

Woman centred care or institution centred care?

A discursive analytic study of childbirth-related decisions

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Abstract

This dissertation presents an examination of the ways in which women participate in decisions relating to giving birth in hospitals. The overall aim of the study is to identify and describe aspects of language used to communicate childbirth decisions, since current guidelines promote women's active involvement in maternity care (i.e., woman-centred care). Specifically, this study aims to contribute to empirical evidence about the ways in which decisions in maternity care are accomplished and understood.

The study takes an ethnomethodological approach, framed by discursive psychology (DP) to examine naturally-occurring data. From this perspective, this dissertation presents three articles which together identify and describe aspects of language used to negotiate and communicate childbirth decisions in the context of woman-centred care frameworks. Article one examines online birth narratives for routine ways in which women orient to medical interventions as an accountable matter. Article two illuminates how midwives accomplish the institutional imperative of model of care allocation in interactions between midwives and women. Article three provides an examination of the ways in which decisions are made to plan for an epidural during labour in routine antenatal consultations with midwives.

Together, these three articles add to a growing body of knowledge around the ways in which women participate in making decisions in hospitals related to giving birth.

Drawing on concepts in DP and using thematic analysis, conversation analysis and membership categorisation analysis, these studies examine how participants oriented to the extent to which women are afforded the authority to control their birthing experience.

Drawing on contemporary interactional research which theorises the epistemic and deontic basis of social relations, this study explicates how women's participation in childbirth-related decisions are described and co-constructed in naturally occurring contexts.

The analysis showed that midwife participants oriented to the rights, and indeed responsibilities, of pregnant women to make decisions related to giving birth in a hospital setting. The ways in which women are involved in decisions, however, seem to prioritise the needs of the institution rather than the birth aspirations and preferences of pregnant woman. In this sense, woman-centred care was realised to the extent that decisions were made within the constraints of institutional requirements.

The findings contribute to three main areas of research: women's experiences of childbirth in a hospital setting; the conversation analytic study of institutional interactions; and the re-specification of psychological phenomenon as interactional objects within discursive psychology. The ways in which childbirth-related decisions are made and described can shed light on the practical implementation of woman-centred care principles in a hospital institution. Such fine-grained descriptions of authentic accounts and interactions may contribute much needed empirical detail and specification that can be the basis for refining and developing recommendations for practice.

Declaration

I certify that this work contains no material which has been accepted for the award of any other degree or diploma in my name, in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in text. In addition, I certify that no part of this work will, in the future, be used in a submission in my name, for any other degree or diploma in any university or other tertiary institution without the prior approval of the University of Adelaide and where applicable, any partner institution responsible for the joint-award of this degree.

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Mothers' accounts of unplanned medical interventions in childbirth, International Normal Labour and Birth Conference, University of Western Sydney, NSW, 2016.

- Awarded 'best poster' prize in peer-reviewed category

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1. CHAPTER ONE: Introduction

1.1 Preamble

This study presents an examination of the ways in which women participate in decisions related to giving birth in hospitals. Over the past 40 years, a radical shift towards patient-centred care in hospitals has been promoted to reform healthcare and health-related decisions (Richards, Montori, Godlee, Lapsley, & Paul, 2013). This reform has manifested in maternity services as woman-centred care. Woman-centred care aims to meet the unique cultural, social and physiological needs of individual women (Australian College of Midwives, 2019). A woman-centred care ideology has been justified based on empirical evidence including higher reported satisfaction with birth experience (Morgan, 2015), and improved psychological and physical outcomes for mothers and babies (Dagger, Sweeney, & Johnson, 2007). Most significantly though, woman-centred care principles rest on a moral imperative based on a fundamental right to self-determination, and are reflected in the right to consent to, or refuse, medical intervention (Australian College of Midwives, 2019; Bryant, 2009). This thesis aims to examine women's involvement in decisions relating to giving birth. Drawing on theoretical and methodological principles of discursive psychology, I examine how participation in childbirth-related decisions is described and co-constructed in naturally-occurring contexts.

Despite the growing popularity of woman-centred care philosophies in maternity services across Australia (and other developed nations) (Maputle, 2013; Morgan, 2015), it remains largely unknown how women are provided the opportunity to make decisions in a biomedical system that, in many ways, remains traditionally paternalistic. This research provides a

description of how women attributed accountability for medical intervention in retrospective birth narratives posted online, and the opportunities afforded to women to participate in childbirth-related decisions in an antenatal clinic in South Australia. The research takes a qualitative approach using methods of Thematic Analysis (TA), Conversation Analysis (CA) and Membership Categorisation Analysis (MCA) to examine naturally-occurring data regarding decision-making about childbirth in an Australian context. Three studies are presented in this dissertation. The first examines online birth stories for routine ways in which women orient to medical interventions as an accountable matter. The second study illuminates how midwives accomplish the institutional imperative of model of care allocation in interactions between midwives and pregnant women. The findings of study two highlight the implicative nature of plans for an epidural to available models of care. Therefore, the third paper provides an examination of the ways in which decisions are made to access an epidural during labour in routine antenatal consultations with midwives. Together, these three studies add to a growing body of knowledge around the ways in which women participate in making decisions in hospitals relating to giving birth.

1.2 Giving birth in Australia

Contemporary childbirth in Australia is dominated by technology and typically takes place in highly-medicalised settings. The most recent statistics available show that in 2017 in Australia, the percentage of births that took place out of hospital was less than 1%, similar to the US and other developed countries (Australian Institute of Health and Welfare, 2019; Catling, Dahlen, & Homer, 2014; Victoria State Government, 2015). South Australia (the site for the antenatal clinic studies) recorded only 0.5% of home births in 2016 (SA Health, 2018). For the over 99% of women who gave birth in hospital, most births involved medical

intervention: a population-based cohort study in Australia reported that, of low-risk healthy women, only 15% birthing in the private hospital system, and 35% in the public system, delivered without some form of obstetric intervention (Dahlen et al., 2014). Statistics from 2016 showed that only 52.7% of all South Australian pregnant women had a spontaneous onset of labour (SA Health, 2018).

The prevalence of caesarean section births is also continuing to rise, with 35% of Australian births in 2017 resulting in a caesarean (Australian Institute of Health and Welfare, 2019). This is in stark contrast to the World Health Organisation's recommendation that the caesarean section rate should not be higher than 10-15% (World Health Organisation, 2018). Despite the rising rates of birth intervention, perinatal death rates are not declining and there is significant concern that obstetric intervention might cause short- and long-term negative consequences for mothers and babies, including infections, eczema and metabolic disorders (Peters et al., 2018); further medical intervention (Tracy & Tracy, 2003); infection associated with surgical procedures (Alfirevic, Milan, & Livio, 2013); barriers to bonding and breastfeeding (Kendall-Tackett, Cong, & Hale, 2015); increased incidents of postnatal depression (Kendall-Tackett et al., 2015) and post-traumatic stress disorder (Reynolds, 1997); and microbiota abnormalities (Dominguez-Bello et al., 2010; Hanson & VandeVusse, 2013). Varying philosophical frameworks underpin such concerns. For example, feminist researchers have argued that childbirth is becoming increasingly medicalised in a patriarchal system that is designed to control women's bodies (Davis-Floyd, 2001). Other researchers have contended that the rise in caesarean section births reflects women's choices (Klein, 2012). Common to each of these arguments is an assumption that women have, or should have, the

right to be involved in decisions regarding the use of medical intervention (Malacrida & Boulton, 2014).

A National Review of Maternity Services was commissioned by the Australian Government's Department of Health and Ageing in 2009 to examine how maternity services in Australia could be improved. Over 900 submissions from stakeholders were included in the Review, with 54% received from women and their families. Among the most prevalent issues raised by women who took part in the review were: desire for models of care that reflected their birthing choices; greater access to information about pregnancy and birth; respect for personal perceptions of risk; and a desire for birth to be understood as a natural process rather than as a medical procedure (Bryant, 2009). In response to the findings, most hospitals in Australia introduced woman-centred care guidelines that recommend women have the right to make choices about how to birth. The Review also resulted in the framing of a National Guidance on Collaborative Maternity Care (National Health and Medical Research Council, 2010), aimed at standardising service delivery in accordance with a woman-centred care approach. This document promoted women's rights to maternity services that support their psychosocial, emotional, cultural, spiritual, and physical needs. In 2014, the Lancet Series on Midwifery called for change in the provision of maternity care by introducing an international framework for Quality Maternal and Neonatal Care (QMNC) that places the needs of mothers and infants at its centre (Renfrew et al., 2014). Despite such changes at policy level, a recent Australian study reported that women still describe limited opportunity to enact control over the birth process in the hospital system (Petrovska, Watts, Sheehan, Bisits, & Homer, 2016).

1.3 Analytic approach and study aim

Although there are numerous policy and practice initiatives on woman-centred maternity care, little is known about how these initiatives are realised in practice. The present study takes an Ethnomethodological approach, framed by Discursive Psychology (DP), to examining naturally-occurring data. DP rejects traditional cognitivist assumptions that language provides a reflection of enduring beliefs, attitudes and values (Edwards, 1997). Instead, DP treats language as social action. That is, language is designed to achieve something (e.g. justifying, defending, blaming, describing situations and constructing identities) (Stokoe, 2006). A discursive psychological approach centres attention on rhetorical devices and linguistic structures (such as defensive detailing and extreme-case formulation) used to perform such social actions (Edwards & Potter, 1992).

From this discursive perspective, language not only arises from social connections, but it performs them (Edwards & Potter, 2001). This performative view differs from the traditional representational conception of language as a mirror image of stable intrapersonal or interpersonal reality (Edwards & Potter, 2001). In and through the use of words, people perform their relationships using cultural resources and practices for understanding and influencing each other (Potter & Wetherall, 1987; Potter & Wetherell, 1988).

The overall aim of the study is to identify and describe aspects of language used to negotiate and communicate childbirth decisions in the context of woman-centred care frameworks. Specifically, this study aims to contribute to empirical evidence about the ways in which decisions in maternity care are accomplished and understood. The fine-grained investigation of naturally-occurring communication can contribute much needed empirical detail and specification about how ideals of woman-centred care are realised in practice. These

descriptions can in turn be used as a basis for refining and developing recommendations for practice.

The approach of examining the use of language in the context of women's birth choices illuminates orientations to the ways in which responsibility and accountability is performed in social interactions. Women are increasingly held accountable for their birth choices and are responsible for consenting to the care and interventions used. Health professionals are required to take a dual stance reflecting both woman-centred care principles along with their professional knowledge of pregnancy, birth and institutional imperatives. While woman-centred care principles might be characterised by reciprocity of communicative efforts, that reciprocity can be unequal with negotiations tilted in favour of health professionals' understandings and preferences (Pilnick & Zayts, 2016).

1.4 Chapter summary

Chapter one has contextualised the study through a broad description of giving birth in Australia. A description of the overall aim and analytic approach of this thesis was then presented. The next chapter will review literature pertaining to research on maternity care and childbirth experiences.

2. CHAPTER TWO: Review of the literature

Since the turn of the 20th century, the medical discipline has dominated maternity care. The medicalisation of childbirth is generally referred to in the literature as commencing during the period that saw the majority of births occur in hospital. Along with the shift in place of birth (from homes to hospitals), medicalisation also refers to a model of care that focuses on practitioner control and the management of risk, and which involves the routine use of medical interventions (Bayly, 2017). The literature review presented in this chapter is primarily based in midwifery literature, with the inclusion of some relevant literature drawn from the fields of social sciences and medical research.

In what follows I present a review of literature pertaining to the increasing reliance on medical interventions, an evolving discourse of risk, and how current diverging ideologies of birth create tensions between different health professions. Specifically, I focus on the relevance of these issues on women and their childbirth choices. I then consider research regarding women's experiences of childbirth, and the contribution of research using naturally-occurring data to the field of maternity care.

2.1 The medicalisation of childbirth

Advances in science and technology have played a major role in the biomedical dominance of childbirth. Interventions developed to assess, monitor and manage birth can be heralded as beneficial or problematic depending on the context, outcome and/or ideological position.

Although a reduction in maternal, perinatal and infant mortality is often attributed to medical technology, scholars have argued that improved mortality rates are more highly correlated with improved disease control, diet and standard of living than with medical interventions in

childbirth (Goer, 1995; Tew, 1998). The development of technologies aimed at assessing and monitoring risk in labour have contributed to the standardisation of the birth process, and have been linked to premature and unnecessary interventions (Catling et al., 2014; Davis-Floyd, 2001).

Standardising the birth process has been used to manage a large number of birth procedures and this is achieved through the use of routine interventions such as vaginal examinations, fetal monitoring and pharmacological management. Monitoring procedures are used to determine the progress of labour and the baby's heart rate (used to detect fetal distress). In South Australia in 2016, cardiotocography (CTG) was performed during labour for 64.7% of women who gave birth (SA Health, 2018). However, some procedures have been argued to serve to benefit a standardised medical system and schedule, rather than meeting the requirements of a healthy, natural vaginal birth (Davis-Floyd, 2001). For example, vaginal examinations are used to determine progress of labour, but can have unintended negative consequences such as risk of infection and interruption to physiological processes, and might be uncomfortable and intrusive for the labouring woman (Dixon & Foureur, 2010; Kitzinger, 2006). The universal application of clinical standards that are based on an expectation of a minimum cervical dilation threshold (i.e. one centimetre per hour) has been challenged, with research finding that labour progression is not always linear (Oladapo et al., 2017; Oladapo et al, 2018). A Cochrane review found no evidence to support routine vaginal examinations (Downe, Gyte, Dahlen & Singata, 2013).

Similarly, Cochrane reviews of evidence for continuous fetal heartrate monitoring have found that it does not improve fetal outcomes and is associated with a significant increase in instrumental birth, including increased rates of caesarean section birth (Lavender, Hart, &

Smyth, 2013; Alfirevic, Gyte, Cuthbert & Devane, 2017). These findings suggest that routine monitoring might cause false concerns, leading to further unnecessary medical intervention.

