can ask questions and talk about my worries with her and will not be judged". Sarah talks about the fact that Nicole has remained open to Sarah's place of birth and right from the beginning, supported her inquiring about a VBAC. "This was a big deal for me; to

be able to explore having a vaginal birth after what happened last time with the preeclampsia and C/S so her complete comfort with that has been so important to me".

Sarah and I met several times throughout her pregnancy. She told me at one point that "the decision about where she will have the baby is blurry – [she] can't imagine or create in [her] mind, the picture of a birth at the birth centre. A birth at home seems riddled with things to think about and plan whereas a birth at hospital can be straightforward as long as Nicole is there". "I'm still unsure about where this baby will be birthed".

Sarah continued to experience a healthy pregnancy, she met monthly with the birth trauma counsellor and felt well supported by her midwife. "All was going well. I was planning a VBAC but then, we learned the baby was breech. Originally that didn't really mean much to me; the baby was going to come out upside down – okay. But then Nicole explained to us that a VBAC for a breech presentation can be complex. Nicole was still very comfortable in supporting me to have a VBAC, but it would be better if we could get the baby to turn before he was born".

Sarah recalls telling her family members and close friends about the fact that her baby was breech. Her in-laws and her aunt "pressured me a great deal to have a C/S. They even tried to sell it to me by saying things like *you can even pick your baby's birth date!* But I didn't want a C/S. I wanted to try to have a vaginal birth. I wanted to try to understand what being in labour felt like and to experience bringing my baby into the world without all the medical staff going crazy around me".

Sarah did the exercises and positions that are meant to coax a fetus to turn from breech to cephalic (head down) position but by the time she went into labour, a little early at 37weeks, her baby was still breech.

Remembering Charlie's Birth

I am the mother of the moon
sister of the stars
child of the light in your eyes.
I am powerful.
The geometry of my shape shifts
from gently curved lines
to expanding circles:
earth, moon, sun.
I am powerful.
I am strong.
The tempo of my vibration quickens,
increasing from
butterfly wings, to floundering fish,
to beating drum,
erupting volcano,
the rhythm as old and constant as
the cycles of the sun
and the turn of the tides.
I am powerful.
I am strong.
I am beautiful.

I hold the hope of my ancestors

the knowledge of my time

the fate of my future.

I am powerful.

I am strong.

I am beautiful.

I am mother.

by Jana McCarthy

Sarah's labour was long. She laboured at home for the first while and she doesn't "remember exactly how far along (dilated) [she] was when [they] ended up going to the hospital for an epidural so [she] could rest". "I didn't want to give birth with the epidural but after labouring for so long, I was exhausted, and we thought that resting might allow the baby to come down a little better".

"Because I had an epidural, the obstetrician (OB) and the nurses had to be involved in my labour. It wasn't something that I had wanted but it's the hospital policy. At that point, it seemed like the monitoring ramped up, and I started to feel a lot of pressure from the staff to have the baby. Nicole remained there with me which I'm so happy for; in fact, if she hadn't been there, I believe the birth would have been very different".

"After about 25 hours I was only 7cm. I stayed at 7cm for a couple more hours and was making zero progress so Nicole kind of stepped in to delay the OB talking with me. She knew that this particular OB would pressure me to have a C/S immediately and apparently, this OB is known for her terrible bedside manner. Both Nicole and the nurse advocated with the charge

nurse to switch me to the other OB because they knew how badly I needed a kind voice. I'm so thankful for that because in the end, I was able to rest 5-6 hrs without the added pressure from the OB".

"I ended up having a C/S because I just didn't dilate any further. We tried position changes and oxytocin and nothing. But it's incredible how different I felt this time. Yes, I ended up having a 2nd C/S, but it happened after me being able to experience the labour and trying and allowing my body to do what I believed I could do. I don't feel that this C/S was a failure. My husband was in the O.R. with me this time whereas, with Luca's birth, he wasn't allowed to come in. My midwife was there, and also, my neighbour – you know the OB that I mentioned before – she happened to be on the unit as we were going into the O.R. so she was in my surgery also! It was actually quite incredible".

Sarah admits that "maybe [she] still feels that [she] was not able to have the birth that [she] wanted but, [she] was able to reconcile her last birth". "I did everything that I could to ensure that I did my birth my way". She took the opportunity to choose her place of birth, she was prepared and had developed a very clear birth plan. She had strong support from her husband, midwife and doula (Nadia – not her real name) and she "knew that the people around [her] understood how important it was that [she] had control over the decisions".

"The way that I have met people and people have come into my life over the past year has really impacted my life and the experience of Charlie's birth. When a person is pregnant and a mother; we are so vulnerable in a different way than for any other person. There's so much pressure to be perfect and to make perfect decisions. Unless you've experienced it, you can't truly understand that pressure and the burden. I don't know how I would have been able to deal

with fighting to do this birth the way I wanted to if I hadn't met Marissa, Nicole, and Nadia. They have changed my life".

Chapter Five: Narrative Threads

Through the months of conversations with each co-participant of this project, I was asking questions. I asked the co-participants questions, but I also asked myself questions. What are my assumptions? Where is this response in me coming from? What can I uncover about myself from this learning? Now, as I consider the weaving and interplay of commonalities across each co-participants' stories, I must ask myself another question – what was the purpose of bringing these women's stories and voices forward?

When decisions are being made, multiple influences play on one's mind. Influences from one's past, influences from one's present and, influences rooted in visions for the future. Decisions are made based on what is known but also, what one wants to know: the past and present knowing, as well as what one wishes to experience in the future, influence decisions made today. The purpose of this project was to unravel and make evident, the common threads that influence the experience of decision-making about place of birth, to understand how best, birth care providers can walk alongside women on this journey.

Through the co-creation of the narrative accounts of Lisa, Michelle, Jennifer, and Sarah, narrative threads emerged. Commonalities that each of these women brought forward through conversation and which were integral, even in their unique expression, became clear. The threads are laid out in the following section and become the foundation for what I suggest are the potential contributions that this project might bring to nursing, other birthing professions, and birth care system design.

My Past, My Present, My Future: Everything Intertwined

Is it possible to know thyself well enough to make a decision today, that will impact an event that will occur months in the future but that will leave one contented for the remainder of

one's life? This question has been debated for centuries – since the days of Socrates – and will likely continue to be debated for centuries more. It is an important question to ponder, and one that lays the foundation for revealing that decision-making about anything in one's life, from what to eat for breakfast, to which career to pursue, requires knowledge of oneself in the past, in the present and the future. Decision-making about place of birth is no different; this decision requires knowledge of oneself brought from the past. It requires one to acknowledge inexperience, as well as any new knowledge gained in the present. Finally, it requires one to consider how decisions today, will impact one's future. To muddle the situation further, decision-making about place of birth is often the first time in a woman's life when she is making a decision alongside someone else. With her baby's health and future in mind, she is decision-making.

This research has brought forward with clarity, that the grand narrative specific to decision-making about place of birth, and possibly all birth related decisions, is the influence of the childbirth culture. One's personal childbirth culture influences all aspects of decision-making. As I make visible the experiences of women as they made decisions about place of birth, this grand narrative is always present. It influences women, their friends, and family, it is apparent in the media and therefore influences broader society, and it influences healthcare providers and politics.

Because of the power of the childbirth culture, it can be difficult to comprehend and make visible, influences separately. This, however, is the point; influences cannot be separated out. One is not necessarily more obvious or more influential than another. Influences work together to weave a pattern that for every woman, becomes a completely unique tapestry of experience. In the sections that follow, I will attempt to unravel the dominant threads

(influences) that Jennifer, Michelle, Lisa, and Sarah guided me toward unraveling. These threads include childbirth culture but also, personal experience, and the influence of others.

Thread One: The Influence of the Childbirth Culture

> "A woman's moral agency does not reside exclusively in her bones and sinews and her moral peril is not limited to damage thereto. Rather, in addition to anatomy and physiology, values also animate us and, accordingly, should factor as thumbs upon the scale when physicians support women as they weigh their options" (Minkoff & Atallah, 2018, p. 16).

The idea that a woman's decision-making about pregnancy and birth is rooted in that woman's culture, is not new. The childbirth culture influences what options women are offered, how those options are perceived, and how women are able to access those options (Lambert, Jomeen, & McSherry, 2018; Murray-Davis et al., 2014). When a woman becomes pregnant, especially for the first time, she is "thrown into the world of birth…and faced with an array of options and must choose possibilities of action that are conditioned by [her] enculturation into the practices of [her] specific childbearing community" (Kay et al., 2017, p. 286). Because women in Canada (and North America) are growing up and learning about pregnancy and birth embedded in a culture of medicalized childbirth, medicalized childbirth is seen as the norm (Bayly & Downe, 2018).