Pharmacological developments have also impacted women's experiences of childbirth, particularly in regards to pain relief. At the turn of the 20th century, the promise of safe and pain-free childbirth was promoted. Women embraced the advances in childbirth pain relief, which led to most women opting to give birth in a hospital where doctors administered 'Twilight Sleep', a powerful analgesic that rendered women incapacitated and unable to remember birth (Leavitt, 1980). Labouring women under the effects of Twilight Sleep were often restrained and required episiotomies and forceps deliveries. Babies born this way typically required resuscitating due to the impact of the drug (Leavitt, 1980). These days, pharmacological pain relief is promoted as safe and effective, and is received by around 78% of Australian women in labour (Australian Institute of Health and Welfare, 2019). The most common types of pain relief in 2017 were nitrous oxide (inhaled) (54%), regional analgesic (including epidural and spinal analgesia) (38%) and systemic opioids (16%) (Australian Institute of Health and Welfare, 2019). However, some obstetric and medical research has indicated that an epidural can impact the physiological process of labour and birth. For example, a cohort study of 42,268 women who delivered vaginally indicated that epidural use increased the duration of the second stage of labour by two hours (Cheng, Shaffer, Nicholson, & Caughey, 2014). This finding was further supported in a Cochrane review showing that women who had an epidural experienced longer first and second stages of labour than women who had opioid pain relief (Anim-Somuah, Smyth, Cyna & Cuthbert, 2018). In addition, epidurals have been linked to interference with the production of necessary hormones, affecting the mother's ability to bond with her baby (Buckley, 2015).

Although the benefits of new birth technologies are generally welcomed, some scholars argue that the constant monitoring of physiological processes sends powerful cultural messages to women that positions birth as a high-risk event (Davis-Floyd, 2001; Goer, 2002; Kitzinger, 2005). It has been argued that biomedical hegemony might generate feelings of incompetence in women, which in turn serves to maintain control and power over the choices women make (Fisher, Hauck, & Fenwick, 2006). The use of medical interventions, then, can be understood as reinforcing a discourse of risk, which underpins the rationale for treating birth as a medical event.

2.2 A discourse of risk

It has been argued that a growing risk discourse exists within Western societies resulting in heightened sensitivity to risks (Beck, 1992; Possamai-Inesedy, 2006; Zadoroznyj, 2001). Beck (1992) coined the phrase 'risk society' to conceptualise Western culture's preoccupation with minimising and constantly evaluating risks. In contrast to a pre-industrialised world in which risks were mostly related to natural disasters and infectious diseases, risks currently at the centre of attention are largely man-made, such as global warming and nuclear weapons (Beck, 2000). Advances in science and technology are argued to be largely responsible for reinforcing an ideology of risk (Beck, 1992). In childbirth, technology is often heralded as the solution to minimising and predicting risk in childbirth (Bryers & van Teijlingen, 2010; Possamai-Inesedy, 2006). However, Smith, Devane & Murphy-Lawless (2012) conclude from a concept analysis of risk in maternity care, that risk in this context is diverse and dynamic. The authors make the argument that what constitutes as a risk today may not necessarily be viewed the same way tomorrow (Smith, Devane & Murphy-Lawless, 2012).

A current growing culture of risk exists in healthcare and has specific implications for the management of childbirth as a medical concern. Risk theory, as conceptualised by Zinn (2008), is a framework designed to explain decision-making through a cognitive process of weighing up of 'rational' knowledge and 'non-rational' strategies. Rational (or objective) knowledge is associated with 'expert' and technological knowledge, while non-rational strategies refer to personal values, beliefs and experiences. In the domain of childbirth, risk theory as a framework for decision-making reflects the technological (rational) versus natural (non-rational) perspectives of birth.

The technological perspective of birth is argued to focus on the identification and management of potential problems, emphasising the dangers of pregnancy and birth (Davis-Floyd, 2001). Constant monitoring, evaluating and medical interventions are routine and typical of the medicalised management of birth, and are argued to be akin to 'rational knowledge' (Davis-Floyd, 2001). A systematic review of how perceptions of risk impact midwives' and obstetricians' practice demonstrated that practice is influenced by an assumption of birth as abnormal and is compounded by issues such as institutional risk management, lack of midwifery responsibility, fear of involvement in adverse outcomes and personal values regarding physiological birth (Healy, Humphreys & Kennedy, 2016).

Conversely, a natural birth perspective emphasises the normalcy and naturalness of birth that women are typically capable of achieving without medical intervention. A natural perspective of birth draws attention to the risks associated with an overuse of unnecessary interventions. Despite more recent maternity service policy that promotes a return to a social model of care (as opposed to the medicalised model), a slow uptake has been attributed to perceptions of risk (Bryers & van Teijlingen, 2010). Healy, Humphreys & Kennedy (2016)

argue for a shift in focus away from risk and towards health and wellbeing in the planning of maternity care to address the increasing intervention rates for low-risk women.

These diverging philosophies reflect the polarised attitudes of obstetric (technocratic) and midwifery (natural) professions. Varying perspectives of risk have been argued to lead to a lack of collaboration and respect between these professions resulting in detrimental impacts on the quality of women's healthcare (MacColl, 2013).

2.3 Diverging ideologies: medical vs. midwifery

Maternity care has a long history of tension between medicine and midwifery, dating back to the 1900s when the management of childbirth (previously a midwifery practice) became of interest to medical institutions (O'Malley-Keighran & Lohan, 2016). Today, childbirth in Western societies is dominated by a biomedical model and midwives are largely governed by medical institutions. The biomedical model typically involves treatment of the human body as a machine, with a focus on risk aversion, as discussed in the previous section. In this model, pregnancy and birth are treated as a 'condition' to be managed (Davis-Floyd, 2001).

Practitioners rely on test results and screenings to provide women with health-related advice and recommendations. By contrast, midwifery philosophies have been described as treating pregnancy and birth as a normal and natural process, with a focus on the holistic well-being of the woman (Davis-Floyd, 2001). Fundamental to midwifery service provision is the relationship between midwife and woman. The embedding of midwifery within medical institutions (i.e. hospitals) has raised concerns about how midwives manage the tension between facilitating a normal birth and attending to an array of risk-focused tests and measurements (for example, Scamell, 2011). Scamell (2011), in an ethnographic study,

demonstrated that midwifery activity during labour and birth implicitly introduced a sense of danger which confined practice and operated to unsettle normality. Both the midwifery and the medical models of pregnancy and childbirth now embrace a woman-centred care philosophy, but with women typically reporting increased opportunities for shared decision-making in the midwifery model (Homer, 2016; McCourt, 2006).

Maternity care continues to be a highly politicised field, which has implications for women's opportunities for informed decision-making. Contradictory research findings and opposing practices can make women's decisions particularly complicated. The Australian National Review of Childbirth Services (2009) called for increased collaboration between different health professions, with greater flexibility and choice for women's individual birthing preferences. However, recent literature indicates ongoing tensions within the field of maternity care. A Cochrane systematic review of maternity models of care recommended that all women have access to midwifery-led care (Sandall, Soltani, Gates, Shennan, & Devane 2016). The review found no adverse effects of midwifery-led care when compared with a standard medical model of care, and increased benefits, including fewer epidurals and instrumental births (forceps and episiotomies). Other benefits of midwifery-led care have been reported, including reduced obstetric intervention, increased cost effectiveness (Tracy et al., 2013), higher onset of spontaneous labour (Tracy et al., 2014), women's increased satisfaction with birth (Cluett & Burns, 2013; Hodnett, 2012), higher breastfeeding rates (Dyson, McCormick, & Renfrew, 2005; Moore, Anderson, Bergman, & Dowswell, 2007), reduced incidence of preterm birth (Turienzo, Sandall, & Peacock, 2016) and reduced postpartum depression (Dennis & Dowswell, 2013).

By contrast, some research has shown adverse outcomes associated with midwifery-led care. A population-based study in New Zealand similarly reported higher adverse effects for midwifery-led care compared to obstetric services (Wernham, Gurney, Stanley, Ellison-Loschmann, & Sarfati, 2016). The study has been widely criticised, however, for methodological flaws such as missing data, lack of randomisation, and lack of measures of socio-demographic factors (such as income) (Australian College of Midwives, 2016; Byrom, 2016; McCowan, Farquhar, & Fleming, 2016; Tracy, 2016). Nonetheless, some researchers have accused midwifery of putting women and babies at risk by promoting a ‘vaginal birth at all costs’ ideology and failing to alert women to the risks associated with natural birth (Dietz, 2017). In response to Dietz, Page (2017) highlighted failure on the part of medical practitioners to alert women to the risks of “over-medicalising” childbirth, including the harm associated with the overuse of medical interventions in a normal physiological process. Other medical literature has suggested that the rising rates of interventions in childbirth is a reflection of women’s choices (Klein, 2012), weight (Kerrigan, Kingdon, & Cheyne, 2015), and age (Cleary-Goldman et al., 2005). Inconsistent research findings, and apparent tensions between midwifery and obstetric professions, make it difficult for women to access non-biased information on which to plan their childbirth experiences.

The remaining sections of this chapter consider how women’s experience of childbirth has been researched.

2.4 Conventional approaches to qualitative childbirth research

Interview and focus group methods have traditionally been used to explore women’s experiences of giving birth. Such studies have focused on women’s perceptions of risk (Catling-Paull, 2013; Chadwick & Foster, 2014; Petrovska et al., 2016), the role of power in

medical institutions (Davis-Floyd, 1994; Root & Browner, 2001; Tully & Ball, 2013), and women's satisfaction with models of maternity care (Happel-Parkins & Azim, 2015; Malacrida & Boulton, 2014). Typically, studies draw attention to the difficulty women face when trying to enact control over their birth choices.

Studies with a focus on women's perceptions of risk have consistently highlighted a dichotomy of risk assessment. Women have typically been demonstrated to construct birth risks from either a biomedical perspective or a natural perspective. For example, in a Ph.D. thesis, Catling-Paull (2013) examined interviews with Australian women who chose publicly-funded homebirths. The overarching perspective of women in the study involved descriptions of faith in the normalcy of childbirth. These findings are consistent with other literature examining women's choices to birth at home (Bernhard, Zielinski, Ackerson, & English, 2014; Coxon, Sandall, & Fulop, 2013; Jackson, Dahlen, & Schmied, 2011; Murray-Davis, McDonald, Rietsma, Coubrough, & Hutton, 2012). However, women in Catling-Paul's study also drew on a biomedical construction of birth in accounts of feeling reassured by the 'safety-net' of the hospital system. Similar findings were reported in a study by Chadwick and Foster (2014) who interviewed 24 pregnant South African women who had chosen either to homebirth or have an elective caesarean section. In a comparison of accounts, women in the caesarean section group constructed childbirth as a risk from a biomedical perspective, while home birthing women's accounts shifted between endorsing and rejecting the biomedical perspective. Home birthing women typically described threats associated with hospital birth including the objectification of women's bodies, and the loss of dignity and empowerment (Chadwick & Foster, 2014). In an Australian study, Petrovska et al. (2016) interviewed women who had resisted medical advice to undergo a caesarean section due to breech positioning. Common

themes in women's descriptions of their experience of pursuing a breech vaginal birth highlighted the difficulties associated with resisting a dominant biomedical discourse of pregnancy and birth. Women reported accepting that they would be viewed as irrational by their friends and family, reported confidence in their body's ability to birth vaginally, stated that they needed to convince their partners of their choice, and routinely sought support from online groups (Petrovska et al., 2016).

In a seminal work on the right of women to control their bodies and the birthing process in a context where birthing in highly medicalised, Davis-Floyd (1994) interviewed American women on their experiences of childbirth. She demonstrated how obstetrical procedures conveyed strong cultural values to birthing women and were used to enhance the courage of practitioners by deconstructing birth in to identifiable and controllable segments, then reconstructing it as a mechanistic process (Davis-Floyd, 1994). However, in her study she found that even if the birth was not natural as planned, women were still pleased with the experience if they felt they had been in control of the decisions made (Davis-Floyd, 1994). Root and Browner (2001), in a collection of interviews with American women, argued that a powerful (and disciplining) biomedical discourse was largely accountable for their compliance with medical advice during their pregnancy. Women were shown to justify their prenatal behaviours through descriptions of medical advice, media representations of medicine and motherhood, and family and friends' experiences. In a more recent interview-based study, Tully and Ball (2013) interviewed 115 English women to examine the ways in which they accounted for their caesarean section birth. The authors highlighted how women spontaneously defended themselves against requesting surgical birth. Although the women described preferences for a vaginal birth, they expressed belief that the operation was

necessary to minimise harm to their baby. These studies reflect a dominant discourse of risk minimisation, addressed in women's descriptions of a biomedical approach to childbirth.

Such studies are based on fundamental assumptions of diverging perspectives of risk in childbirth and have sought to examine commonalities of women on either end of the spectrum. These studies have contributed to the understanding of how women make sense of their choices and experiences, yet lack insight into how their experiences unfolded.

Women's satisfaction with maternity care has also been examined using interviews.

Malacrida and Boulton (2014) reported a disjuncture between women's planning of birth, and the lived experiences of births that typically did not go to plan. Findings were reported to counter assumptions that women are driving the increased medicalisation of birth (Malacrida & Boulton, 2014). Happel-Parkins and Azim (2015) likewise reported that women's plans to birth naturally were often disregarded or ignored in an American hospital. Additionally, women in the study reported medical staff created 'false dilemmas' in order to gain women's compliance with medical opinion (Happel-Parkins & Azim, 2015). Typically, then, interview and focus-group based research has consistently reported that women have difficulty enacting power to control their birth experience in a hospital setting.

Conventional approaches to understanding women's experiences have been useful in highlighting a consistent disjuncture between the rhetoric of woman-centred care, and women's reported experiences. A broad understanding of women's involvement in decisions is generally accepted, however what is lacking is knowledge about how this imperative is accomplished in practice. Research conducted in naturally-occurring contexts has been credited with allowing close examination of interactional practices that can contribute to the

understanding of how interactions unfold, including practices that enable and hinder participation (Potter & Hepburn, 2005).

Studies in which accounts of childbirth experiences are given in research settings are arguably different from accounts provided in naturally-occurring contexts. Interview-based analyses have been criticised for failing to consider interviews and focus groups as social interactional projects (Potter & Hepburn, 2005), instead treating participants' accounts as factual reflections of events, rather than as locally-produced descriptions to achieve particular discursive functions (for example, justifying or defending). Previous childbirth research using naturally-occurring data has yielded a small body of findings about how childbirth decisions are co-constructed and understood in real-life situations. The present thesis builds on (and contributes to) this stream of research, which will be reviewed in the next section of this chapter.