The medicalized childbirth culture has and will continue to have, the potential to influence women's decision-making about place of birth. However, this influence is complex; it is not necessarily obvious to women or care providers and as such, is often unrecognized as being as powerful as it is. In the pages that follow, I will bring forward evidence related to how the medicalized childbirth culture is the overarching and dominant influence in women's

decision-making about place of birth and specifically, how the intersections of gender, professional experience, and control, influence how options and choice are interpreted and enacted.

Options and Choice in Decision-Making

The ability to decide about one's pregnancy care provider (midwife or physician), place of birth (home, birth center or hospital) and to make informed decisions about labour and birth rooted in one's personal values and beliefs is highly appreciated by women around the world (Houghton et al., 2008; McCourt & Pearce, 2000; Noseworthy et al., 2013b). Unfortunately, options for place of birth, provider, and labour support approach are not always available, and even when they are, women experience barriers to autonomous decision-making (Jarrett, 2015; Vedam et al., 2014).

For decades, consumers and others have been fighting for sustained and equal access to options in childbirth. However, consumers, the birth professionals that provide birth care, and the governments that fund them are at odds regarding what constitutes safe options, and how these options should be offered. This discourse has led to a wide variety of outcomes in Canada in particular, ranging from access to Caesarean section on demand to government funded access to homebirth and midwifery care. Yet there is no stability. Access to particular providers varies depending upon location; the scope of practice of providers is restricted in many areas; and hospital birth, although touted as the safest option, continues to carry significant risk to women's physical and psychological health and the health of their baby (Boutsikou & Malamitsi-Puchner, 2011; Henderson & Redshaw, 2013; Niklasson et al., 2015).

For choice and decision-making to be possible, there need to be options available. As I have already established, this is not always the case; and even when options are available, the

ability of a woman to choose across options and to make a decision can be difficult and for some, impossible (Barber et al., 2006; Bayly & Downe, 2018; Jomeen, 2007; Houghton et al., 2008; Pitchforth et al., 2009; Woog, 2017). This is especially relevant in situations where decision-making is embedded in a system whereby the power to decide is limited or restricted altogether.

> *"I was never given a choice about where I was going to have my babies. I don't really have a clear understanding of what my options are for my birth – I mean, I'm having twins so I guess that impacts what my options would be. But there is a lack of education in the system about where, and how, and with whom women can birth. There is a lack of educational materials like brochures and no real discussion about it. My obstetrician delivers at hospital A so apparently, I'm having my babies at hospital A". (Lisa)*

> *"At my first prenatal appointment, my doctor asked me which obstetrician I wanted to care for me during my pregnancy and birth. My doctor called me high risk – he told me that I'm an elderly primip – what does that even mean? I'm not saying that I would have chosen a midwife or a home birth … but they are telling me that because of my age I'll be induced at 38 weeks. I'm not sure I want that". (Michelle)*

> *"…she didn't offer me another family doctor or a midwife. I know that I will have access to an obstetrician at the hospital because someone always has to be available for emergencies, so I am open to having a family physician at my birth.*

I also know that I'll get more time with a family physician or midwife during my pregnancy appointments". (Jennifer)

The experiences of each of the co-participants of this study, highlight that options about place of birth were never presented. Instead, each woman's primary care provider took control of decision-making power and pushed pregnancy care toward an obstetrician and place of birth was then organized around that obstetrician's choice.

"Choice is given in a controlled way; the professionals that are meant to be supporting us – they control the choice – they control when its offered, accessed, followed through on. Women are not allowed to choose because our options are never made clear". (Sarah)

Choice is a socially constructed concept that reflects both cultural and social norms (Pilley Edwards, 2004, p. 2). By this, I mean that the options available to women are made available within socio-cultural boundaries. Options carry value – there are socially and culturally determined benefits and risks associated with every option. When a woman chooses the option that is favored, a 'good' choice is made. This is in contrast to the 'bad' choice that comes from deciding in favor of the alternative. For women making decisions about birth, the risk of being blamed for poor outcomes that result from making the 'bad' decision is often at the forefront of her mind (Coxon et al., 2014a).

As a single woman who had chosen to get pregnant through the adoption of a donor blastocyst and who experienced multiple early losses before her current pregnancy, Michelle brings forward her experiences of feeling pressured to make the 'good' choice – the choice that in her life and her professional environment as a healthcare provider, was deemed acceptable.

"Women work so hard to get pregnant and there's so much pressure to make the 'right' decision – how could a woman then risk a home birth? I don't know how I'd go back to work having to explain to the people that I work with that I made a decision that lead to my baby dying. I would rather hand over responsibility to someone else and not carry that with me". (Michelle)

Intersectionality in Decision-Making

To make the concept of choice and the process of decision-making even more complex, I suggest that each woman comes to any decision, with a lifetime of socio-cultural experiences. Which option is selected in any situation will be influenced by a multitude of factors including; her life experiences (that are socially and culturally considered), her knowledge about each option, access to the resources that will allow her access to options, and by her cognitive, emotional, and psychological capacity to make a choice (Noseworthy et al., 2013b). Hence, choice is influenced and limited by the intersections of values, resources, life experience, and knowledge. I would argue, that one's gender also contributes to the intersectionality of place of birth decisions (Chodorow, 1995; Kirkham, 2004; Nelson, 1983; Zadoroznyj, 1999).

Each woman comes to making a decision about options as a woman; her gendered self, influences how she perceives, interprets and decides about the options available to her (Martin, 2003) and, her gendered self also influences how she reacts and responds to the barriers placed in front of her. Women as patients and consumers of maternity care come to the system with "internalized [identities] of gender that discipline [them] from the inside out. [The identities] influence who [they] are, even during seemingly natural experiences like birth…and compel [them] to act in gendered ways from within" (Martin, 2003, p. 57). Some feminist researchers have suggested that internalized identities of gender constrain women to conform to socially and

culturally defined behaviors and ways of being; that women 'do gender' (West & Zimmerman, 1987, p. 126) and as such are disciplined to being relational, selfless, caring, polite, nice and kind sometimes at the expense of their goals (Martin, 2003).

"For women to go against the cultural/social norm, to go against the social institution of medicalized childbirth, is to challenge the oppressive patriarchal institution of contemporary birthing and motherhood" (O'Reilly, 2004, p. 160). It requires strength and resources that women often find difficult to gather. Further, the pressure to birth and mother within the confines of the institution of gender, and to behave and do the right thing (to be monogamous, heterosexual, married to the father of your babies, birth by the rules, etc.) is so strong and so rife with fear mongering that even women who 'know better' give in to it (O'Reilly, 2004; Rich, 1986).

For Michelle, Jennifer and Lisa their professional experiences and the environments within which they practice as healthcare providers has impacted and influenced their understandings, beliefs, and opinions about birth.

> *"As a nurse practitioner, I work in a very paternalistic environment and in a role that is framed by, and functions within, a paternalistic viewpoint of patient and provider. I've been a part of this system to this point in my life as a provider, and now, as a patient, I feel like a cog in the wheel just like any other patient. I used the system to get pregnant and came out pregnant. I will go into the hospital to have my baby and will come out with my baby. Do I really want to challenge that by choosing a midwife or a home birth or questioning what I'm told?" (Michelle)*

"The normal to us (healthcare providers) is the abnormal. We see really awful things all the time and those awful things sit at the forefront of your mind. The positive and normal experiences are understood but personal/professional experiences have more weight". (Jennifer)

"Even though in my heart I wanted to give myself the best option for a natural birth and to believe in myself and my body and trust my philosophy of life, I went to a physician to be extra safe. I don't know why I went, but I think it was fear. I wanted to be extra safe and to do things the right way". (Sarah)

Control

Birth care professionals also come to the transactional spaces that they share with women with socio-cultural experiences. Their professional experiences (or lack thereof) influence the manner with which they work with women, as well as their attitudes toward care options (Bayly & Downe, 2018; Coddington et al., 2020; Difilippo, 2015; Vedam et al., 2009). This experience is sometimes used to coerce women (whether consciously or unconsciously) into making particular choices. As an example, consider the situation whereby the promise of a live baby is used as leverage to convince women to birth in hospital with a physician or, to have that C/S for fetal distress (Gregg, 1995 in Mavis Kirkham, 2004). This practice of leveraging hospital birth over out-of-hospital birth by declaring it safer is prevalent and has contributed to the belief that hospital is the safest location in which to give birth (Woog, 2017).

The use of information, withholding information, and partial information sharing by providers is also prevalent in the contemporary birth culture. Whether intentional or rooted in a lack of awareness of their paternalistic approach to information sharing (Charles et al., 1997),

this behavior can be harmful (ibid). Multiple authors have brought forward the experiences of women navigating the pregnancy and birth care environment in the U.S. and the systemic racism that is described (Altman et al., 2019). Experiences of disrespect, abuse, discrimination, as well as feeling powerless to access information about or make decisions reflected the "power and privilege in patient-provider information exchange" (Altman et al., 2019, p. 3). Information was partially or incompletely shared and "packaged" in a way that appeared to reflect particular providers' were using the information as a mechanism of control (ibid). This can and does happen to women of all backgrounds, ethnicities, and vulnerabilities. Whether intentional or not, co-participants in this study, also found that information sharing was insufficient.

In preparing for the birth of her first son, Sarah recalls that her family members pressured her into seeing an obstetrician for pregnancy care. She went to the obstetrician because she wanted to do things the right way.

> *"The physician that I was sent to, who was an obstetrician, told me that I was at risk, for what I don't know, and she instilled so much fear in me that things would not turn out well if I chose an alternative provider. Before that appointment, I was living my pregnancy in a happy bubble and I felt well and healthy. I didn't believe that I had any need to be concerned about my pregnancy or labour. But then, all of my questions were challenged, and my decisions were questioned; I went home crying and continued to struggle with my decision to have an obstetrician at my birth in hospital for a long time". (Sarah)*

For Michelle, the speed and lack of intentional information sharing on her physician's behalf, left her feeling as though she couldn't keep up and was being left behind.

"...when my doctor started talking about inducing me, I started to panic a little – like, what do you mean you're going to induce me? Why? Isn't that putting my baby at risk? But I didn't say anything to him because he quickly moved on to something else and I got lost in the conversation. After I left the appointment and since then, I've been struggling with how I'm going to move forward with this plan – it doesn't feel right to me, but I don't know how I'm going to have this conversation". (Michelle)

For many birth care providers, their approach or their manner of working with patients has been influenced by years of seeing the worst but it can also be influenced by having not been involved in physiologic, straightforward birth. (Coddington et al., 2020) demonstrated that for midwives who have only walked alongside women in hospitals, exposing them to birth at home can be pivotal to altering their perspective, approach, and beliefs (ibid).

The Consequences of Restricting Choice and Decision-Making

There are consequences to women and their families when options are not made available, access to options is restricted, or the power to make decisions about birth is limited. These consequences include postpartum mood disorders. Specific factors related to access and choice that have been shown in the published literature to be connected to mental health problems in the postpartum period include; a perceived external locus of control of the woman during birth (De Schepper et al., 2014), having an instrumental delivery, describing birth care less positively, being given information too late to make decisions about care, and having restricted access to the [birth care provider] (Henderson & Redshaw, 2013). In contrast, high

levels of satisfaction and personal control were consistently and reliably linked to positive psychological outcomes (Jomeen & Martin, 2008).

A woman's mental health in the postpartum period is important to the woman, as well as the health of her child. When a woman suffers from a postpartum mood disorder, the child is at increased risk of displaying aggression and inattention at three to five years of age and in later years (10 to 11 years of age), is at increased risk of anxiety and other mental health problems (Letourneau et al., 2013; Pawlby et al., 2008; Soet, 2001). Although postpartum mood disorders and the outcomes of a woman's health to her children and family have not been directly correlated with her ability to make informed choices about birth, it is evident that for some women, the patriarchal system within which they birth has long-standing effects.

> *"My first birth took place outside of Canada and it was a terrible experience. I've had four years to think about everything that lead up to my son's birth and what happened and I'm still struggling. I'm having a very hard time making a decision about where I should have this baby and who to trust. I'm having a hard time trusting medical people in general because of my experience with Luca (her first born son). This is not the way that any woman should be preparing for a birth; burdened with all this negativity". (Sarah)*

The mistrust and fear that some women have related to birth in a hospital can contribute to them making the decision to birth outside of the hospital. For some women, freebirth[7] is seen as the only option for them; it's the only way that they feel they can realize their need to disengage with the medical model and the limitations and interventions that they believe will be

[7] Freebirth is a term used to describe a decision to birth without professional support. The literature reflects that this decision comes often from a place of dissatisfaction, fear and trauma related to a previous birth experience (Jackson et al., 2020)

forced upon them (Bayly & Downe, 2018; Feeley et al., 2019; Jackson et al., 2020). But freebirthing places the burden of negativity and strong judgment on women who choose it and as well, can in and of itself, be risky (ibid). And when options like a midwifery supported birth centre or home birth is not available, the risks related to hospital birth are just too high.

Consumer and professional groups in high-income countries have been vocal in advocating for choice related to place of birth, as well as a provider (personal reflection). In Canada specifically, consumer groups have been highly influential in achieving allocation of government funding for low-risk maternity care with midwives that have resulted in up to 20% of Canadian women having access to physiologic birthing supports outside of the medicalized hospital setting (personal reflection; Bourgeault, n.d.). Unfortunately, as with many healthcare programs globally, birth care in Canada is often the focus of government cuts during times of economic downturn or, at the hands of conservative and more traditional leadership (personal reflection). It is difficult for some to comprehend why birthing options are reduced or cut altogether when midwifery care and home birth result in lower government expenditures in comparison to the medical alternative and offer equal, if not better, outcomes to women and their families (Janssen et al., 2009, 2015; Tracy & Tracy, 2003).

As a woman who is committed to bringing forward the inequities in maternity care, I find myself returning to blaming this situation on patriarchy. Women in the maternity care system, as consumers and as midwives, are being oppressed by the stronghold of the medical system, which is rooted in patriarchy. Until physician financial gain from having a monopoly on maternity care is taken out of the question, consumers and their midwives will continue to struggle.

Gazing Forward

There is a lot of work to be done. Options and access are not stable, and with each change

in government and healthcare system leadership, maternity care options are at risk. There is also a great deal to be done about the hospital environment and the manner with which birth care providers interact and work alongside women as they make decisions about birth. Even with research and policy readily available to them, providers continue to work against efforts to transform the system from the archaic patriarchal medicalized hierarchy that it is, to a system that respects women, their needs, and their power. I feel the key promise of working with women making decisions about birth is that with time and the "efforts of a critical mass of courageous, committed and stubborn insiders..." (Simkin, in Klein et al., 2006, p. 247) change will take place, and women will be given back the power to determine where, with whom and how they wish to experience the sacred transition to motherhood. With time and continued effort, women will be able to construct a maternity care system that meets the needs of all women, regardless of their socio-cultural baggage or the intersections within which they live life, and it will be a system that values and respects the gendered identities that we carry with us. Perhaps the most important promise of all will be that the health of women and their babies will no longer be put at risk by the very system that they are led to believe will keep them safe.

The most significant challenge in working with women as they make decisions about birth is that the current birth culture in Canada limits women's access to options and influences her experience and ability to make decisions about her birth. The system as it currently functions makes it difficult for some women to see the socially and culturally constructed options that are available and for others, makes it challenging or impossible to access them. Decision-making about birth is made even more difficult because it requires women to enter into a transactional space with birth care providers that have been socialized by the medicalized, technocratic, capitalistic, and hierarchical system. This transactional space is not always respectful and for

some women results in adverse health outcomes. Out of the discourse that continues about safe options, funding, access to options, and respectful maternity care, there is an ongoing opportunity for women to imagine and construct a system that is supportive of their right to safe options and control over birth. As one of the 'stubborn insiders', I look forward to being a part of this work.

Thread Two: Experience as Influence

I can't guess what's outside my mind
I even don't know what's inside
there's only words that I can find
still trapped beyond their wrong and right

I tried to analyze what's me
and I did find I am not there
'though I'm still trying hard to see
myself gets lost within my stare

it seems this is the final line
there is no answer from beyond
my mind plays tricks on my weird mind
so I can't tell what I have found

I sense a gap yawning at me
extremely bored by useless tries

I can't control what I can't see
and what I see still blinds my eye

this gap is wide and it is deep
I would get lost if I should try
to cross it with a logic heap
since every meaning is a lie

hope I'm not ****** to realize
that there's no way for going on
that going further won't be wise
may cause confusing right with wrong

I blame my helplessly forced thoughts
for showing what I can't deny
although I know it's them of course
that hide the world from my fooled eye

I can't guess what's outside my mind
and don't know what is all inside
there's only words newly combined
to live on beyond wrong and right

the gap is deep and it is wide
I'm lost no matter if I try
to reach out for the other side
since every reason is a lie

but writing on to change what's true
may lift me to a novel top
a strange one with a wider view
for getting closer there's no stop

'though gaps restrain what I can do
but there's no way for giving up
lost, yearning for a self-that's true
maybe I already went one step
too far and fell into the gap.

Unknown

Everyone is biased. Our life experiences create the lens through which we consider and make decisions about literally every aspect of day-to-day existence. And when offered the opportunity to make a choice, our experiences and our biases allow us to make quick decisions but also, influence how options are considered and resolutions are made.