2.5 Naturally-occurring data used in childbirth research

Online investigations

Online narratives have been a source of naturalistic data for other recent studies, and have been argued to provide genuine accounts in that women might feel more at ease in sharing personal details in an anonymous context than is the case in face-to-face research settings (Bylund, 2005). In a thematic analysis of online blogs on the topic of Vaginal Birth After Caesarean (VBAC) or repeat caesareans, Dahlen and Homer (2013) identified two key themes that were used to justify and defend these forms of birth. "Child-birth" narratives depicted the child's experience of birth as paramount, with a focus on VBACs or repeat caesarean deliveries as a matter of risk avoidance. "Mother-birth" narratives, by contrast, highlighted

the importance of a natural birth to the mother's experience of bonding with her baby, breastfeeding successfully, and transitioning into motherhood with confidence.

Another study of online narratives, this time focusing on unassisted birth, reported that women drew on competing discourses of childbirth as a natural process, or as a medical procedure, to frame their accounts of their experiences (Miller, 2009). Both discourses were sometimes drawn on in the same account by women who were describing their opportunities to control the birth process. A quantitative study of references to decision-making in 285 online birth stories, reported shared decision-making being described in only around six per cent of narratives. In contrast, descriptions of clinicians' unilateral decisions occurred in 39 per cent of narratives. Shared-decision making most often occurred in reference to pain relief, whereas decisions about induction, caesarean sections and timing of pushing typically involved clinician-initiated or clinician unilateral (autonomous) decisions (Bylund, 2005).

Previous studies of online birth narratives have focussed attention on broader themes of childbirth, such as choice and control. The aforementioned studies of online data examine narratives on face value, overlooking important situational factors such as presenting the self in a positive light. In contrast, the first study of this thesis looks more specifically at the ways in which women perform social actions in their attributions of accountability for the use of medical intervention in hospitalised birth. This has allowed a deeper and more nuanced examination of women's reported experiences, while explicating how particular social actions are performed in the context of online communication.

The second and third studies consider how decisions about aspects of maternity care (i.e. model of care allocation and access to an epidural) are made in real-life interactions between midwives and women. These studies examine the ways in which midwives and women orient to epistemic and deontic resources in and through talk to attend to the institutional imperatives of routine antenatal consultations. Using Conversation Analytic and Membership Categorisation approaches this thesis builds on previous literature to provide a nuanced, in-depth understanding of how decisions are made in situ.

Conversation Analytic research

Conversation Analysis (CA) is increasingly being used to explore the complexities of healthcare interactions, and has been described as representing the 'gold standard' for collaborative research and training in healthcare communication (Kitzinger & Kitzinger, 2007). In the UK, researchers have used CA to improve antenatal outcomes for women and their families. For example, McCourt (2006) compared three models of care to identify differences in interactional styles during consultations. Midwifery-led models were shown to involve more fluid conversational interactions than standard medical models of care, which were observed to be shorter and more structured. Additionally, CA has been used to examine the process of agreement to nuchal translucency screening in a UK hospital (Pilnick, 2008). It was found that midwives presented the choice for screening, but that subtle interactional features influenced whether or not women realised they had an opportunity to refuse the screening (Pilnick, 2008). Such studies have provided valuable information to practitioners on ways in which to better enable women's participation in their care in line with woman-centred care principles.

More recently, antenatal consultations have been the focus for a small body of CA research considering the interactional skills employed by midwives to accomplish institutional tasks. For example, a study of antenatal consultations in Hong Kong highlighted the ways in which doctors stepped back from decisions regarding antenatal screening tests, and instead deferred to the woman's level of 'worry' to guide the decision-making process (Pilnick & Zayts, 2016). Through claiming an unknowing epistemic stance towards women's concerns, doctors were found, strategically, to assume the right to advise, but not to decide on, the use of screening tests (Pilnick & Zayts, 2016). Another study examined typical placements and formulations of pregnant women's problem presentations in antenatal encounters (Nishizaka, 2010). The study highlighted routine practices of women self-initiating talk about a pregnancy-related concern, and cycles of problem (woman) and no-problem (practitioner) turns at talk (Nishizaka, 2010). Building on self-initiating problem talk, Nishizaka (2011) subsequently identified two routine practices used by women to expand on the problem presentation. The two main practices involved adding additional information to the already addressed problem, and raising a different possible concern by relating it to the practitioner's response (Nishizaka, 2011). Other professional practices such as accomplishing rapport with women were considered in a study by Petraki and Clark (2016). The authors illustrated how the use of agreements served to validate and endorse women's knowledge and experiences, thus fulfilling woman-centred care goals (Petraki & Clark, 2016). The research presented in studies two and three of this thesis aim to contribute to a relatively small body of literature on the interactional features of antenatal consultations.

An advantage of the methodologies employed in this thesis is that they deal with a concern raised by other scholars in this field (e.g. Davis-Floyd, 2001; Goer, 1995; Klein, 2012;

Malacrida & Boulton, 2014) regarding the rising rates of obstetric interventions, and the driving force behind them. Previous studies in this area have sought to categorise and contrast medical and natural birth discourse, most often solicited through interview, survey and focus group data. Patterns have been emphasised in women's reported experiences and preferences, for example, varying priorities and values (Dahlen & Homer, 2011), as well as the way in which experiences are described (Tully & Ball, 2013). In contrast, the work in this thesis focusses on interactional loci in which women themselves orient to medical interventions in unsolicited online birth narratives and in naturally occurring interactions with midwives.

2.6 Chapter summary

In this chapter I have presented a review of relevant literature regarding current childbirth practices, and the relevance to choices for women in maternity systems. I presented a brief history of the medicalisation of birth, followed by consideration of a risk discourse, and the significance of polarised professional philosophies between medicine and midwifery. In sum, each of these issues has real implications for women's choices which underpin the assumptions of this thesis. An overview of conventional approaches to the examination of women's childbirth experience was then provided followed by a summary of online research and the contribution CA has made to childbirth related research. In the next chapter, theoretical and methodological frameworks will be discussed.

3. CHAPTER THREE: Methodology

3.1 Research design

This dissertation is formatted as a ‘thesis by publication’, which is permitted by the guidelines set down by the University of Adelaide Graduate Centre.¹ This thesis therefore comprises a collection of published research papers, constituting a body of work that focuses on the specific ways in which childbirth-related decisions are accounted for and co-constructed in naturally-occurring contexts. Although each analytical chapter defines its own method, this overarching methodology chapter provides a rationale for the analytic approaches used in this thesis.

3.1.1 Ethnomethodology

The research presented in this thesis belongs within the theoretical framework of ethnomethodology (EM). Founded by Harold Garfinkel, EM provides a functional approach to examining language and the detailed practices of everyday social life (Edwards & Potter, 2001). EM is aimed at explicating the ways in which people make sense of their world, methodically displaying their understandings of it (Stokoe, 2006). Language is examined for its nature as a version of an account, event, or fact constructed for the specific context (Edwards & Potter, 2001). Everyday social interactions are argued to be normative and orderly (Atkinson & Heritage, 1984; Hutchby & Wooffitt, 2008; Rawls, 2000; Widdicombe & Wooffitt, 1995). Through everyday interactions, people work to achieve social tasks of constructing and maintaining social norms. Garfinkel argued that EM enables examination of

¹ <https://www.adelaide.edu.au/graduatecentre/current-students/handbook>

people's methods for producing accountable and recognisable actions. Through EM we can identify routine ways in which particular social tasks are achieved.

3.1.2 Discursive psychology

Grounded in EM principles, this study employs discursive psychological methods to examine naturally-occurring talk and text for the ways in which childbirth choices are routinely constructed, deployed and accounted for in everyday interactions. Discursive psychological methods involve a radical rethinking of the subject matter of psychology, and contrasts with traditional experimental and cognitivist approaches that characterised the discipline in the mid- to late-1980's (Wooffitt, 2005). Critiquing traditional cognitivist paradigms, which treat inner mental processes as the proper topics for analysis, discursive psychology treats language as the topic for empirical research and theorising. That is, instead of treating language as a product of psychological processes, discursive psychology treats talk and text as an activity in its own right (Edwards & Potter, 1992). From this perspective, activities such as justification, attribution, and blaming can be understood as discursive actions (rather than cognitive processes). Such activities are regarded as being performed by participants in social interaction, and attend to a range of concerns, including those related to stake and interest, identity, and morality.

The methods employed in this thesis involve ethnomethodological discursive psychological approaches that aim to avoid imposing the researcher's own understandings and agendas of what is relevant in a particular situation by focussing on the action-orientation of language as displayed by the participants' orientation (Schegloff, 2007). Rather than examining language at the broader, 'macro' level of the historical and cultural production of social meaning, discursive studies informed by EM focus on the detailed structure and local function of

language. The analysis presented here draws on three different methods employed through a discursive psychological lens: thematic analysis; conversation analysis; and membership categorisation analysis. Each of these methodologies will be considered in relation to their use in the published articles.

In what follows, fundamental notions of EM that have particular relevance for the present studies will be introduced.

3.1.3 Accountability

The first study presented in this thesis is concerned with the ways that accountability for medical intervention was constructed and defended in the context of describing a child-birthing experience. A major focus for discursive psychologists has been accountability, specifically where people attribute responsibility for events. Far from accepting descriptions as an objective recall of factual events, discursive psychology is concerned with the ways in which accountability is formulated and deployed in situated contexts (Edwards & Potter, 2001). Edwards and Potter (2001) argued that in recalling past events, participants work to construct their description as factual while accounting for their own actions. A focus of discursive psychology is to deconstruct descriptions and identify patterns in linguistic composition and systematic ways of constructing accountability for events (Potter & Wetherell, 1988).

3.1.4 Epistemic and deontic orientations

The distribution of epistemic and deontic orientations in a woman-centred service is explored as a central theme in the second and third studies (Chapters 5 and 6 respectively). Epistemic and deontic orientations refer to the way in which knowledge and authority are oriented to in talk (Landmark, Gulbrandsen, & Svennevig, 2015; Lindstrom & Weatherall, 2015; Petraki &

Clark, 2016; Pilnick & Zayts, 2016). Aspects of 'power' and 'authority' are central to the analytical framework employed in studies two and three that examine epistemic and deontic rights. Epistemic rights refer to someone's claims to knowledge within specific domains. Deontic rights, on the other hand, refer to someone's claim to the right to determine future actions (Peräkylä, 2002; Stevanovic & Peräkylä, 2012).

Epistemic and deontic rights are claimed and negotiated in talk. That is, they are made relevant through the sequential organisation of turns at talk. Linguistic choices reflect the strength of epistemic and deontic rights claimed. For example, epistemic claims can display more or less certainty of a particular matter (e.g. "I would like to avoid it [epidural] if possible", compared to "I am not having an epidural"). Similarly, deontic rights display more or less authority towards the proposed future action (e.g. "have you thought about using an epidural for pain relief in labour", compared to "don't ever mention the word epidural"). In maternity encounters, midwives and obstetricians are typically afforded increased claims to expert epistemic rights, while women hold experiential epistemic rights regarding their experience of life, pregnancy and labour. Within the biomedical model of healthcare deontic rights have traditionally belonged to the health professional to determine an appropriate course of action based on medical expertise. However, a woman-centred care approach encourages women to take an active role in decision-making regarding pregnancy and birth.

3.1.5 Moral dimensions of childbirth decisions

Issues of morality are a central theme throughout this thesis. In the literature, morality is conceptualised in terms of norms, values, principles and judgements that involve an understanding of what constitutes the "good" (and conversely, the "bad") (Bayly, 2017; Bergmann, 1998). Understanding morality from an EM perspective involves the examination

of the construction of morality in and through social interaction. Morality is therefore examined in terms of the central role that language plays in the expression and enactment of morality, and in terms of the situated context in which it occurs (Kleinman & Kleinman, 1997). According to Atkinson and Heritage (1984), participants' social activities and projects are continuously 'talked into being'. It is this perspective that helped inform research aims for the research that examine how morality is intertwined with, and informed by, culturally dominant ideologies of mothering in contemporary maternity care interactions.

3.2 Study one

The first study presented in this thesis examines unsolicited birth stories collected from Australian-based pregnancy and parenting websites. The overarching objective of the study was to examine how women described childbirth in a naturally-occurring context. The first study subsequently aims to examine in detail how women described the use of medical intervention using thematic analysis to identify common linguistic practices.

3.2.1 Data collection

Publicly available birth narratives were sourced using the search terms "birth story" and "birth narrative" on Google. Four pregnancy and baby websites were identified that provided a broad range of childbirth experiences. I collected data from each of the identified sites in order to gain a cross-section of narratives. Australian-based sites were chosen to reflect experiences in a medical system that promotes a woman-centred care philosophy in maternity services. As the analytic focus of this study was on birth involving medical intervention, stories describing home or unassisted birth were excluded, as were websites dedicated to specific birth experiences (for example, www.freebirth.com.au). Stories involving planned caesarean-section births were also excluded, as were narratives where the

author was not the mother. A total of 106 narratives (ranging in length from 200 to over 5,000 words) were collected, describing a variety of medical interventions (pharmacological induction, pain relief, episiotomy, forceps, fetal heart-rate monitoring, fetal scalp monitoring, ventouse, and caesarean section).

3.2.2 Thematic analysis

The first article presented takes a thematic approach to examining naturally-occurring birth stories published on the Internet. The aim of Thematic Analysis (TA) is to identify common themes and sub-themes in data through an empirical coding method (Braun & Clarke, 2013). In keeping with EM ideologies, this study takes a discursive approach to TA to explore systematic ways of reporting agency and accountability for medical interventions during labour and birth. A discursive approach to TA involved understanding narratives in terms of an account designed to be shared with other women online. In line with a performative view of language (Edwards & Potter, 2001), women sharing birth stories have stake and interest in presenting themselves as rational and good mothers. Rather than a description of facts, we examined narratives for the social actions they perform (Edwards & Potter, 2001). An inductive, data-driven analytical process allowed for the identification of recurring themes in the data (Boyatzis, 1998). Essentially, this process enabled the data to genuinely reflect accounts given in birth narratives without preconceived ideas. Chapter 4 presents this first study, which was used to inform and guide research questions for studies two and three.

3.2.3 Ethical considerations

There is ongoing discussion in the research literature regarding the use of data sourced online (British Psychology Society, 2017; Kozinets, 2010). A particular ethical issue concerns consent and anonymity. Consent from participants is deemed to be relevant if they would not expect their online activity to be observed by others. Where there is any ambiguity, the

consensus is that researchers should weigh up potentially damaging effects for participants with scientific value (Markham & Buchanan, 2012). There is also agreement that particular care should be taken to ensure that any data from such sources that is used for research purposes remains confidential, and in the present study this is achieved through anonymisation. Pseudonyms are used throughout the paper in place of names, places and other information that might identify posters.

3.3 Studies two and three

The second and third studies presented in this thesis focused on how decisions about aspects of maternity care are made in real life interactions between midwives and women as they occur. In these two studies I used conversation analysis (CA) to examine the ways in which midwives and pregnant women orient to epistemic and deontic authority in and through talk to negotiate and communicate decisions related to planning for childbirth in hospital. building on the findings of study one, and using previous conversation analytic literature I provide a nuanced and in-depth understanding of how childbirth-related decisions are made in situ.

3.3.1 Data collection

Data were collected in naturally-occurring consultations in a large metropolitan public hospital in South Australia. Six midwives were recruited through a consultative process following approval by the hospital's human research ethics committee.

The consultative process involved establishing a trusting relationship with midwives working at the hospital. I was able to achieve this through an initial meeting with the Director of Nursing and Midwifery to pitch my project. The Director was satisfied that my research would not be burdensome for the midwives and had potential to contribute positively to their work.

This support allowed me to directly access the midwives at a staff meeting. I presented my proposal at the meeting and provided the midwives with information sheets and consent forms. The midwives were under no obligation to participate. There was some initial apprehension around participating. The apprehension centred around two main areas: research participation fatigue, and concern about their performance being 'monitored' including who would have access to the data. I was able to reassure most of the staff that participation in the research would not involve any more than starting and stopping an audio recorder (pressing of a single button). There was no obligation on their part to recruit or gain the consent of pregnant women as I would manage that task in the waiting room. More challenging was overcoming midwives' concerns about their performance being monitored. I explained in detail that I am not a midwife, and that while one of my supervisors is a midwife, the aim of the research was not to comment on whether the midwives were doing the 'right' thing or not, but rather to increase knowledge about the ways in which childbirth is planned in Australia. Participation in the research would in no way affect their employment. Midwives were told that I would transcribe the data and it would be analysed by the research team for patterns and similarities in how women and midwives talk about childbirth choices. Midwives were also reassured in the knowledge that they could withdraw their consent at any time, including retrospectively and collected data would be deleted. This situation never arose during the study. Six midwives agreed to participate (five worked in the standard model of care and one worked in the Midwifery Group Practice). The midwife participant information sheet can be found at Appendix 2.

I was then invited to collect data once a week when the midwifery clinic was open. Over a period of six weeks I attended the clinic and respectfully approached pregnant women while

they were waiting for a routine antenatal appointment and asked for consent to audio record the consultation for research purposes. Most women agreed to participate and had relatively few concerns. Even so, I assured them that they were under no obligation to participate and could withdraw consent at any time, including retrospectively. I also explained what the research was about and how their data would be used. Only one woman declined to participate. All pregnant women (and any support people present, including mothers, partners and friends) agreeing to participate signed a consent form and were provided with information about the study including contact details of the first author. Thirty-nine pregnant women attending consultations at the midwifery clinic agreed to participate.

Each time that a woman agreed to participate I discretely informed the midwife participant as the woman entered the consultation room. The midwife often confirmed with the woman before starting the audio recorder. I was never present in the room during the recordings. This was important to reduce the impact of being observed.

Arrangements for data collection with the midwife working in the Midwifery Group Practice were slightly different as most of her consultations were conducted in women's homes. In this situation, the midwife took the audio recorder and agreed to recruit women participants. She felt this was more appropriate anyway as she had an already established relationship with her women and thought the women may be more open to participating if the invitation came from her rather than a cold calling researcher. Seven pregnant women in the Midwifery Group Practice agreed to participate.

All data was transcribed according to the Jeffersonian Transcription system (Jefferson, 2004). This system of transcription enables a detailed description of interaction including not only

the words that are spoken, but *how* they are spoken. The basic premise behind this transcription system is that even minute details of talk, such as pauses, elongation, volume, stress, inbreaths, an overlapping speech, are constitutive of the actions that talk performs and so cannot be ignored in transcription. These vocal features of talk are then denoted using different transcription symbols (Appendix A provides an outline of the symbols used in the present thesis).

3.3.2 Conversation analysis

The second and third studies presented in this thesis provides a Conversation Analysis (CA) of talk between women and midwives in antenatal consultations. EM assumptions inspired the development of Conversation Analysis (CA) and Membership Categorisation Analysis (MCA). Sacks (1979) established CA as a methodology that sought to explicate the “organisation of talk-in-interaction in its own right, as a ‘machinery’” (Hutchby & Wooffitt, 2008). CA aims to identify the sequential organisation of talk to describe ways in which social actions are accomplished. This method was identified as the most appropriate to analyse naturally-occurring midwife-woman interactions with the aim of explicating precisely how allocation to a model of care is achieved in situ. Study two is presented in Chapter 5, and study three is presented in Chapter 6.

3.3.3 Membership categorisation analysis

Study two also draws on Membership Categorisation Analysis (MCA) to examine the function of categories in talk about appropriate model of care options. Whereas CA is primarily concerned with the sequential organisation of talk, MCA focuses attention on the common-sense knowledge of categories used to accomplish social action in and through talk (Stokoe, 2006). MCA also aims to explicate the range of practices that people use in the routine accomplishment of everyday social interaction through the invocation of knowledge about

membership (Fitzgerald & Houseley, 2015). Empirical understanding of the use of categories in real-time and in situ can generate insights into ways in which identity work is accomplished. MCA focuses on people as members of particular groups, and how that membership is utilised to make sense of one another and society generally. The focus of analysis then is on the discursive ways in which people are constructed as belonging to a particular group and what this categorisation accomplishes in talk.

Categories constructed in and through talk are embedded with culturally rich common-sense knowledge (Schegloff, 2007). That is, category-bound descriptions embody assumptions about the person's knowledge and engagement in particular activities (Sacks, 1992). MCA, then, is useful analytically to examine how these taken-for-granted categories are constructed in talk and used to account for experiences and to understand/challenge the experiences of other members of society. In this thesis, MCA is used to examine how midwives draw on certain categories to make recommendations for women's model of care options.

Utilising the three discursive methodologies (TA, CA and MCA) this thesis presents a triangulated perspective in understanding how women's involvement in birth choices are accomplished and communicated in and through interaction. The various methodologies are used to corroborate the findings in the final discussion, strengthening validity and relevance, as well as credibility (Mays & Pope, 1995). This qualitative thesis contributes to existing maternity care literature by providing a detailed and nuanced description of how woman-centred care is actually described and accomplished.

3.4 Reflexivity

As a researcher, mother, woman and human being I brought my own assumptions, values, interests and experiences to this work. Most contemporary qualitative researchers accept that research and meanings are co-constructed, so that the researcher is an active participant in determining what data is generated and how it is analysed and presented (Finlay, 2002). Therefore, some reflection on my own position as a researcher is warranted as form of transparency and 'quality control' (Braun & Clarke, 2013, p37).

Reflexivity in qualitative research requires researchers to position themselves within the context of the studied phenomenon (Burns, Fenwick, Schmied, & Sheehan, 2012) and to consider their various positionings and the ways these might have shaped the collection and analysis of the data (Braun & Clarke, 2013, p 335). Acknowledging and identifying the personal philosophical stance of the researcher is important to realise motivations behind undertaking the study and to address biases. Personal philosophical stances can be influenced by the researcher's background; their religious and political beliefs, gender, knowledge and culture. An understanding of a philosophical stance also increases credibility to the nature of the analysis and interpretive ability of the researcher (Catling-Paull, 2013).

I have given birth three times: twice in a private hospital under the care of a private obstetrician, and once at home under the care of two midwives through the midwifery group practice program at a public hospital. It was through these experiences that I developed a sense of the variances in the level of involvement that I had as a pregnant woman in my antenatal care and birthing experience between the two models of care. I attributed the differing opportunities for involvement to the system in which I was being cared for. All three pregnancies were uncomplicated and all three births were positive experiences; all resulted

in normal vaginal births and healthy baby boys. However, the sense of control and empowerment I felt during my third pregnancy and birth was far greater when compared to my first two births. I brought these experiences and perceptions into the research presented in this thesis. The more I learned about midwifery philosophies, the more interested I became in how midwives were able to practice midwifery within a hospital system.

Reflexivity involves the researcher reflecting constantly on their decisions throughout the study (Finlay & Gough, 2003) and on their position (Berger, 2015). As a researcher, I have created the study and actively constructed the collection and analysis of the data. In this way, my approach is integral to the outcome and interpretation of the study. I chose the research design carefully to minimise the impact of my own biases. The collection of naturally-occurring data (as opposed to interviews, focus groups or researcher-initiated surveys) allowed for a neutrality between me and the raw data. Throughout the research I was aware that my own personal beliefs and experiences of childbirth (which are more situated in midwifery philosophies than medicalised discourse) might encourage particular interpretations of the data. I engaged in on-going reflection on this as I analysed the data and attempted to present an analysis which fairly explored the narratives and interactions while honouring the diversity in the data.

Reflexivity also involves a consideration of how factors like our embodiment (our physical bodies and what we do with them) can influence the production of knowledge within research (Burns, 2003). My decision not to directly observe the midwife-woman interactions minimised the impact of my own embodiment on the research. Instead, I chose to seek consent from both the midwife and woman (along with anyone else attending, for example partners, support people and in some cases a student midwife) to place a small audio

recorder on the midwife's desk. In this way, I avoided any direct personal impact on the unfolding interaction. However, it is acknowledged that behaviours may change when participants are aware of being recorded (Fernald, Coombs, DeAlleaume, West, & Parnes, 2012). It was apparent in some recordings that participants (midwives in particular) were conscious of the data collection. For example, one midwife was heard to say "I'll just leave this [recorder] there. We'll have to be careful what we say, won't we? Ha ha ha". That said, there were more often occasions where the recording was clearly forgotten, evidenced by it being left on after the consultation ended. Midwives, more than pregnant women, appeared concerned with the collection of research data. This was highlighted in the initial difficulty I had recruiting midwife participants. Midwives initially expressed concerns about being 'assessed' or 'monitored'. I was able to overcome this barrier through transparent communication about how the data would be used and who would have access to it, as well as establishing a rapport and trusting relationship. I was able to reassure midwife participants that my intention was to explore the language used in antenatal care, rather than any individual assessment of practice.

To acknowledge my own biases in the analysis phase of all three studies I engaged in deep reflexivity throughout the processes, often checking to ensure that any claims were objectively supported by the data. To do this thoroughly, I engaged my supervisory panel in a series of data sessions, and had regular transparent communication about patterns and particular constructions observed in the data. During these sessions, debate and discussions eventually resulted in consensus on the evidenced claims.

3.5 Chapter summary

This chapter has outlined the theoretical framework underpinning the research presented in this thesis. A description of an ethnomethodological approach to discursive psychological research has been presented along with a description of the three research methodologies used to examine data in each of the three articles. Furthermore, an outline of three fundamental concepts central to the studies in this thesis: accountability; epistemic and deontic stances; and morality. In the next chapter the first study is presented.

4. CHAPTER FOUR: “Trying to give birth naturally was out of the question”: Accounting for intervention in childbirth

4.1 Statement of Authorship

Title of Paper	“Trying to give birth naturally was out of the question”: Accounting for intervention in childbirth
Publication Status	Published
Publication Details	Cole, L., LeCouteur, A., Feo, R., & Dahlen, H. (2019). “Trying to give birth naturally was out of the question”: Accounting for intervention in childbirth. <i>Women and Birth</i> , 21(1), pp. e95-e101. doi: 10.1016/j.wombi.2018.04.010

Principal Author

Name of Principal Author (Candidate)	Lindsay Cole		
Contribution to the Paper	I am responsible for the conception and primary authorship of this article. I conducted the literature review, developed the research aims, conducted analysis, and wrote the manuscript. I was identified as the first author when this article was submitted for publication, and I have been responsible for all communications with journal administration including responses to review feedback.		
Overall percentage (%)	80%		
Certification:	This paper reports on original research I conducted during the period of my Higher Degree by Research candidature and is not subject to any obligations or contractual agreements with a third party that would constrain its inclusion in this thesis. I am the primary author of this paper.		
Signature		Date	24/12/19

Co-Author Contributions

By signing the Statement of Authorship, each author certifies that:

- i. the candidate’s stated contribution to the publication is accurate (as detailed above);
- ii. permission is granted for the candidate to include the publication in the thesis; and
- iii. the sum of all co-author contributions is equal to 100% less the candidate’s stated contribution.

Name of Co-Author	Associate Professor Amanda LeCouteur		
Contribution to the Paper	I was involved in the study design and principal supervision of the research process. I provided comment and feedback on working drafts of the article, and made suggestions on the presentation of material in the article. I also provided advice on responding to comments by the journal reviewers and editor. I hereby give permission for this article to be incorporated in Mrs Cole’s submission for the degree of Doctor of Philosophy from the University of Adelaide.		
Signature		Date	21/11/20

Name of Co-Author	Dr Rebecca Feo		
Contribution to the Paper	I was involved in the study design and supervision of the research process. I provided comment and feedback on working drafts of the article, and made suggestions on the presentation of material in the article. I also provided advice on responding to comments by the journal reviewers and editor. I hereby give permission for this article to be incorporated in Mrs Cole's submission for the degree of Doctor of Philosophy from the University of Adelaide.		
Signature		Date	21/11/19

Name of Co-Author	Professor Hannah Dahlen		
Contribution to the Paper	I was involved in the study design and supervision of the research process. I provided comment and feedback on working drafts of the article, and made suggestions on the presentation of material in the article. I also provided advice on responding to comments by the journal reviewers and editor. I hereby give permission for this article to be incorporated in Mrs Cole's submission for the degree of Doctor of Philosophy from the University of Adelaide.		
Signature		Date	25/11/19

4.2 Abstract

Problem: Studies of women's childbirth preferences repeatedly show that natural birth remains highly valued, yet the majority of births involve some form of medical intervention. Reasons for this lack of correspondence have typically been investigated through interviews and focus-groups with women. Relatively little research explores the ways in which women describe their experiences of childbirth outside of such research settings.

Background: Most maternity services promote woman-centred care, whereby women are encouraged to take active roles in deciding how to give birth. However, recent research indicates that women often report feeling disempowered during labour and birth in hospital settings.