There are many types of bias that individuals carry including availability bias, anchoring bias, confirmation bias, risk aversion, and others. Bias is informed by one's past and can be difficult to recognize, acknowledge, and change because of the multiple events that create and

reinforce it. When women become pregnant and are asked to make decisions about their health, about their labour and birth, and about potential events that will impact the future health and wellbeing of their child, experiences from the past, as well as biases that women hold, influence what path is chosen. In the pages that follow, I will bring forward the idea that experience (or lack thereof) and the resulting biases that are held by women (as well as others around her) significantly influence decision-making about place of birth. Again, this common thread, brought forward through the narrative accounts of all co-participants in this study, is weaved so tightly and is so intricately intertwined with one's birth culture, that I suggest it is almost impossible to discern which comes first; culture or experience (and bias).

Inexperience as Experience

Stories Shared in Relation

As Lisa, Michelle, Jennifer, and Sarah (as a primipara) were decision-making about their place of birth, they were considering knowledge of birth brought from the past to the present through stories of friends and family who had experiences of birth. Because these women were personally inexperienced with pregnancy and birth and were unable to rely on personal meanings from their own past, they turned to others. As Kay et al.(2017) brought forward, "birth stories are cultural 'productions' that convey various ideologies and belief systems [and they shape] women's expectations and experience of childbirth" (p. 292). Stories "colonize consciousness" (Ewick & Silbey, 1995, p. 213), and contribute to a woman's understanding of birth as well as her biases. Because negative stories appear to be shared more readily (Kay et al., 2017), it is understandable that the stories of others contribute to the continued dominance of a medicalized childbirth culture.

"Our friends really struggled with the turn of events after the birth of their baby. He was born with multiple undiagnosed genetic abnormalities that were incompatible with life. When he was born, the paediatrician was right there and the baby was able to be resuscitated and intubated long enough that our friends were able to hold him before he died. If they hadn't been in the hospital and there were experts available from the NICU, our friends would have watched their baby die in their home. I couldn't imagine that let alone, having to go on living in the place where my baby died". (Jennifer)

Whether Jennifer, Lisa, Michelle, and Sarah remember, or had ever heard stories of joy and ease and positivity about birth before becoming pregnant, these stories were not evident. None of the women involved in co-creating this project brought forward stories of friends that reflected birth outside of the hospital or, birth that was joyous. Even stories about labour and birth of a healthy newborn to a healthy woman involved reflection of the pain.

"I've talked to a lot of my friends who tell me about how awful their non-pain relieved birth was compared to their birth with an epidural. Some of my friends had their first child naturally but then for their second child got an epidural, and they talk about how much easier the second time was. I just don't think I'll be able to cope so I want to be in hospital where I can get an epidural when I decide I need it". (Jennifer)

Women involved in this study spoke about the weight of the unknown in the future; how they would cope with pain, how they would cope with loss, and how they would cope with the judgment of others or their guilt as having an impact on their decision to birth in one place. It's

the unknowns about pregnancy and birth laid alongside stories shared in relationships that influence and guide women toward decisions.

The Experience of Medicalized Pregnancy Care

Michelle and Lisa both spent several years trying to achieve a pregnancy and became intimately familiar with the medical system through their fertility treatments. Both spoke about the impact of their experiences; of the "poking and prodding to get pregnant" (Lisa) which became normal over time. The lived experience of fertility treatments had an impact on both of these women; trust in the medical system was strengthened as it allowed them to become pregnant and to be able to experience planning for birth. And although their situations for requiring fertility support were different, they both were doing the process as single women of advanced maternal age (over age 35yrs). With no lived experience of pregnancy and birth from which to drawn on, Michelle and Lisa continued to be guided by their birth care professional and place their trust in others to achieve a positive outcome.

> *"I am so used to the poking and prodding to get pregnant and it's become almost normal. I'm so used to the process and the matter of factness – having my baby with my obstetrician and in hospital is just part of it all" (Lisa)*

> *"I'm really reluctant to question my doctor or go against the grain. I had to work so hard to get this far along and who knows, maybe there's some risk that I'm not aware of that or that in my limited pregnancy and birth are experience, I don't know about. I don't have the energy to fight against his plans for me". (Michelle)*

Experiences as a Healthcare Provider

Lisa, Michelle, and Jennifer are all healthcare professionals with advanced degrees. They all work in the acute care environment and admit their perspectives and understandings about pregnancy, labour and birth to be both limited and risk focused.

> *"My experiences in undergrad in postpartum were completely overwhelming for me. What was going on, on the unit, was very difficult for me; sad things were happening to women and newborns. Awful, horrible things at a time when people are healthy and young, and it should be such a happy time". (Jennifer)*

> *"As a healthcare professional myself, I'm the decision-maker for my patients all day long and it is exhausting. It is a heavy burn to carry every day and at times I feel worn down by the responsibility. I feel as though the responsibilities I have in my professional life have really affected the energy that I could put into this pregnancy". (Michelle)*

> *"The normal to us (healthcare providers working in acute care) is the abnormal. We see really awful things all the time and those awful things sit at the forefront of your mind…positive and normal experiences are understood but personal/professional experiences have more weight". (Jennifer)*

> *"I've worked alongside some very caring and wonderful physicians and I know that my physician, and most physicians for that matter, have the patients' best interest at heart. I've rarely seen a situation where one of my peers has put their*

own needs or goals ahead of a patient's. Trust in your medical professional is very important, and in my situation, I have full confidence that I'll be well cared for". (Lisa)

Decision-making does not occur in a vacuum but, is a result of social influences women are exposed to in their everyday lives (Budgeon, 2003). For those women who know nothing personally of physiologic birth or, birth at home or in a birth centre, it is understandable that they would choose birth in a hospital where they feel safe. The hospital is what they know, it is an integral part of their professional life and offers them the comfort or confidence that they desire.

"We want to have our baby in the hospital where there is a NICU and support services for me and our baby in case something goes wrong. I can understand that some women feel that their birth experience is important but for me, it's about safety. And the hospital is the safest place in my opinion". (Jennifer)

Coming to a pregnancy as a professional who functions as a decision-maker in the healthcare system adds another layer of influence as to what decisions are made during pregnancy and birth. As healthcare decision-makers, we have an intimate knowledge of how one choice can, and usually does, cause a ripple effect of outcomes. And we carry this intimate knowledge with us from our professional past, into the decision-making moment. This knowledge nudges us to consider things that other women don't think about. Which nurses will be in the hospital where I'm birthing and, do I trust them? What sorts of patients will be in the hospital rooms where I will labour and how will I cope with them? Which specialists will be available if I need them (e.g., anesthesiology) and, do I trust them? If I question this physician, what will the

outcomes be to me as a birthing woman or as a professional down the road? Because all of these people know I'm pregnant, how will they treat me if I make this decision?

I wonder for Michelle, Lisa, and Jennifer, if the place within which they function as professional women, has influenced their decisions to not challenge their providers or, to even ask for alternatives? In our daily lives as healthcare providers (but non-physicians), we are expected to live by the hierarchy of the medical system. I wonder if this commitment to the hierarchy is so ingrained within us that it controls our personal lives as well?

As a woman who has walked both sides of the birthing world as NICU nurse and midwife, I see how the medical hierarchy can influence patients and healthcare providers' decisions. Until I spent time with these highly educated, successful healthcare professionals, I had not realized how powerful this hierarchy can be.

Lived Experience of Pregnancy and Birth

Sarah was decision-making about place of birth having personal experience of pregnancy, labour, birth, and mothering. Her personal knowledge brought forward as memories of her pregnancy with Luca, and Luca's birth influenced her. Her knowledge of how she coped in the past with the trauma of Luca's birth, and the fact that she knew she needed to reconcile for herself in the present and for tomorrow, influenced her.

"Decision-making is highly complex, critical and delicate for women…and influence causes both positive and negative experiences for women that can have long-term effects for them" (Lambert et al., 2018). Sarah's past, and the trauma and struggle of Luca's birth, had a significant impact on her life. She approached decision-making about place of birth for her 2nd baby with very different goals than the other co-participants and sought an alternative to a

hospital birth because of her past, her present, and knowledge of herself. “Research demonstrates the extent to which the character of obstetric encounters is influenced by previous obstetric encounters; childbirth itself needs to be recognized as a critical reflexive moment which for many women, contributes to changes in lived identity” (Zadoroznyj, 1999, p.286).

Knowledge can come in many forms, but it is always gained and utilized through experience. Lived experiences influence how knowledge from the past is interpreted or reinterpreted. Lived experiences are also influential to how new information is interpreted. As a result, whether a woman has experienced pregnancy and birth in her past, will influence how she experiences decision-making about her current pregnancy and birth. Her previous experiences of pregnancy and birth will also influence what or whom she decides to allow to influence her today.