Aim: We sought to examine how women account for use of medical intervention in hospitals by examining narratives posted on online discussion forums. **Method:** A thematic analysis of 106 publicly available birth stories, sourced using the Internet search terms 'birth story', and 'birth narrative', was undertaken.

Findings: Medical interventions in childbirth were routinely described as unwanted, yet as unavoidable, and two types of account were typically drawn on to explain their use: Protection of the baby/mother; and inflexible hospital policy/practice. We examine these two types of account, focusing on how their design oriented to the discordance between mothers' reported desires for a natural birth, and their experiences in hospital.

Conclusion: The experience of medical intervention in childbirth is routinely oriented to as a matter that requires explanation or account in online birth narratives. Women repeatedly

referred to their preference to avoid intervention, but described being unable to do so in hospital.

4.3 Introduction

A growing body of research is concerned with rising rates of medical intervention during labour and birth, in part due to the increased risk of morbidity associated with surgical birth compared to normal birth (Tully & Ball, 2013). In the developed world, most births take place in hospitals, where pharmacological intervention and/or surgical procedures are commonplace (Dahlen et al., 2014). A recent Australian study of around 700,000 low-risk first-time mothers, for example, found that only 15% of those giving birth in private hospitals, and 35% of those in public hospitals, did not experience some form of medical intervention (i.e., Induction, epidural, episiotomy, forceps, vacuum extractor/ventouse, caesarean section) (Dahlen et al., 2014). Concern about the negative consequences of increasing medical intervention has been noted in a range of disciplines associated with maternity care, including obstetrics, medicine, midwifery, sociology, and physiology (Dahlen et al., 2014; Dweik, Girasek, Toreki, Meszaros, & Pal, 2014; Goer, 2002; Johanson, Newburn, & Macfarlane, 2002; Lee & Kirkman, 2008). Increasing reliance on medical intervention in childbirth is argued to stem from broad causes ranging from patriarchal social structures that function to control women and their bodies (Davis-Floyd, 2001; Kitzinger, 2006; Lee & Kirkman, 2008; Malacrida & Boulton, 2014), to a general shift toward a consumerist approach in medicine that results in increasing numbers of women actively requesting surgical birth (Dweik et al., 2014).

Despite high rates of medical intervention, 'natural childbirth' remains highly valued in Western culture (Malacrida & Boulton, 2014). Previous research on women's childbirth

experiences has focussed attention on the inconsistency between women's reported preference to avoid medical intervention, and their lived experience of giving birth in hospital (Dweik et al., 2014; Lee & Kirkman, 2008; Malacrida & Boulton, 2014; Smyth, 2012; Tully & Ball, 2013). Cultural ideals of 'good mothering' have been argued to contribute to the valorisation of 'natural' birth, with researchers investigating the impact of a range of normative and moral orders around labour and birth (Lupton & Schmied, 2013; Smyth, 2012; Spinelli et al., 2016). It has also been argued that a sense of control for women is central to positive birth experiences, and also to a transition into satisfied mothering (Cook & Loomis, 2012; Geerts et al., 2014; McCourt, 2006; Spinelli et al., 2016).

Over recent decades, hospitals in Australia, and internationally, have embraced a woman-centred approach in childbirth policy that emphasises women's active involvement in maternity services. Despite such policy developments, research on women's experiences of maternity care in hospitals continues to highlight their limited opportunities to enact control. There is ongoing evidence, then, of a disconnect between cultural valorisation of 'natural' birth combined with a focus on women-centred care in hospital settings on the one hand, and women's actual experiences of giving birth on the other. In this sense, it is important to examine how women describe and account for the use of medical intervention during childbirth. The present article takes as its focus a corpus of descriptions contained in birth stories posted on Australian-based pregnancy, birth and motherhood websites. These descriptions of medical intervention are analysed in order to shed light on how sense is made of the lack of correspondence between reported birth preferences and instances of medical intervention during childbirth. We start with a brief overview of recent literature on the valorisation of natural birth, and on women's experiences of current maternity services,

followed by a review of childbirth research that has examined online material. We then present a thematic analysis of women's accounts of their birthing experiences in Australian hospitals collected from online discussion forums on pregnancy birth and motherhood websites.

4.3.1 Valorisation of natural birth

The ideology of 'natural birth' is underpinned by an understanding of women's bodies as physiologically designed to birth babies (Smyth, 2012; Tully & Ball, 2013). In recent times, the valorisation of natural birth has culminated in a 'natural birth movement' driven by women and health advocates, who argue that physiological birth is superior to other forms (e.g., the technocratic, medical model). Research has reported women's feelings of disappointment around not being able to achieve a natural birth (Lupton & Schmied, 2013; Smyth, 2012; Spinelli et al., 2016). Spinelli et al. (2016), for example, conducted interviews in the neonatal unit of an Italian hospital with thirty mothers of pre-term babies. These women described their experience of highly medicalised and controlled births as having a negative impact on their transition to motherhood. Similarly, an Australian interview study involving 25 women who had recently given birth to their first child reported that those who birthed vaginally ($n = 16$) described fewer difficulties transitioning to motherhood than did those who gave birth by caesarean section ($n = 9$) (Lupton & Schmied, 2013). Increasing reliance on medical technology during childbirth has also been reported as having other adverse impacts. In interviews with 40 mothers in Ireland and America, Smyth reported on how birth was characterised as an instinctual ability that was threatened by over-medicalisation (Smyth, 2012). It has been argued that the natural birth movement has set women up to fail by promoting an ideology of 'vaginal birth at all costs' (Dietz, 2017). However, in general,

research on women's experiences suggests that feelings of disempowerment and lack of control that occur during highly technological and medically controlled births can have detrimental ongoing effects.

4.3.2 Woman-centred maternity care

In Australia, the National Guidance on Collaborative Maternity Care defines woman-centred care as focusing on “the woman’s individual, unique needs, expectations and aspirations, rather than the needs of institutions or maternity service professionals ... recognis[ing] the woman’s right to self-determination in terms of choice, control and continuity of care”p.14 (National Guidance on Collaborative Maternity Care, 2010). The guidance was developed following a National Review of Maternity Services (Bryant, 2009) that highlighted a range of improvements requested by women including: models of care that reflected their birthing choices; greater access to information about pregnancy and birth; respect for women’s perceptions of risk; and greater recognition of birth as a natural process rather than as a medical procedure. Despite the creation of policies formulated to reflect women’s preferences, a number of recent studies have reported women’s continuing experience of disempowerment when birthing in the hospital system (Bernhard et al., 2014; Happel-Parkins & Azim, 2015; Malacrida & Boulton, 2014; Petrovska et al., 2016). These studies, using interview and focus-group methods, have highlighted issues around power and decision-making in the birthing process as key. They describe women’s difficulties in attempting to resist medical advice (Petrovska et al., 2016; Root & Browner, 2001), their inability to follow Birth Plans that they have made (Happel-Parkins & Azim, 2015; Malacrida & Boulton, 2014), and to control the hospital-birth experience (Bernhard et al., 2014).

Although interview and focus-group studies have provided important insights into women's experiences and their sense-making around childbirth, it has been argued that there are limitations associated with such methods (Potter & Hepburn, 2005). It has been shown, for example, that interviewees' responses are impacted by the framing of interviewers' questions (Silverman, 2006; Ten Have, 2004; Widdicombe & Wooffitt, 1995). Another consideration involves the way that analysts typically treat participants' talk as a matter of factual reflection, rather than as a form of accounting that is designed to achieve particular functions in a local, research-oriented interaction (e.g., positive self-presentation; justification; assisting the research/researcher (Goffman, 1959; Potter & Hepburn, 2005). Goffman (1959) for example, discussed the ways in which descriptions involve impression management. Most often, people construct accounts in order to maintain a favourable identity, attending strategically to potentially problematic issues, actions and events for which they may be held responsible. In other words, they have stake or interest in the descriptions they provide (Drew & Heritage, 1992; Edwards & Potter, 2001; Potter & Hepburn, 2005; Ten Have, 2004). Researchers have identified a range of interactional and linguistic practices that function to manage impression/stake or interest in descriptions, such as defensive detailing (Drew, 1998), extreme-case formulation (Pomerantz, 1986), and prioritising membership to particular categories (Dillon, 2011). Goffman's work on presentation of the self has been applied to online forms of communication (Bullingham & Vasconcelos, 2013; Christopherson, 2007). The present analysis considers the dataset from this general perspective. We take our lead from Potter and Hepburn (2005) who pointed out that the study of naturally occurring (i.e., unsolicited) material can avoid many of the problems associated with the use of interview and focus-group data. In the present study, unsolicited narratives - in the form of online reports of hospital childbirth experiences - are

used as a source of data with the aim of overcoming the limitations of interview and focus group methods. This is particularly important in respect of talk about childbirth, where normative moral orders – matters of responsibility, blame, and social evaluation – have been shown to be fundamental to sense-making and identity work (Lowe, 2015; Smyth, 2012).

4.3.3 Childbirth research using online data

Online accounts of childbirth represent a relatively new form of information about women's experiences of pregnancy and labour. Online blogs in which mothers discussed choosing Vaginal Birth After Caesarean (VBAC), or repeat caesarean, were examined by Dahlen and Homer (2013) who identified a dichotomy in the philosophical framework or perspective drawn on by women in their posts. A 'childbirth' form of accounting referenced sacrifice on the part of the mother for the good of the baby, in order to minimise risk (prioritising the baby). 'Motherbirth' accounts involved orientation to the idea that giving birth is important to women, and that happy, healthy mothers are necessary for happy healthy babies (both mother and baby prioritised). Online birth narratives written by women who had chosen to birth unassisted, at home, were analysed by Miller (2009). In these birth stories, women presented themselves as independent and self-determining, describing how they controlled what they did and when, as well as the environment in which they gave birth, and how they interacted with others. In particular, these birth stories routinely concluded with statements about the joy and sense of empowerment associated with unassisted birthing. Online support and information forums about breech presentations were the focus of analysis in another study (Kozinets, 2010) where a "clear difference in tone" was identified in posts by women who felt supported in their choice for vaginal breech birth (VBB) by their care provider, compared to those who did not. Women who had access to services that supported

VBB were described as posting using “excited, joyous language”, whereas those who lacked such support described feeling a lack of control, and disappointment about the lost opportunity to give birth vaginally.

The present study was designed to build on previous research examining online descriptions of particular forms of birth. The focus, here, is on how women account for forms of medical intervention during childbirth in hospital settings. The analysis is undertaken in the context of recent changes to policy around childbirth and maternity services in Australia, and internationally, that place emphasis on the importance of woman-centred care in the hospital birth experience.

4.4 Method

4.4.1 Data collection

Publicly available birth narratives were sourced using the search terms “birth story” and “birth narrative” on Google. Four pregnancy and baby websites were identified that provided a broad range of childbirth experiences. We collected data from each of the identified sites in order to gain a cross-section of narratives. Australian-based sites were chosen to reflect experiences in a medical system that promotes a woman-centred care philosophy in maternity services. As the analytic focus of this study was on birth involving medical intervention, stories describing home or unassisted birth were excluded, as were websites dedicated to specific birth experiences (for example, www.freebirth.com.au). Stories involving planned caesarean-section births were also excluded, as were narratives where the author was not the mother. A total of 106 narratives (ranging in length from 200 to over 5,000 words) were collected, describing a variety of medical interventions (pharmacological

induction, pain relief, episiotomy, forceps, fetal heart-rate monitoring, fetal scalp monitoring, ventouse, and caesarean section).

4.4.2 Data analysis

Narratives were coded following Braun and Clarke's (2013) guide to Thematic Analysis. Initial repeated reading was undertaken and codes were generated to identify aspects of the narratives that involved description of medical intervention during labour and birth. These codes were grouped together following discussion by the researchers, according to their perceived similarity, in order to produce a set of themes. These themes were subsequently refined and labelled in a process that involved repeated re-reading of the narratives and discussion by the researchers, with the aim of capturing the nature of the accounting practices involved.

4.4.3 Ethical considerations

There is ongoing discussion in the research literature regarding the use of data sourced online (British Psychology Society, 2017; Kozinets, 2010). A particular ethical issue concerns consent and anonymity. Consent from participants is deemed to be relevant if they would not expect their online activity to be observed by others. Where there is any ambiguity, the consensus is that researchers should weigh up potentially damaging effects for participants with scientific value (Markham & Buchanan, 2012). There is also agreement that particular care should be taken to ensure that any data from such sources that is used for research purposes remains confidential, and in the present study this is achieved through anonymisation. Pseudonyms are used throughout the paper in place of names, places and other information that might identify posters.

4.5 Analysis

Analysis focused on identifying common themes in accounts of use of medical intervention during hospital childbirth. A broad pattern observable in the data involved descriptions of medical intervention as unavoidable, despite being unwanted by the mother (in 66 of 106, or 71% of accounts). In this sense, medical intervention was presented as an accountable matter: narratives routinely involved claims that the author had wanted a 'natural' birth – either through the use of explicit statements, or by virtue of naming specific interventions they had wanted to avoid (such as epidural or caesarean). Accounts of why authors were unable to achieve natural birth (or avoid unwanted interventions) typically referenced physiological complications, either in relation to the woman (e.g., small pelvis, and/or lack of progression in labour) or to the baby (e.g., positioning or weight). This broad pattern in the data involving claims of a preference for avoiding medical intervention accompanied by descriptions of the use of medical intervention - and the accountability involved - became the focus of further investigation. Two recurring types of account were identified: (1) medical intervention as unavoidable in order to protect the baby/woman from 'stress' or 'distress'; and (2) medical intervention as unavoidable due to compliance with hospital policy/practice. Each broad type of account is discussed in detail below.

4.5.1. Theme 1: Medical intervention as necessary to avoid stress/distress

Accounts that described medical intervention as necessary in order to protect the baby or the woman from some "stress" or "distress" associated with physiological aspects of the birth were typically introduced in terms of 'concern' on the part of a medical professional. Such 'concern' constructions involved explicit use of the term, 'concern', as well as use of the similar lexical term, 'worry'. Extract (1) illustrates the general pattern. It comes from an account describing a highly medicalised birth (involving monitoring; gas and epidural for pain

relief; a catheter; and a hormone drip) that resulted, ultimately, in a caesarean section. Here a doctor is described as 'concerned' about the size of the baby in relation to the size of the woman's pelvis (line 6). The extract comes just over half way through a 2,500-word narrative. The extract begins after the woman has described the posterior presentation of the baby as threatening her preferred method of vaginal birth. As in all extracts, pseudonyms are used.