> *“With my midwife, I feel at peace and confident. I know that I can ask questions and talk about my worries with her and I will not be judged. It is so different this time around because of my midwife. I instantly felt connected and safe with her; it’s just so different than it was with my last pregnancy”. (Sarah)*

Having lived experience of pregnancy, place of birth decision-making, and birth influences women’s present and it will impact her future decisions. In fact, all experiences in one’s life impact and influence decisions. For Sarah, her experiences being pregnant with Luca and feeling pressured to birth in hospital with an obstetrician, feeling as though she had given up power for decision-making, and then experiencing a traumatic birth, influenced her to take control of her pregnancy and birth decisions the second time around.

> *“When a person is pregnant and a mother; we are so vulnerable in a different way than for any other person. There’s so much pressure to be perfect and to*

make perfect decisions. Unless you've experienced it, you can't truly understand that pressure and the burden. (Sarah)

Choosing a different place of birth or, a different provider after a negative birth experience is common (Coxon et al., 2014b; Difilippo, 2015; Lambert et al., 2018) but not surprising. And like any experience, having done something and lived with the outcomes of a decision or path, is a powerful and significant influence on one's present and future decisions.

When decision-making about place of birth with no previous lived experience to draw from, Lisa, Jennifer, Michelle, and Sarah (as a primipara) were influenced by their inexperience. Each of these women were vulnerable (as described by Brisco et al. 2016) to the medicalized birth culture and their interactions with it as women and professionals but also, to others' stories shared in relation. This vulnerability could have been experienced as an opportunity to expand knowledge and understanding about options but because of the power of the birth culture (and the medical system culture which Lisa, Jennifer and Michelle are very much entrenched in), all were guided toward birth in hospital.

As I write this reflection today, women and care providers around the world are learning about the negative outcomes of medicalized childbirth because of the COVID-19 pandemic (Brooks et al., 2020; Davis-Floyd et al., 2020; Dell'Utri et al., 2020; Gan-Or, 2021; Lebel et al., 2020). Healthy women who have been experiencing healthy pregnancies are presenting at hospital to have their babies and being forced to labour alone (Gan-Or, 2021), many with epidurals because of low nurse to woman ratios which mean less nurse to woman support and being further controlled by policies that have nothing to do with birth (Carmon, 2020; Laucius, 2020). In some countries, the rate of premature birth and intrauterine death has significantly increased which when examined, seems to be related in many ways to reduction in pregnancy

care (Been et al., 2020; Dell'Utri et al., 2020; Green et al., 2020). As well, there is evidence that the pandemic has contributed to increased rates of anxiety and depression during the perinatal period (Brooks et al., 2020; Lebel et al., 2020).

The significance of birth related decisions (including place of birth) has come to the forefront of many people's minds because of the experiences of women birthing during this pandemic but, if women had always been offered choice, and supported to birth outside of the hospital where they are safest, these traumatic events would be significantly less common. As well, over time, the birth culture might be allowed to change to one of opportunity, choice, and learning about the power and possibility of physiologic birth without intervention outside of the medical system.

It is my hope that for every woman who experiences the vulnerabilities of the pregnancy and birth continuum, that they are supported to explore their options and to discover their power and strength as they make decisions. For this to happen, the birth culture will require a significant shift; a shift that may occur in small increments, one woman or healthcare provider at a time.

Thread Three: The Influence of Others

Studies that have involved women who have chosen out of hospital birth (birth at home or birth centre) reveal that women make decisions that express their personal ideology and with personal agency (Coxon et al., 2014b; Difilippo, 2015; Murray-Davis et al., 2012a; Wood et al., 2016). For these women, trust in their ability to birth without medical intervention and being able to take action to achieve the birth that they wanted, were common reasons for seeking out of hospital birth. Out of hospital birth reflects a desire for safety, autonomy, and a physiological birth experience where safety is conceptualized as being able to be in control and being able to

choose and enact personal preferences whilst away from medical influence (ibid). In contrast, the literature demonstrates that women who choose to birth in hospital, do so in part, because of the safety that the available medical technology offers (Grigg et al., 2014b).

When considering these two seemingly dichotomous perspectives, it may be assumed that one's belief about what safety is, and how safety can be achieved, is what leads a woman to choose a birth in or out of hospital. But what this study demonstrates is that it's actually much more complex. Across the pregnancy and birth continuum, women are vulnerable to the birth culture but as well, to others. The knowledge, experiences and opinions of healthcare providers, as well as family and friends, are significant to the decisions of women.

In the pages that follow, I will bring forward the idea that the power that is given to and held by others can be significant and is often misused. I suggest that it is the responsibility of women, to resist and relearn about birth, and to seek out the opportunity to turn vulnerability into strength.

Health Care Providers as Influencers

Michelle, Jennifer, Lisa, and Sarah (for her first birth) all presented to their primary care physician knowing that they were pregnant and sought guidance related to next steps. In each of these situations, the women were referred to an obstetrician for their pregnancy care and plans were made for these women to have their baby in a hospital of the receiving physician's choice. None of these women discussed alternate options with their provider even though, as our conversations demonstrated, they were not necessarily comfortable with the plans as suggested.

Lisa, Jennifer, and Michelle are all healthcare providers; highly educated, independent decision-makers, and fully capable of seeking out and accessing information about options. However, none of them chose to follow through with discussing alternatives with their care

provider. They chose to have a hospital birth, and each talked about a sense of *going along with their physician's plans* for a variety of reasons. Lisa was deemed high risk and was confident that birth in hospital was the best option for her related to her health status. Jennifer knew she wanted to birth in hospital because the interventions and support options that she wished to access were only available there. She knew what she needed and how she would have to navigate the system to get it. She did, however, follow the lead of her physician related to care provider even though she could have accessed someone else.

Michelle on the other hand brought forward the sentiment that she wished to hand over decision-making to someone else. She wasn't necessarily comfortable with what her obstetrician planned for her, but she chose not to question or discuss alternatives. Michelle made a conscious decision to do what her physician suggested even though she could have chosen otherwise.

> *"I feel as though the responsibilities I have in my professional life have really affected the energy that I could put into this pregnancy. As well, over the course of the past few years, I have worked so hard and had to make so many decisions about getting pregnant that now that I've gotten to this stage, I need to be able to finally pass the decision-making to someone else… I'm fine with having an obstetrician and birthing at [the hospital] so I can hand over the decision-making and worrying to my provider". (Michelle)*

Sarah's experience for her first birth was similar whereby she was led toward a hospital birth by her provider and felt it difficult to choose differently.

> *"The physician that I was sent to, who was an obstetrician, told me that I was at risk, for what I don't know, and she instilled so much fear in me that things would not turn out well if I chose an alternative provider…Eventually I resolved myself*

to approach the birth with an attitude of 'ignorance is bliss'. I would go to the hospital like everyone else and just have the baby and accept the outcome". (Sarah)

What the conversations with each of these women independently, and then considered together, brings forward is the power that health care providers have specific to decision-making about place of birth and, other birth decisions. None of the four co-participants in this study were offered or informed about, options related to place of birth. None were suggested a midwife or a family physician but instead, were organized with an obstetrician to provide pregnancy and birth care. What is perhaps even more concerning, is that three of the co-participants were labeled by their care provider as high risk, when there was not a clear indication as to why, predisposing them to obstetric care and a hospital birth.

"Choice is given in a controlled way; the professionals that are meant to be supporting us – they control the choice – they control when its offered, accessed, followed through on etc. And if we ask about options, it seems as though they quickly find a way to push you in the direction, they wish you to go". (Sarah)

Whether a woman believes that she is safest in or out of hospital for the birth of her baby is almost irrelevant if the actions of the care provider demonstrate a belief that hospital is where a woman should be. Several studies have shown that women wish to be in-relation and to make decisions along with their care provider (Cook & Loomis, 2012; Wood et al., 2016). Hence, when the care provider is leading the patient down a particular path, it is that path that most patients will follow (Cook & Loomis, 2012; Flores, 2018; Wood et al., 2016). Women take the lead of their care provider. Even when they know that alternative options are available, they will go along with what is suggested thinking that the provider knows better.

"...maybe there are unforeseen risks that, in my limited pregnancy and birth care experience, I don't know about. I'm fine with having an obstetrician and birthing at the [hospital] so I can hand over decision-making and worrying to my provider". (Michelle)

"My obstetrician delivers at hospital [A], so apparently I'm having my babies at hospital [A]...I wasn't given a choice and wouldn't have been able to make a different decision anyway. I'm too high risk for all of that". (Lisa)

The power that is held and often used, whether intentionally or unconsciously, by healthcare providers can be damaging. For Sarah who felt confused and powerless when it came to how the obstetrician for Luca's birth made her feel, she struggled for years afterward. Her experience in dealing with the lack of control she felt during Luca's birth and in her early days as a mother, influenced everything about how she approached Charlie's birth. She self-reflected and acknowledged her needs for her 2nd birth and sought out information and supports so that she could keep herself safe. She had to come to terms with who she was as a mother and what she wanted for her labour and birth and surround herself with people who were willing to know her to avoid risk of being retraumatized. Her inexperience at the time of Luca's birth led to her acknowledging the experience of that birth, and to moving forward with that experience at the forefront of her mind. And when faced with the opportunity to decide place of birth again, Sarah chose a provider who would support her wishes.

Friends and Family as Influencers

There are multiple influences on decision-making about place of birth. The process is very complex and includes one's consideration of relationships with family and friends.

Jennifer's experience of living alongside her husband who was anxious about parenting and as well, with the story of a friend's traumatic birth, is an example of how powerful the stories of others are. When considered alongside one's own life experiences, fears, and beliefs, the stories of others can work to strengthen biases that birth is riddled with risk. And for those women who are then not exposed to positive narratives or information about the benefits of home birth, midwifery or both, their decision-making about place of birth can be rooted in fear and resistance (Difilippo, 2015) and, put them at risk for negative physical or psychological outcomes. Of course, one would assume that positive birth narratives shared from those who are considered referential influences could do the same; unfortunately, these sorts of narratives were not shared or accessible to any of these women as primiparas.

Although not explicit, the unwavering support of parents, as brought forward by Lisa and Jennifer, is its own type of influence. Knowing that one has the support of those important to them, regardless of one's decision, can be very empowering (Grigg et al., 2014a; Hollander et al., 2020; Wood et al., 2016; Woog 2017). In contrast, when one's close family and friends express concern or negativity about one's decisions, it can be distracting or harmful. Sarah's reflections about the opinions of her in-laws and her aunt whilst she was pregnant with Luca, and even after the birth of Charlie, are sources of continued discontent for Sarah.

> *"After Charlie's birth, my mother-in-law actually said to me what was that about? Did you just want to feel labour – are you happy now? Like I was making a conscious choice to put my baby at risk just to feel labour! I'm so upset about this because really, all I wanted, was to give my baby a chance to be born without all the trauma and drama. It wasn't about wanting anything more than a chance to do things naturally". (Sarah)*

Having access to options, and the ability to choose the place of birth where one feels most comfortable, without coercion from others, is what women want (Jackson et al., 2020; Reed et al., 2017; Westergren et al., 2019). Whether wishing to hand over decision-making to a birth care professional or, wishing to hold the power to decide as things progress in a pregnancy and birth, women should be able to do what works for them. The multiple influences that come together and which women are forced to consider can be overwhelming but can also, offer the opportunity to acknowledge, explore, relearn and reconsider (Difilippo, 2015) toward a journey that one might never have imagined.

It is through reflection on one's experience (or lack thereof), one's biases, the stories and experience of others, and in consideration of the context of the current birth culture, that women can uncover and discover their needs and goals and take back the power to decide for themselves, how their pregnancy and birth will unfold. But it requires women to take back the power. This is difficult and challenging and it is riddled with barriers that are significantly entrenched into our culture. Hence, birth care advocates and advocates for choice and determination in healthcare, must do their work loudly. Even if it means influencing one student, one citizen, one healthcare provider at a time.

Chapter Six: Discussion

One of the most significant challenges facing advocates for options and choice in maternity care is the fact that birth is entrenched in a medicalized, technocratic, hierarchical system (Davis-Floyd, 1994). The system makes it difficult for some women to see that they have options (because they too are rooted in this system), and it makes it difficult for other women to access the options. The system has been this way for decades and unfortunately, it doesn't look to be changing very quickly despite significant effort on the part of consumers, practitioners, and advocates.

From the beginning of western obstetrics, the female body was considered to represent the natural, savage and abnormal. "In the 18th and 19th centuries, amidst the beginnings of formal medicine, biomedical science discourse linked nature with women and culture with men" (Brubaker & Dillaway, 2009, p. 34). This socially constructed perspective of the female in need of control came to be pervasive in medicine and especially in obstetrics.

There are multiple explanations suggested in the published literature as to how the birth culture has come to be so highly influenced by the medical model. For example, Davis-Floyd (1994) suggests that medicalized birth offers humans the technology to *control* the primitive feminine nature; introducing human control into the birth process. Arney (1982) and Oakley (1984) suggest that "physicians and those in the medical field feel the need to actively manage labour and delivery for fear of the pathological potential" (Brubaker & Dillaway, 2009, p. 36). Others suggest that "our medical system reflects contemporary society's core value system; that which is oriented toward science, high technology, economic profit and patriarchally governed institutions" (Davis-Floyd, 2002, p. S5).

With the introduction of technology, the natural, physiological, and unpredictable processes of birth (and other womanly transitions) were constructed as pathological, abnormal and in need of continual monitoring (Brubaker & Dillaway, 2009; Davis-Floyd, 1994; Katz Rothman, 1989). In contemporary times and where we are situated today, this view of birth is deeply rooted in the deficiency/deviation extreme of the health spectrum where birth is equated with illness and thus rightfully treated with medical interventions.

Medicalization has led to childbirth in most countries being designed and funded specifically for medicalized birth. As an example, in some regions in Canada, there is limited government funding available for midwifery care (and physiologic birth) whilst there is unrestricted funding for births that are supported by physicians (personal reflection). Such biased funding limits the number of healthy low-risk women that are successful in accessing safe alternatives to hospital and physician-supported birth, and forces many women to birth in an environment with a provider that is not of their choice (Miller et al., 2012; Silversides et al., 2013). I suggest that this system is a direct reflection of government and healthcare bureaucracies' commitment to maintaining the status quo, whereby the medical model and the value of technocratic obstetric care supersedes that of a woman's right to choose in maternity care.

As I have already established, hospital birth puts women and their babies at higher risk of unnecessary intervention (Davis et al., 2011; Reitsma et al., 2020; Tracy et al., 2007), negative physical, emotional and developmental outcomes, and hospital birth can also be highly traumatic (Ayers, 2017; Jackson et al., 2020; Reed et al., 2017). Despite these facts, many women feel safer in hospital. So, what then is our role or place in this dichotomy, as providers and advocates for options and choice?

I am in no way suggesting that we take away options from women, but we certainly need to work harder and better to ensure that all women are offered the opportunity to explore their needs and wants related to birth; to be able to take control of their decision-making; and to feel supported in having conversations about options. This pervasive system of expecting women to go along with what the provider assumes is best does not serve women or their babies as the outcomes demonstrate.

Personal Significance

As a second year NP student with a background in midwifery, I was offered the opportunity to do a placement alongside a family physician (Joanne - pseudonym) that supported families during pregnancy and birth. Joanne is a kind, open-minded and gentle person and is a care provider who believes in committing to person-centred care and informed choice.

As part of my clinical placement, I attended the births of Joanne's patients with whom I had provided pregnancy care. During one of the births, the partner of the labouring woman asked if they could 'catch' their baby. Considering the couple's history, the woman's labour laid alongside the heathy birth of their first child, Joanne decided that this was something that she could support. Joanne guided the partner in what to do and as the newborn was slipping into the joyous father's hands, the hospital door burst wide open and in walked an obstetrician unannounced. I remember seeing his white coat approach and then forcing myself to turn my attention back to the woman, her partner and their baby as they were fully exposed to the hospital hallway. My mind was racing as I recognized that the temperature in the room had dropped with the opening of the door, and the newly birthed baby was still unwrapped as Michelle was supporting the couple in connecting with him. Suddenly, the obstetrician in the white coat started yelling "what are you doing? Did I just see the father deliver the baby?"

I was horrified. The woman, her partner, and Joanne stood there in shock. Quickly Joanne ushered the obstetrician out of the room while I took over the care of the family.

It wasn't until a few hours later that Joanne and I were able to speak about the birth and the interruption. Joanne was so upset by what happened but for me, the behaviour of the obstetrician was not surprising.

I had been the preceptor on that unit with undergraduate nursing students and observed the very same obstetrician bullying unit clerks, nurses and women on multiple occasions. The unit and the obstetrician were known for their high birth rates, high intervention rates, and general environment of negativity. But even though I wasn't surprised, I was still sickened. How can someone get away with this sort of behaviour and why do we put up with it?

The labour and birth units in North America and in some other parts of the world have become notorious for the traumas that they induce in patients (Yildiz et al., 2017) and yet women still choose to go to hospital to have their baby.

I came to this project because I hoped to understand the experience of making the decision to birth in hospital, at a birth centre, or at home. I believe that unless we commit to understanding the multiple influences on place of birth decisions, women will continue to birth in hospital without having been offered an opportunity to choose; without having thought through what she wants or needs; and without reflecting on the potential impact of that decision.