Extract (1), F1-2

1 *"Dr Fred explained to us that bubs was posterior, and that if*
2 *it dropped when he came back for his next check up in an*
3 *hour or so, he would be able to manually turn the baby and*
4 *we could do a natural birth. However, the possibility of a*
5 *caesarean was still there as he was still concerned with the*
6 *size of my pelvis.*
7 (32 words deleted).
8 *Things were finally starting to look up for me. He wanted to*
9 *give me another hour to get fully dilated and then the birth*
10 *would commence. I was so overcome with joy as I really did*
11 *not want to have a c section. 11am and we were getting ready*
12 *to meet our baby. Dr Fred checks me out again; to make sure*
13 *everything was as he needed it to be to begin the delivery.*
14 *However, things were not looking up for me. The baby was*
15 *stuck. My pelvis was too small for the size of its head and it*
16 *could not get any further down. Trying to give birth naturally*

17 *was out of the question as it would just cause too much stress*

18 *on me and bubs and was just not worth it."*

Here, the doctor's 'concern' about physiology (line 5) is used to frame the introduction of the 'possibility' of a caesarean birth. The mother's preference for avoiding this form of medical intervention is made explicit a few lines later in her description of the outcome of the doctor's subsequent examination of her: 'I was so overcome with joy as I really did not want to have a c section' (lines 10-11). An orientation to the normative or moral order around natural childbirth can be seen in the design of this description that uses the extreme-case formulations, 'so overcome', 'really did not want', to present her preference. Extreme-case formulations are practices that invoke the maximal or minimal properties of events or objects (e.g., 'always', 'never', 'completely'). They have been shown to be used interactionally to defend against, or counter, potential challenges to justifications, and to portray the circumstances that precipitate actions as external to, or independent of, the speaker (Pomerantz, 1986; Whitehead, 2015). Here, the description works to defend against potential undermining of the claim that the author wanted to avoid a caesarean-section birth. The narrative then moves to a description of the doctor's final check-up prior to birth where the previously introduced 'concern' about physiology is presented as fact ("The baby was stuck. My pelvis was too small for the size of its head and it could not get any further down", lines 14-16). As a result, giving birth naturally is described using another extreme-case formulation as "out of the question" (line 17), that is, as unavoidable, rather than as an active choice on the part of the mother. It is at this point that a reference to "stress" occurs. Trying to give birth "naturally" is described in terms of the non-specific negative outcome of causing "too much stress" (line 17) - in this case, for both the baby and the woman. An idiomatic expression "it was just not worth it" (line 18) rounds off the description of this aspect of the

birth story. The vagueness of such idiomatic expressions has been argued to make them difficult to challenge or contradict (Antaki, 2007). This feature contributes to their routine use at points in interaction where there is potential for questioning a participant's stake or interest in the descriptions they are producing (Antaki, 2007). In this example, then, reporting of a health professional's 'concern', together with use of the descriptive category 'stress', provide warrants for an account of a medical intervention that was unwanted, but unavoidable.

Extract (2) provides another example of a 'concern' construction, again framed in terms of a baby's size. Here, the category descriptor, "distress" is used to account for an unwanted caesarean-section birth. The extract comes near the end of a 2,000-word narrative about a pharmacologically induced birth.

Extract (2) F4-12

1 *"He (doctor) was concerned about the baby gaining more weight*
2 *and then having complications due to its size, and then not*
3 *engaging well enough and placing both myself and the baby in*
4 *distress.*
5 *(12 lines on decision-making process omitted)*
6 *I agreed to have the c-section. And then promptly burst into tears,*
7 *partly for not being able to deliver my own baby vaginally and*
8 *partly because I was tired, and I think partly because I was going*
9 *to meet my baby so soon."*

Here, the woman's preference for avoiding medical intervention (a caesarean) is evidenced by her reported emotional reaction "burst into tears, partly for not being able to deliver my

own baby vaginally” (lines 6-7). Similar to the construction illustrated in Extract (1), a description is presented in which the mother’s preference for a natural birth is contrasted against the unavailability of medical intervention. The non-specific term ‘distress’ (line 4) is used here, again in relation to both the woman and the baby, to provide further warrant for the need for medical intervention.

Caesarean sections were not the only intervention women explicitly claimed to want to avoid. The following extract from the corpus comes midway into an 800-word narrative illustrating a preference to avoid an epidural or use of pethidine. It describes a spontaneous labour that resulted in a surgical birth.

Extract (3), F1-15

1 *“I wanted to avoid an epidural or pethidine as much as possible,*
2 *and felt able to continue as I was, although I was worried about*
3 *how long it was going to take... (53 words deleted). When the*
4 *midwife came in a while later, I just mentioned my pad and asked*
5 *her to have a look. Immediately there was concern as it was*
6 *meconium (the substance in baby’s first bowel movements, which*
7 *can indicate that a baby is in distress). After much difficulty*
8 *getting in and out of the shower because of the intensity of the*
9 *contractions, the monitors were put on so the baby’s heart could*
10 *be listened to. Much to our concern, each time I had a contraction*
11 *his heart rate was going down considerably. The doctors were*
12 *alerted and after another internal examination (revealing that I*

13 *was only six centimetres) they decided that an emergency*
14 *caesarean was the only option.”*

Here, the midwife’s concern about the presence of meconium (line 6) builds to a description of shared concern on the part of the mother (line 10). The descriptive category ‘distress’ (line 7) is used here in relation to the baby, and the birth outcome of an emergency caesarean is presented as a decision made by “the doctors” (lines 11) using the extreme-case formulation, “the only option” (line 14).

It should be noted that our aim here is not to question whether medical intervention was necessary in individual cases, nor to speculate about whether or not babies and/or women might have experienced stress during birth. Rather, we are interested in exploring how narratives that draw on constructions of health professionals’ ‘concern’, and on ‘stress / distress’ as descriptive categories, are used in accounting for medical intervention during birth in hospital settings. In the next section, a second recurring pattern of accounting for unwanted medical intervention during birth is described.

4.5.2 Theme 2: Medical intervention as hospital policy / practice

In this broad pattern of accounting, women routinely positioned themselves as having little agency in the birth process as a result of hospital policy and/or practice. Typically, they referred to their belief in their physiological ability to birth without intervention, but described being impeded or overridden by hospital policy/practice. In some cases, general institutional policy was mentioned, in others, practices of individual doctors were described as limiting birth options. As in accounts that referenced the ‘concern’ of medical professionals, references to physiology were also often made in accounts that described hospital policy/practice as the reason women did not birth in the way they claimed to prefer.

However, unlike descriptions of intervention as unavoidable that were framed in terms of medical ‘concern’ and invoked ‘stress’ as a warrant, descriptions of intervention that invoked compliance with hospital policy/practice typically constructed medical intervention as unnecessary. Typically, in this second pattern of accounting, as well as claiming not to want the intervention, women claimed not to need it. Extract (4) below provides an example of this pattern. Here, a woman claims that she could have birthed her baby without a caesarean section, but was unable to do so because the hospital did not support breech vaginal birth. The extract comes from a 2,600-word narrative about the birth of the woman’s third child.

Extract (4), F2-40

1 *“Sarah (baby #3) was delivered by caesarean section in Hastings*
2 *as she was breech. A c/s was something I never wanted, yet the*
3 *Drs insisted I have one due to her breech position. I was happy to*
4 *go ahead with a vaginal birth, but the Drs were not confident and*
5 *since they no longer practice breech deliveries I ended up with a*
6 *scheduled c/s. She was delivered at 39wk 4d happy, healthy and*
7 *oh so perfect. Everything went really well thankfully. I still regret*
8 *not trying harder to get a vaginal birth, as I knew I would have*
9 *done it.”*

Here the doctors’ insistence on a caesarean (line 3), and their lack of confidence around breech presentations (line 4), are cited as reasons for the caesarean-section birth that the woman “never wanted” (line 2). The description concludes with a statement of her belief

that she could have birthed the baby vaginally: “I still regret... as I knew I would have done it” (lines 7-9).

Extract (5), provides another example of this form of accounting. The extract comes from a 570-word narrative describing an induction, against the woman’s wishes, that ultimately resulted in a caesarean.

Extract (5), F3-44

1 *“I spent 30 minutes in the shower and thought if the midwives and*
2 *doctor left me alone I could most certainly birth my baby in the*
3 *shower but another midwife came in to stop my shower as I was*
4 *connected to a machine and said I wasn’t allowed in the shower*
5 *because of it, I cried.”*

In this account, the woman references her knowledge of her ability to give birth without intervention, privileging it over that of the health professionals using an extreme-case formulation (“I ... thought if the midwives and doctor left me alone I could most certainly birth my baby”, lines 1-2). She describes how she is ‘stopped’ (line 3) and was not ‘allowed’ (line 4) to birth in the shower as she wanted, due to hospital policy about needing to be “connected to a machine” (line 4) to monitor her baby.

Not all narratives describing ‘unnecessary’ medical intervention involved caesarean-section births. Extract (6) describes a birth involving an artificial hormone drip to strengthen contractions, an epidural for pain relief, and the use of a ventouse to assist with the birth. The woman describes the medical interventions as physiologically unnecessary, but as unavoidable, due to hospital policies/practices. Similar to Extracts (4) and (5), she describes

not feeling, physically, in need of medical intervention in her labour (“I didn’t feel exhausted. I felt I had a lot more to give”, lines 5-6). In Extract (6), however, the labour’s progress is described as having violated hospital policy (line 4), resulting in intervention. The extract comes around half way through a 2,250-word narrative.

Extract (6), F3-73

1 *“After an hour, the midwife said the baby was stuck. His head was*
2 *in the wrong position – facing sideways not tucked under. We*
3 *were both fine, but she was worried I’d get exhausted. She had to*
4 *warn me it was hospital policy not to let women push for more*
5 *than two hours. The funny thing was, I didn’t feel exhausted. I felt*
6 *I had a lot more to give. I had a sense that I was waiting for the*
7 *real pushing contractions to start – so far they’d certainly not*
8 *been overwhelming. But half an hour later, things were just the*
9 *same. So the midwife went out to talk to the consultant. She*
10 *reappeared saying that they thought it would be a good idea to*
11 *set up a Syntocinon drip to strengthen the contractions. If that*
12 *didn’t work, then they’d try a Ventouse extraction. They thought I*
13 *should have an epidural so I’d be ready, whatever they needed to*
14 *do.”*

Here, the woman positions herself as having little agency in the birthing process, as was typical in narratives citing hospital policy/practices to account for medical intervention. Similar to the pattern observed in Theme one, a ‘worry’ construction on the part of the midwife is drawn on (line 3). However, here, the woman undermines this construction,

reporting her own feelings that she and the baby were 'fine', and specifically stating that she did not 'feel exhausted' (line 6), adding that she had "a lot more to give" (line 6). She attributes the requirement for intervention to hospital policy (lines 4-5). As was the case in Extract (4), an orientation to medical authority can be seen here. The agency and control of the midwife and consultant is referenced by repeated use of the pronoun 'they' in her description of the third stage of labour: 'they thought it would be a good idea to set up a Syntocinon drip' (line 11), 'they'd try a Ventouse extraction' (lines 12-13), and 'They thought I should have an epidural so I'd be ready, whatever they needed to do' (line 13-14). The medical intervention is positioned as part of an institutional imperative to adhere to hospital policy (line 4) thus avoiding the attribution of blame to specific individuals or professions.

Rather than describing medical intervention as warranted in terms of minimising risk to the baby or to the mother, narratives in this theme contained descriptions of mothers' fears that consenting to interventions would hinder natural birth. Extract (7), below, from a narrative that described the birth of twins, illustrates this type of construction. The woman describes her hesitation to induce labour and her preference to avoid caesarean section. Unlike Extracts (4)-(6), considered above, Extract (7) positions the author as having some agency in the decision, describing her agreement to a dis-preferred artificial rupturing of membranes (lines 9-11).

Extract (7), F1-52

- 1 *"This was my 4th pregnancy... All were vaginal births with no*
- 2 *problems but it became clear early on that it would be a struggle*
- 3 *to even have a vaginal birth, with a 65% or higher c/section rate in*
- 4 *Melbourne for twins.*

5 *The due date was (date removed) and I had no intention of*
6 *agreeing to induction at 38 weeks as recommended. No evidence*
7 *was offered to me to support the assertion that carrying twins*
8 *past 38 weeks is dangerous, and I still don't believe it. At the last*
9 *minute though, I agreed to be induced by ARM (artificial rupture*
10 *of the membranes) on (date removed) at 38 weeks & 2 days.*
11 *The reason I agreed to it was because the 'good' obstetrician*
12 *(consultant) was rostered on that day, and we were convinced I*
13 *had a much better chance of a vaginal birth with this guy & not*
14 *some random doctor."*

This narrative describes the woman's justification for agreeing to have her membranes ruptured, despite her claim to have "no intention of agreeing to induction" (lines 5-6) which was described as routine hospital practice for a twin birth (lines 2-4). The woman constructs her decision as reasonable (lines 11-14) given the rostering of her preferred ("good") consultant (lines 11-12). Had she chosen not to be induced, the implication is that she would have been assigned "some random doctor" (line 14) with whom there would have been little possibility of managing the birth in line with her wishes. In agreeing to have her labour artificially induced (a decision that was constructed as giving her a higher chance of vaginal birth), the woman accounts for intervention (rupturing of the membranes) by referencing the constraints of institutional practice.

4.5.3 Summary

This analysis of descriptive patterns, and broad themes, in online birth narratives illustrates ways in which accountability was managed: women reported that they wanted to avoid medical intervention but described how such intervention was nonetheless involved in their

births. Unwanted medical interventions were described as being unavoidable in accounts that were warranted with descriptions of professional 'concern' for the baby and/or the woman if intervention did not occur (Theme 1). Unwanted medical interventions were described as unnecessary in accounts that referenced hospital policy/practice (Theme 2) as the reason for their use. Descriptions drawing on the non-specific category, 'stress/distress', that would result for both mother and baby if intervention did not occur was a common pattern throughout the narratives.