Socio-Political Significance

As I met with Lisa, Michelle, Jennifer and Sarah over time, and learned that each were choosing to birth in hospital, I wondered what influenced them to make this decision and what their experience of making this decision was like for them. As I got to know them and we spent time together talking and reflecting, they shared events and experiences in their lives that nudged

them toward their decision but, they also talked about other influences including the childbirth and healthcare culture.

Lisa, Michelle, Jennifer and Sarah brought forward stories of coercion by primary care physicians as well as obstetricians. I heard stories of fear, but I also heard stories of confidence in the system to keep them safe. What gave me pause was that these women, who had every opportunity to learn, access, dream and discover physiologic birth in a place of their choosing with a provider of their choice, followed. These privileged women decided to go along with the physician; they chose to keep quiet and not question and they chose to hand over decision-making.

I believe that the most important thing that this project brings to nursing, pregnancy and birth care practice, health system design and the birth culture is evidence that women are being actively oppressed in the current pregnancy and birth system in our community, and probably nationwide. Relational ethics, person-centered care, and a commitment to the practice of supporting informed consent and informed decision-making was not demonstrated - not by the physicians involved in the care of the women that co-created this project and I imagine, not by others. As well, this study highlights that the medicalized birth culture is so pervasive and so dominant that even those who have the privilege to choose, or perhaps should know better, don't take advantage of that privilege.

From Vulnerable to Resilient

Navigating a birth system like ours, whist also living at the intersections of gender and pregnancy, is complex and can put women in a situation of vulnerability (Briscoe et al., 2016). Women are vulnerable to experiences of their past, to influence from those around them, and to the system within which they are forced to function and often, in ways that are unrecognizable to

them. For Lisa, Michelle and Jennifer, their place of birth decisions were theirs (they were not physically forced to birth in hospital), but the actions of their pregnancy care providers did not offer them the opportunity to approach their birth having explored options. Furthermore, decision-making at the intersection of living as a female healthcare provider, placed them in position of risk by virtue of the blame that they knew would be placed on them should they birth differently, and things went wrong.

Thinking about and reflecting on the narratives of all four co-participants, as well as the threads that were revealed, makes evident the complexity of decision-making. There may be a dominant reason, explanation or influence identified by women for why they chose to birth where they did, but that one reason is the culmination of a lifetime of experiences. It was not just about safety or risk for example, but about the stories and experiences of pregnancy, birth and parenting that are heard and lived over a lifetime that create and form a viewpoint and belief that a particular place is 'safe'. For each co-participant, her experience as a woman, a professional, a daughter, a friend, a child, and so on, influenced her and contributed to her understanding of pregnancy, planning for her birth and, decision-making (Coxon et al., 2017).

Each woman's experience is different from every other woman's experience and so, she is vulnerable to that uniqueness. No one else can understand her perspective, her hopes, or her worries and therefore, only she can know what decision is best. And when offered an opportunity to trust in another and to share in the responsibility of decision-making in a space filled with unknowns, it is understandable why these women *went along*. These findings are similar to those brought forward by Coxon et al. (2017) where examples of healthcare professionals making assumptions about or persuading women to birth in hospital were described.

For Sarah, her previous pregnancy and birthing experience drove her toward exploring other options. For her, feeling safe came from taking back control and the decision-making power from others and taking full responsibility for finding a provider in whom she could trust. Sarah's different life experiences changed her perspective and viewpoint about safety and because of the different environment, different time and different place, she was able to pursue a different path.

'Feeling safe' is a common theme in the maternity literature specific to place of birth decision-making (Coxon et al., 2017; Hinton et al., 2018; Holten & de Miranda, 2016; Murray-Davis et al., 2014; Nolan, 2015; Woog, 2017), but when the reasons behind that belief are explored, they vary widely and are rooted in experience (ibid). In a culture of medicalized childbirth, where women more often than not, see babies born in hospital, the dominant or common decision contributes to the idea that the path of the majority must be the *best* path. That the system is and has been, supporting women to birth successfully for years, allows women to feel confident in the system (Grigg et al., 2015). And for women who have no personal experiences of pregnancy and birth to learn or live from, they are vulnerable to the power of the common or popular.

A unique contribution from this study is the influence of one's birth care provider. The outright neglect to share information or to provide options to women, coupled with inappropriate use of labels like "high risk" was coercive. This behaviour takes power away from women with respect to decision-making and takes advantage of her vulnerability. Instead of creating a space for reparation and growth, the birth care professionals involved in the lives of Lisa, Michelle, Jennifer and Sarah forced these women into a position of risk related to vulnerability. The birth care professionals became barriers to these women gaining strength and power by limiting access

to health care, stigmatizing, and labelling. As women birthing for the first time (or the first time in Canada) and vulnerable to the unknown of pregnancy and birth, the co-participants in this study could have experienced their birth in many different ways. But because of the complexities of intersectionality, the risk-focused and medicalized childbirth culture, and most disturbingly, the actions of the birth care professionals with whom these women interacted, they were left to navigate their experience separately and away from the very system and provider with whom they should have been able to trust.

Briscoe et al., (2016) suggest that vulnerability is a journey; whereby identified threats and barriers exist but continued movement and energy, along with positive and empathetic support, allow reparative solutions to be created and realized. Considered alongside the work of Coxon et al. (2017), the potential impact and influence of a birth care provider is further emphasized.

It is true that decision-making about place of birth is complex and women's decisions are influenced by a multiplicity of experiences. Women make decisions pragmatically but always socially. The people around her play an integral role in her being able to explore and understand options as well as to create and achieve the birth that she desires. And as this research demonstrates, birth care providers can be highly influential to the woman's experience of both decision-making and birth.

Whether a midwife, nurse, family physician or obstetrician, we have a responsibility to ensure that we remain committed to our patient. We have a responsibility to learn, teach, challenge, and not only acknowledge, but move beyond our bias toward medicalized childbirth. We have a responsibility to engage in conversation and understanding with the women we are fortunate to walk alongside; in order to ensure that decision-making is happening in a

transactional space that is safe, open and honest. And finally, we as healthcare providers have a responsibility to each other to challenge the status quo.

A close friend said to me recently; “you won’t be able to change the system”. This statement was hard to hear but also allowed me clarity specific to what I can do. I don’t have the power to change the birth care system on my own. Things need to change but it will take a collective effort on the part of consumers, researchers, politicians, and health system leaders. But perhaps the greatest impact can be made by birth care providers themselves.

Chapter Seven: Conclusion and Implications for Research & Practice

Conclusion

The goal of this project was to bring forward the experiences of women as they made decisions about place of birth. The stories brought forward by Lisa, Michelle, Jennifer, and Sarah, center around the need to birth in a place that is safe. Despite the individual and unique life experiences of each woman, the influence of safety is threaded through and embedded in all conversations. How one understands or conceptualizes safety is, like everything else; dependent upon one's history. The lens with which events are experienced or opportunities evaluated is influenced by experiences from one's past. The difference with the concept of safety related to childbirth is that it is also influenced by the childbirth culture.

The medicalized birth culture, in which each of the co-participants is embedded, has subtly and profoundly influenced their decisions during pregnancy and specifically, about place of birth. Birth in hospital is the norm in Canada and it is how each of these women has experienced birth through the eyes of their friends and family. Further, as healthcare professionals, Lisa, Michelle, and Jennifer have an intimate, insider understanding and connection with the medical environment and feel safe amongst their medical peers. And with no knowledge of birth outside of hospital, their understanding of their options, as well as the benefits and risks associated with those options, is limited.

I believe that it is essential for pregnancy and birth care providers to understand and to embrace the reality that women come to pregnancy with experiences, goals, and dreams, with multiple influences and influential stories. And for many women, navigating the system whilst also considering, learning, reflecting, and juggling multiple influences is overwhelming. It's an experience of stress and burden and can be traumatic. But whilst this is the reality, so too is the

fact that with considerate and engaged support, pregnancy can be a time of relearning and realizing (Difilippo, 2015).

Each woman comes to their pregnancy with unique experiences, knowledge, understandings, biases, and stories, which are not unlike any other day or moment in life. No two people can be said to ever experience something in the same way because no two people have come to an experience with the same history. This is what makes this work unique: it does not assume that there should or will be, consistencies in the experiences of women as they make decisions about place of birth. In fact, although interesting to consider, models of decision-making can be restrictive because they provide a frame within which an individual's experience is meant to be understood when in reality, no two experiences of decision-making about birth can be the same.