4.6 Discussion

This study explored how women accounted for medical intervention in childbirth using unsolicited descriptions contained in narratives posted on online birth and pregnancy forums. Two broad patterns of accounting were identified in descriptions of medical intervention as unwanted, yet unavoidable. In accounts that drew on 'concern' constructions on the part of health professionals, intervention was framed as *necessary*, whereas in accounts that drew on policy/practice explanations for the unwanted procedures, intervention was positioned as unnecessary. Both forms of accounting demonstrated an orientation, on the part of women, to institutional authority in relation to childbirth. This is perhaps unsurprising in the context of hospital-based childbirth. However, recent decades have seen significant changes toward policies of woman-centred care in western maternity systems. Such policies recognise the need for women's active involvement and opportunities to enact control over various aspects of the birth process.

Findings reported here are in line with evidence from previous research indicating that that natural birth continues to be valourised in contemporary society (Bayly, 2017; Malacrida & Boulton, 2014; Tully & Ball, 2013). The overarching theme identified in our analysis of online

birth narratives involved the positioning of medical intervention as unwanted. As such, narratives routinely displayed attention to issues of accountability for the medical intervention that women had experienced during birth. In our dataset, a construction of medical professionals' 'concern' around some physiological aspect of the birth was repeatedly used to warrant the use of medical interventions that women described as having wanted to avoid. Malacrida and Boulton (2014) demonstrated a similar pattern in their analysis of women's talk about their use of Birth Plans. The Canadian women they interviewed did not blame medical staff for the use of medical interventions that altered their plan/preference for maximizing the potential for natural birth, but instead described their own body's failings, internalising or individualising responsibility for the unwanted interventions. Malacrida and Boulton referenced Lupton's (1999) discussion of the 'proliferation of risk discourse' in Western countries that has resulted in the framing of pregnancy as a 'perilous journey' (p. 66) in which women are held accountable for avoiding risks and protecting the wellbeing of the baby. In the present study, a recurring pattern involved women describing unwanted medical intervention as warranted in order to protect the baby/themselves from 'stress'/'distress', a general, non-specific, negative descriptive category. Fisher, Hauck and Fenwick have described how biomedical hegemony can be maintained in maternity services through the promotion of fear of childbirth amongst women, and undermining of their confidence to give birth without medical monitoring (Fisher et al., 2006). The findings presented in this article support the assertion that a lack of opportunity to resist medical interventions in hospital births exists.

A second pattern of accounting for unwanted intervention in birth - that positioned intervention as unnecessary - was also identified in the online narratives we examined. In this

pattern, women drew on descriptions of hospital practice and/or policy to account for the use of intervention. A large body of feminist research has criticised the medicalised management of birth as a form of control over women's bodies (Fisher et al., 2006; Freeze, 2010; Goer, 1995) that benefits standardised medical systems and their scheduling (Davis-Floyd, 2001). These claims are reflected in the pattern of accounting seen here, in which women described undergoing treatment and practices they felt they did not require. Our analysis thus supports claims that the power of biomedical discourse continues to contribute to women's experience of decision-making during childbirth (Root & Browner, 2001), even in the context of woman-centred care. The descriptions of birth examined here were consistent with previous work that shows women position themselves as responsible patients, comply with medical advice, and submit to medical scrutiny and intervention in order to avoid risks to their own, and their baby's health. The evidence from our analysis of online narratives describing unplanned medical intervention reinforces reports in respect of a number of atypical forms of birth. Dahlen & Homer's (2011) examination of women's decisions to pursue vaginal birth after previous caesarean section (VBAC), for example, highlighted the difficulties women encountered when resisting medical advice (in this case to undergo repeat caesareans). Similarly, women in Petrovska, Sheehan & Homer's (2017) study reported pressure from medical professionals to opt for medical management when planning for a breech birth. Findings from the present study thus provide further insights into women's experiences of medical authority in hospital birth settings. Examination of the ways in which both women and medical professionals make sense of, and account for, childbirth experiences in other naturalistic settings - such as birthing and parent education classes, clinic visits, during labour and birth, and at postnatal check-ups - may provide additional useful insights into the nature of what is often a difficult, complex and contested experience

for women. In the context of increased focus on woman-centred care in maternity services, knowing more about how actual interactions around decision-making are routinely managed is likely to yield significant benefit for the continuing development of policy and practice.

5. CHAPTER FIVE: “Cos you’re quite normal, aren’t you?”: Epistemic and deontic orientations in the presentation of model of care talk in antenatal consultations

5.1 Statement of Authorship

Title of Paper	“Cos you’re quite normal, aren’t you?”: Epistemic and deontic orientations in the presentation of model of care talk in antenatal consultations
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Overall percentage (%)	80%		
Certification:	This paper reports on original research I conducted during the period of my Higher Degree by Research candidature and is not subject to any obligations or contractual agreements with a third party that would constrain its inclusion in this thesis. I am the primary author of this paper.		
Signature		Date	24/12/19

Co-Author Contributions

By signing the Statement of Authorship, each author certifies that:

- i. the candidate’s stated contribution to the publication is accurate (as detailed above);
- ii. permission is granted for the candidate to include the publication in the thesis; and
- iii. the sum of all co-author contributions is equal to 100% less the candidate’s stated contribution.

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Signature		Date 25/11/19

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Contribution to the Paper	I was involved in the study design and supervision of the research process. I provided comment and feedback on working drafts of the article, and made suggestions on the presentation of material in the article. I also provided advice on responding to comments by the journal reviewers and editor. I hereby give permission for this article to be incorporated in Mrs Cole's submission for the degree of Doctor of Philosophy from the University of Adelaide.	
Signature		Date 21/11/19

5.2 Abstract

Women's involvement in decision-making around antenatal care is an issue of ongoing debate and discussion. Most research on the topic has used interview and focus group methods to examine women's perspectives. The present study uses a different kind of evidence. By analysing recordings of actual antenatal consultations, this paper presents a preliminary exploration of model of care talk in a hospital setting where a policy of woman-centred care underpinned practice. Conversation Analysis was used to examine how model of care pathways were introduced by midwives and discussed with women in consultations. Drawing on interactional work on deontic (i.e., the rights and responsibilities of speakers to determine courses of action) and epistemic (i.e., speakers' claims to knowledge) orientations, this paper offers an account of how woman-centred care is accomplished in a hospital setting. The findings demonstrate how midwives routinely relied on their epistemic knowledge regarding women's health to invoke a "normal" categorisation that worked to position midwifery-led care as an appropriate pathway. Examination of model of care talk also demonstrated how authority to choose a pathway was typically managed so as to reside with the woman. Talk that topicalised epidural forms of pain management was also examined, as institutional policy around where birth could occur in the hospital system under study restricted women's options (a planned epidural precluded woman access to midwifery-led care during delivery). The findings demonstrate the various ways in which midwives created opportunities for woman-centred care in an institutional setting in which there were logistical restrictions on women's choices.

5.3 Introduction

The extent to which women have the right – and opportunity – to control their birthing experience continues to create debate in the literature (Malacrida & Boulton, 2014; McCourt,

2006; Pilnick & Zayts, 2016). Increasing rates of medicalised childbirth have been a topic of particular discussion. In Australia, the incidence of medical intervention in childbirth for low-risk women receiving public hospital care is reported to have increased by over 5% in the last decade, with an increase of over 10% in private hospitals (Dahlen et al., 2014). Warnings against the high rate of obstetric intervention during birth have appeared in World Health Organisation recommendations and in the Lancet Series on Maternal Health and Caesarean Section (Brownlee et al., 2017; Miller et al., 2016; World Health Organisation, 2018). Despite cultural valorisation of “natural” childbirth in the developed world (Smyth, 2012; Spinelli et al., 2016), rising rates of medical intervention are routinely rationalised in terms of a moral responsibility to protect the health of women and babies (Robson, Laws, & Sullivan, 2009). This perspective underpins the standard hospital delivery of antenatal care, where medical management takes the form of regular screenings and health checks for pregnant women. Opportunities for women to exercise control over their birth experience are also argued to be constrained by a more general moral obligation requiring participants in hospital settings (i.e., patients) to act in accordance with medical advice (Bayly, 2017; Root & Browner, 2001).

The two key professional bodies involved in antenatal care: medicine and midwifery, have also contributed to the ongoing debate. In midwifery models of care, midwives act as the lead professionals, providing continuity of care during labour, where the focus is on facilitating natural, physiological processes (Sandall, Soltani, Gates, Shennan, & Devane, 2016). In medical models, obstetricians or physicians take the lead within a standardised institutional system that has a primary focus on risk-avoidance and an increasing reliance on technology (Johanson et al., 2002). Research on women’s perceptions of these different approaches to maternity care, typically solicited via interviews or focus groups, has

consistently reported that women prefer minimal intervention, and report higher satisfaction when they experience agency or control during birth (Bernhard et al., 2014; Dahlen, Barclay, & Homer, 2008; Hodnett, 2012; McCourt, 2006; Walsh & Devane 2012). When compared to conventional doctor-led care, midwifery care has been described by women as helping them feel more involved in birth-related decisions (Homer, Davis, Cooke, & Barclay, 2002; Walsh & Devane 2012). A recent Cochrane Review (Sandall et al., 2016) reported that midwifery-led care resulted in less intervention and fewer adverse outcomes for babies when compared to medical models of care, and also produced higher satisfaction, on the part of women, with the birth experience.

Despite research findings highlighting the benefits of midwifery-led care, the Australian Institute of Health and Welfare (2019) reported that in 2017, almost all Australian women (97%) gave birth in conventional hospital maternity wards. Midwifery-led birth centres accounted for only 1.8% of births, with fewer than 1% of women giving birth under midwifery care at home. In short, there appears to be a disjunct between what women say about their birthing preferences in interview and focus-group studies, and what they typically experience. To understand the difference between what women say they want when asked by researchers, and what they experience when giving birth, this paper looks at how talk about models of maternity care typically unfolds in an antenatal clinic in which a woman-centred care policy underpins practice. This paper examines recordings of interaction between midwives and women in the clinic of a large metropolitan public hospital in Australia, focusing on talk that concerned the hospital's institutional imperative of allocation to a model of care, and specifically women's opportunities to participate in this allocation. A brief overview of woman-centred maternity care is presented below, followed by a review of

interaction-based research that pertains to health-related decision-making in medical settings.

5.3.1 Woman-centred care

Most hospitals in Australia, as in other developed nations, have adopted policies that emphasise the importance of women's involvement in decision-making around birth. The most recent National Review of Maternity Services in Australia recommended an increase in models of care that reflected women's birthing choices, together with increased availability of information about pregnancy and childbirth, respect for personal perceptions of risk, and increased recognition of birth as a natural process (Bryant, 2009). The National Guidance on Collaborative Maternity Care (2010) was a key outcome of the review, aiming to standardise service delivery in Australia in accordance with this woman-centred-care approach (National Health and Medical Research Council, 2010).

Despite this emphasis on woman-centred care, research has demonstrated that many women continue to feel disempowered when giving birth in conventional hospital settings (McCourt, 2006). The present study aims to shed light on the types of opportunities and practices occurring in maternity services that might facilitate women's active participation in negotiating their care. Analysis focuses on how talk about models of maternity care were introduced by midwives and discussed with pregnant women in a hospital antenatal clinic. The method of Conversation Analysis was used to examine sequences of talk that involved discussion of, and decision-making around, appropriate models of care.

5.3.2 Talk in institutional settings

Conversation Analysis (CA) has been used to examine a range of institutional interactions to understand how particular tasks are achieved in relation to the context in which they occur. In comparison to everyday talk, institutional interaction might be structured in a more

regular way, with components characteristically emerging in a particular order (Drew & Heritage, 1992; Heritage & Maynard, 2006). For example, Robinson (2003) identified the specific and routine interactional resources physicians used to progress an ordered series of medical activities in GP consultations. In institutional CA work, analysis centres on how specific types of turns and actions are implemented to achieve institutional objectives (Heritage & Clayman, 2011). This study examines the ways in which midwives and pregnant women, interactionally, achieve specific goals that are tied to their institution-relevant identities within the healthcare system.

Communication in healthcare settings and its potential to affect a person's health has been a significant area of focus in interactional research (Thompson, Robinson, & Brashers, 2011). Communication in antenatal care is also likely to have direct and significant consequences for women's experiences of childbirth. Through the close examination of interactions, conversation analytic researchers have been able to shed light on how certain institutional tasks are accomplished *in situ*.

5.3.3 Epistemic and deontic orientations

Conversation Analysis allows for fine-grained examination of the ways in which authority is managed and negotiated in and through talk. Participants have been shown to orient to both the epistemic (concerning knowledge) and deontic (concerning power) dimensions of authority (Stevanovic & Peräkylä, 2012). Epistemic authority is about knowing how the world "is" and deontic authority is about determining how the world "ought to be" (Stevanovic & Peräkylä, 2012). Participants' orientations to epistemic and deontic concerns within healthcare contexts have shed light on how decision-making unfolds *in situ*. For example, analysis of interaction sequences in primary medical consultations that involved GPs'

treatment recommendations has demonstrated how patients' explicit acceptance of such recommendations was required before such sequences could be closed (Koenig, 2011). A similar pattern was demonstrated in neurologists' talk about treatment decision-making, where two formulations, "recommending" or "option-listing," were routinely observed (Toerien, Shaw, & Reuber, 2013). Greater opportunities for patient participation were shown when lists of treatments were provided, as patients were able to choose an option. Studies such as these have begun to illustrate some of the ways in which patient involvement and authority in shared decision-making is routinely accomplished in various types of medical interaction.

Examining the deontic and epistemic orientations of midwives and women in the context of antenatal consultations has important implications for understanding how woman-centred care, and more specifically shared decision-making, are accomplished in practice. The present study responds to the call of Toerien et al. (2013) for future studies to "map out the range of ways in which 'decision-making-in-action' is managed, and the implications, for patient participation" (2013, p. 887). The present study aims to contribute to this literature by examining how decisions about birthing unfold in the context of antenatal consultations in a public hospital. Arguably, maternity care is different from other medical encounters. Antenatal consultations are system- rather than patient-initiated, with a general purpose that involves surveillance and/or regular testing or screening, rather than the generation of solutions to health-related problems. Nonetheless, in hospital-based antenatal interactions, the institutional philosophy is that women should be involved in decisions about their care, with policy orienting explicitly to the principle that women are able to choose a model of care that best meets their individual needs.

5.3.4 Interactional research in antenatal care

Routine antenatal consultations have been the focus of a small number of CA studies.