The childbirth continuum can be a time of vulnerability but, as brought forward by Briscoe et al. (2016), it can also be a time of growth. Even for women who are coming to pregnancy and birth at risk physically, psychologically, and/or socially, the pregnancy and birth continuum can be a time of transformation. But growth and transformation require curiosity, commitment, relearning, and often support. As the stories and narratives of Lisa, Michelle, Jennifer, and Sarah were shared, it became evident that there are multiple different types of support, and not all will guide positive transformation.

As we face an unknown future amidst the COVID pandemic, now is the time for women, birth advocates, researchers, and birth care professionals to determine how to move pregnancy care and birth out of the medical realm. If this pandemic has done nothing else, it has highlighted the risks to pregnant and birthing women as they enter the hospital, a place for the sick. It has made us question how, during a time of acute stress, the rates of premature birth have decreased;

why women are birthing alone in hospital with no support persons; and who is deciding that hospital policy can override a woman's rights to excellent labour support (Rocca-Ihenacho & Alonso, 2020). Many of us have questioned these things before, and we likely knew something drastic would have to happen to make any significant change. But the time is now. And perhaps if enough women, providers and advocates speak out, it may be possible to see a different birthing culture emerge. I plan to investigate the experiences of women as they have been forced to navigate the pregnancy and birth care system during this pandemic in order to contribute to these efforts.

Implications for Research and Practice

There were two key limitations of this project, the most important being that all of the women involved are Caucasian, professionals which I must acknowledge represents the privileged in our community in their ability to access options and to decision-making. I believe that women who live at the intersections of being a new Canadian, and/or with language differences, and/or at different socio-economic places would tell very different stories of their experience of decision-making about place of birth.

The second key limitation of this project is that it represents the experiences of women who chose a hospital birth for their first pregnancy. I wonder what experiences women who chose to birth outside of the hospital would have shared?

Moving forward, research about decision-making about place of birth must be committed to understanding each woman as an individual with unique experiences. At the same time, birth care must be provided with the deepest respect for that experience. The context (time, place and alongside others) that surrounds each woman as she navigates pregnancy and decision-making must be an essential commitment. In fact, "neglect of context is the greatest single disaster which

philosophic thinking [and I would propose birth care] can incur" (Dewey In Haddock Seigfried, 1996).

To date, research and birth care has focused on identifying risk factors that will require women to birth in hospital or, to have intervention(s). My hope for our future is that we can shift that dialogue to one of supporting women to explore how we, as care providers, might support them in identifying their personal needs and goals and to achieving them, even in the presence of risk. Perhaps this work might lead to some discourse about how this can become a reality.

Building from the foundation created through this work, I would suggest that as researchers, we shift our gaze toward two essential understandings. Firstly, to reveal a broader understanding (beyond that of these women) of the experience of navigating the pregnancy and birth care continuum and the intersections of gender and pregnancy for the purposes of validating the threads unraveled to date. Secondly, to undertake a critical examination of the conversations and interactions that are experienced by women during pregnancy, labour and birth so that we as providers can more effectively and respectfully walk alongside women and their loved ones. Research of this nature would be best situated in feminist pragmatism whereby the deeply entrenched influences of historical oppression of women can be uncovered and torn away. It is only through this honest work that the medicalized birth culture and its damages will be supplanted.

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Appendix One: Ethics Approval Letter

Notification of Approval

Date:	October 27, 2017
Study ID:	Pro00076332
Principal Investigator:	Susan Prendergast
Study Supervisor:	Magdalena Richter
Study Title: A Narrative Inquiry.	Women's Decision-making about Place of Birth:
Approval Expiry Date:	Friday, October 26, 2018
Approved Consent Form:	Approval Date: 10/27/2017 Approved Document: Participant Consent Form.docx

Thank you for submitting the above study to the Research Ethics Board 1. Your application has been reviewed and approved on behalf of the committee.

A renewal report must be submitted next year prior to the expiry of this approval if your study still requires ethics approval. If you do not renew on or before the renewal expiry date, you will have to re-submit an ethics application.

Approval by the Research Ethics Board does not encompass authorization to access the staff, students, facilities or resources of local institutions for the purposes of the research.

Sincerely,

Anne Malena, PhD
Chair, Research Ethics Board 1

Note: This correspondence includes an electronic signature (validation and approval via an online system).

https://arise.ualberta.ca/ARISE/sd/Doc/0/K7FMNQQJ2SH4N1BPJI6I3CPQ6A/fromString.html[2020-09-27, 1:14:07 PM]

Appendix Two: Participant Information Letter

PARTICIPANT INFORMATION LETTER

Women's Decision-Making about Place of Birth: A Narrative Inquiry

University of Alberta Investigators:

Susan Prendergast
Phone: (780)492-8621
Susan.prendergast@ualberta.ca

Dr. Solina Richter
Phone: (780)492-7953
solina.richter@ualbert.ca

Introduction:
This doctoral research project is being undertaken so that I might understand how a woman's life experiences influence her decision-making about where she will have her baby.

Study Steps:
With your permission, I will have conversations with you about memories, stories or experiences that you feel have influenced you in some way whilst making a decision about where you will have your baby. I will meet with you at least twice (maybe more) for about one to two hours. There is no formal list of questions that you will have to answer – we will simply have a conversation. I may record the conversation to make sure I correctly talk about your experiences. I will record only voices—no photographs of you will be taken.

Along with our conversations, you will be invited to journal about your memories and experiences and how they influenced your decision-making. Any photographs or creative work that you wish to submit as being representative of influences on your decision-making will also be welcome.

If you change your mind about being involved in this study, you can withdraw either in person or by phone, up to 2 weeks after you have read the storied representation of our conversations. If this occurs, you will be asked to decide how much of your contribution to date can be used (including journal entries and creative works). I can then withdraw your conversation, journal and any creative work from the study.

Possible Benefits:
I cannot promise any gain to you or your family but, supporting me in this study may help me to improve understanding of how a woman's life experiences influence her decision-making about place of birth.

Possible Risks:
Participation in this project may cause you some emotion when sharing your stories about your past experiences. Should you require support, I am able to provide that support or, I can refer you to a support provider.

Confidentiality:
Your identity will be kept secret at your request. Any recordings or notes will be given a pretend name (pseudonym), and stored in a locked filing cabinet in a room at the University of Alberta. Your name

will be *only* on this consent form and on one list that links your name to your pseudynym. The consent form and names list will be stored in a different locked filing cabinet at the university. Any computer files about this research will be kept on password protected and encrypted computers that only the research team can get to.

When I report the findings of this study, I will not tell anything about you or your family that would allow others to figure out who you are. The information you provide will not identify you in any way. Some of your ideas may appear as direct quotes or may be grouped with others' answers and be used in presentations, publications, public documents, and in teaching situations. At no time will your identity be revealed.

Future use of data:
All information about you, recordings of our conversations and any work created and submitted by you will be kept in a locked cabinet for a term of 5 years. You may have your created work returned to you after completion of the study. After 5 years all information, transcripts and work will be shredded.

Contact for information about the study:
You may ask any questions, at any time, about any part of this study. You can reach me by phone; see the top of page one for this information.

Consent:
Joining this project is fully voluntary and you may turn down taking part or may leave the study as outlined above.

Contact about the rights of research participants:
The plan for this study has been reviewed for its adherence to ethical guidelines by a Research Ethics Board at the University of Alberta. For questions regarding participant rights and ethical conduct of research, contact the Research Ethics Office at (780) 492-2615.

Sincerely,
Susan Prendergast & Dr. Solina Richter

Appendix Three: Participant Consent

CONSENT FORM for Participant

Part 1 (to be completed by the researcher):

Title of Project: Decision-Making about Place of Birth

Researcher: SusanPrendergastMNRNNP Phone Number(s):780-218-8577
Supervisor: Dr. MagdalenaS. Richter Phone Number(s):780-492-7953

Part 2 (to be completed by the research participant:

	Yes	No
Do you understand that you have been asked to be in a research study?	☐	☐
Have you read and received a copy of the attached Information Sheet?	☐	☐
Do you understand the benefits and risks involved in taking part in this research study?	☐	☐
Have you had an opportunity to ask questions and discuss this study?	☐	☐
Do you understand that you are free to withdraw from the study at any time, without having to give a reason and without penalty?	☐	☐
Has the issue of confidentiality and anonymity been explained to you?	☐	☐
Do you understand that the conversations will be recorded?	☐	☐
Do you understand that portions of the final research may be published in professional journals or presented at conference.	☐	☐

Consent Statement
I have read this form and the research study has been explained to me. I have been given the opportunity to ask questions and my questions have been answered. If I have additional questions, I have been told whom to contact. I agree to participate in the research study described above and will receive a copy of this consent form. I will receive a copy of this consent form after I sign it.

_____ _____
Participant's Name (printed) and Signature Date

_____ _____
Name (printed) and Signature of Person Obtaining Consent Date

The Information Sheet must be attached to this consent form.