Medical professionals in the obstetric department of a Hong Kong hospital were shown to provide advice about screening tests based on women's expressed level of worry about fetal abnormality (Pilnick & Zayts, 2016). A study of antenatal consultations in Japan (Nishizaka, 2010) showed that talk about pregnancy-related concerns was routinely initiated by pregnant women. The positioning and construction of these problems was shown to engender a cycle where the pregnant woman repeatedly attempted to legitimise her problem, and the practitioner repeatedly attempted to confirm a no-problem response. The present study builds on this small body of work by providing evidence about the specific skills midwives employ in managing the institutional imperative of woman-centred practice in relation to decisions about model of care pathways.

5.4 Materials and methods

Conversation analysis (CA) was employed to analyze a collection of 9 instances, across 48 audio recordings, of antenatal consultations between midwives and pregnant women, where the model of care pathway was topicalised by the midwife. The recordings used in this study ranged from 15 to 43 minutes in length, and involved 4 midwives and 9 pregnant women presenting at appointments between 21- and 26-weeks' gestation. Names in transcripts are pseudonyms, and written consent was obtained for all recordings. The study was reviewed and approved by a human research ethics committee prior to data collection.

5.4.1 Setting

Data were collected in naturally-occurring consultations in a large metropolitan public hospital in South Australia that involves one of the state's largest maternity services. When women enter the hospital for maternity care, they are routinely allocated to a model of care

(MoC) that involves midwives facilitating antenatal appointments and managing care. A team of obstetricians is available in this model to provide oversight, and women give birth on the hospital's labor ward. All women remain under this "conventional" MoC unless they are actively referred out, by midwives, to a different model. Within the hospital, four alternative models were available:

- A "Midwifery-led" model involving antenatal care provided by midwives in a birth centre attached to the hospital. In this model, midwives use a low-medical-intervention approach to childbirth;
- A "Group Practice" model involving a small team of midwives providing women with continuity of care. This model includes choice of home or hospital for antenatal appointments, and also for place of birth;
- A "Shared-care" model that allows women's GPs to take an active role in their antenatal care;
- An "Enhanced Recovery Elective Caesarean program" in which women having elective caesarean can be discharged 24 hours after surgery.

In the hospital system under consideration, women who indicated that they wanted access to an epidural for pain relief during labor were required to remain in the "conventional" MoC, where birth took place on a labour ward under the direction of an obstetrician. This institutional imperative followed from the need for epidurals to be administered by an anesthetist, who could only work from within this ward.

5.4.2 Data analysis

Data were transcribed by the first author according to CA conventions (Jefferson, 2004) and analysed with a focus on midwives' presentation of MoC talk in its sequential environment

(i.e., preceding and subsequent speaking turns). A key of transcription notation is presented in Appendix 1. Initial analysis was conducted by the first author and refined through discussion and data sessions with the other researchers. Analytically, the authors sought to identify patterns in how language was used to accomplish the institutionally-relevant task of allocation to MoC. Familiarisation with the data was achieved through repeated reading of instances of MoC talk. During this phase, a pattern was identified that involved midwives positioning women as “normal” in order to make a recommendation for a particular MoC. Membership categorisation was not initially part of the analytic framework, but the emergence of the category “normal” led to a detailed examination of this phenomenon and underpins the present analysis. Whereas CA is primarily concerned with the sequential organisation of talk, Membership Categorisation Analysis (MCA) aims to explicate how people accomplish everyday social interaction through the invocation of knowledge about membership (Fitzgerald & Houseley, 2015). MCA focuses on people as members of particular groups, and how membership is utilised to make sense of one another and society generally. The focus of analysis here, then, was on the ways in which pregnant women were constructed as members of a particular group (“normal”), and what this categorisation routinely accomplished.

In the dataset, antenatal consultations typically involved five broad activities: establishing the reason(s) for visit; physical examination (e.g., listening to baby’s heartbeat, measuring the woman’s uterus and blood pressure); discussion about plans for the birth (including MoC allocation and pain relief); discussion of routine antenatal tests and screenings (including relaying results and presenting available future tests); and closing the consultation. The order

of these activities varied somewhat across consultations, but each activity occurred in every consultation.

5.5 Results

The analysis focuses on the ways in which midwives introduced model of care (MoC) as a topic for discussion and decision-making. There were 9 instances in the data of midwives presenting a decision to be made about MoC to different women.

Typically, MoC talk was introduced as part of establishing a reason for the consultation, or following the delivery of clinical information (for example, previous screening test results or after physical examination). Within these sequences of talk, the midwives routinely drew on a categorisation of women as “normal” to make relevant midwifery-led care as an appropriate model. However, in all instances, midwives also oriented to, or made relevant as a topic for talk, women’s desire for epidural pain relief during labour. Such preferences had implications for MoC in that any woman who was planning to have an epidural during labour had to receive care on the hospital’s labour ward under the “conventional” or doctor-led model. The following analysis illustrates how midwives accomplished a woman-centred practice when presenting MoC alternatives, including instances where women’s preference for access to epidurals would constrain their choice of MoC.

The analysis also demonstrates how epistemic claims (to knowledge), and deontic claims (to determine future actions), were key aspects of this MoC talk. Categorising a woman as “normal” made relevant the midwife’s assessment of her medical status, thus demonstrating the midwife’s epistemic authority. In turn, a normal categorisation worked to make relevant the woman’s suitability for midwifery-led care. However, midwives also typically presented

the midwifery-led MoC in ways that worked to downplay their deontic authority, thus deferring authority to determine MoC to the woman and orienting to the woman-centred nature of the interaction. Midwives thus routinely demonstrated epistemic knowledge of appropriate models of care for “normal” women, while leaving open a space for women to accept or resist their recommendation.

5.5.1 Categorising women as “normal”

The routine practice of introducing MoC talk via a “normal” categorisation of the pregnant woman involved midwives using terms such as “healthy,” “low-risk,” “straight-forward,” or “well fit,” in addition to “normal.” One such instance is illustrated in Extract 1a. Prior to the start of this extract, which occurs 4 minutes into the consultation, the pregnant woman (at 26-weeks’ gestation with her first child, represented as PW in the transcript) has been describing why she has come to the clinic: she was unhappy with her care at another hospital. The midwife offers to communicate these concerns to the previous hospital on the woman’s behalf and then transitions to talk around the “options of care” (line 2) available in the present hospital. These options are made relevant by, and contingent on, the midwife’s categorisation of the woman as a “first pregnancy” (line 5), “low risk” (line 7), and “a normal pregnant person” (line 12).

Extract 1a PW#20/MW#3

01 MW: so what I want to do first Sarah with yo:u is
02 talk about options of ↓care because I don't know
03 what's been [talked about] but <particularly
04 PW: [mmhmm]

05 MW: with a first (.1) ↑pregnancy .hh that you're
06 having care for in a ↓hospital, .hh i:s we look
07 at sa:ay> (.1) hello she's a [low ↓risk]
08 PW: [mmhm]
09 MW: t' start with .h if we're look at a history
10 there's nothing here that goes alarm bells to
11 ↓me:: .h um for us to overly worry about ↓you
12 and not treat you as a normal <pregnant person>
13 .hh so (.) we would look at care options as be:ing
14 you've experienced ↑share ca:re?
15 PW: mmhmm
16 MW: um idea .h um <we have> midwife care in a hospital,
17 so you can have a group practice midwifery so
18 you come to the hospital for [appointments]
19 PW: [mmm hmm]

Here, the midwife's categorisation of the woman, together with her professional assessment of the woman's medical history (line 9) as not presenting any "alarm bells" (line 10) or issues that would warrant "worry" (line 11), serve as epistemic resources for the midwife to present alternative models of care. The categorisation of the woman ("first pregnancy," "low risk," "normal") is implicative – it demonstrates that she is an appropriate candidate for midwifery-led models of care. The implicative nature of the midwife's talk is further evidenced by the use of "so" (line 13) to introduce appropriate care options. Bolden (2009) demonstrated how the particle "so" serves to indicate an inferential connection between two propositions. In

this case, the woman's positioning as normal implies the appropriate allocation to midwifery-led models of care.

By drawing on her professional assessment of the woman, the midwife positions herself with the epistemic authority to suggest the most appropriate MoC ("we would look at care options as being ...," line 13). She presents these midwifery-led options to the woman in a list format: "shared care" or "midwife care in a hospital," "group practice midwifery." The formulation is designed with a degree of neutrality via the institutional invocation "we have" (line 16), and the modal formulation "you can" (line 17), which both work to avoid directly advising the woman which course of action to take, and place deontic authority for choice with her, in line with woman-centred principles. Hence, in this extract, although the midwife draws on her epistemic authority to suggest appropriate models of care, the way in which she presents these options serves to position deontic responsibility for choosing as residing with the woman.

A variant on the strategy of invoking a "normal" categorisation is presented in the next extract. Here, the midwife initially uses the category "normal" to describe screening results for the baby (line 1), before categorising her *own* professional group, and the type of care they provide, as normal (line 10). She then includes the woman in this normal category (line 16). The fragment occurs two minutes into a consultation with a woman at 22-weeks' gestation with her first child. The midwife has just finished relaying screening test results when she transitions to MoC talk.

Extract 2a PW#11/MW#1

01 MW: um (.) tch all the morphology of the baby is no:rmal

02 they've done all the <measurements>, (.1) .hhum hh
03 tch and these uterine artery dopplers they done are
04 fine. okay
05 PW: °alright°
06 MW: so (.) >°I dunno< wha that was about°=anyway
07 it's all good
08 PW: .hh [\$ohkay awesome\$]
09 MW: [so >doctor=]↑professor John's happy for you<
10 to jus see <normal (.) people>
11 [>like midwives< .hh um tch]
12 PW: [alrigh=wicked heh hh]
13 MW: you can go to birthing unit=>I think you
14 were just havin'a chat to Julie< weren't ya?
15 PW: [yea:h yeah] an I didn' really
16 MW: [.hh um] cos you're quite no:rmal
17 ↑aren't ↓you
18 PW: yeah
19 MW: no real big problems [or anything] (0.2)
20 PW: [nohh]
21 MW: so (.) yea:h so <you can:, go to birth centre if
22 you li:ke>

Here, the midwife's health assessment (lines 1-7) makes relevant an available alternative MoC to the default doctor-led pathway. Relaying results of physiological screening tests (lines 1-3) and reporting on the obstetrician's evaluation (line 9) both serve as epistemic resources for the midwife to work up a "normal" categorisation for the woman. The upshot of the

screening results, and more specifically the assessment of the baby's morphology as "normal" (line 1) and "fine" (line 4), is that the woman is suitable to be cared for by "normal people like midwives" (line 10-11). On line 13, following the delivery of this news, the midwife begins presenting a midwifery-led MoC (the birthing unit), and categorises the woman as "normal" using a tag-question formulation ("cos' you're quite normal, aren't you," line 16-17) that orients to agreement as the expected response (Hepburn & Potter, 2010). The woman is thus positioned as already knowledgeable about her "normal" health status, and the preferred response of agreement is provided by the woman on line 18 ("yeah"). Similar to Extract 1a, here, following her categorisation of the woman, the midwife uses an implicative "so" construction to deliver the information that the woman is a suitable candidate for midwifery-led care (line 21). As in Extract 1, the midwife also presents the recommendation for midwifery-led MoC (the birth centre) in a way that emphasises the woman's (rather than the midwife's) deontic authority. Using the modal phrase "you can" (line 21) and the tag "if you like" (lines 21-22), the midwife makes explicit the woman's agency in deciding on model of care.

This section of the analysis has illustrated how a particular categorisation ("normal") was drawn on by midwives to do the institutional business of initiating MoC talk and make relevant appropriate models of care. Typically, MoC talk was designed to emphasise the agency of the woman in making a decision, thus managing the institutional principle of woman-centred care. The next section examines ways in which midwives oriented to the relevance of women's plans to have an epidural during birth, and the implications of these plans for the achievement of woman-centred care.

5.5.2 Access to an epidural

As described above, the implication of requesting an epidural in the hospital system under study was that women could be allocated to only one MoC: the conventional, doctor-led model. Hence, when presenting midwifery-led care as available and appropriate for normal women, as in the extracts above, midwives also had to attend to an institutional constraint that precluded women from having a choice of MoC: the desire for an epidural for pain relief during labour. This constraint is potentially interactionally challenging for midwives who work from a principal of woman-centred care. In what follows, the analysis illustrates how midwives introduced the topic of epidural pain relief as relevant to MoC choice, while remaining woman centred. The following two extracts involve sequences of talk that are continuations of Extracts 1a and 2a, respectively.

Extract 1b provides an example of how epidurals were topicalised as implicative for MoC allocation. This extract continues Extract 1a, where the midwife's use of a "normal" categorisation served to position midwifery care as most suitable for the woman. Extract 1b occurs 30 seconds after the end of 1a, during which time the midwife explained the difference between midwifery-led care at the birthing unit and Midwifery Group Practice. The first mention of an epidural in the consultation arrives in line 5 as the midwife explains the MoC implication of requesting a planned epidural.

Extract 1b PW#20/MW#3

- 01 MW: now when we have our first baby we'll often come
02 in and go (.) w' ↑I don't really know what I want
03 PW: [↓hmm]
04 MW: [and pe]ople will say .hh you might want an

05 epidural and >as ↑soon as anyone mentions< epidural
 06 they go ↑oh she can't go to the birthing ↑unit but
 07 [you]
 08 PW: [mhm]

09 MW: don't know what's going to happen [for you] .h
 10 PW: [yeah=yep]
 11 MW: there's every option here (.) if you [need it,] .h
 12 PW: [ohka:y]
 13 MW: and you'd need to see <how you ↑go>
 14 PW: yea:hp
 15 MW: .h so don't ever mention the word epidural because
 16 people go she can't go to the normal care [because]
 17 PW: [mhm]
 18 she wants one ↑well you don't ↑kno:w
 19 [so wait and see what happens]
 20 PW: [yeah exactly yeah yep]
 21 MW: .hh I get angry when: people are (.) tch then (.)
 22 not able to: follow through an area of care because
 23 of that
 24 PW: yep

Here, when introducing epidurals as a topic of talk, the midwife demonstrates her epistemic authority around first-time mothers' lack of knowledge about their desires for birth (lines 1-2). She orients to the woman's membership of the "first baby" category (line 1) using reported speech ("I don't really know what I want," line 2) to orient to her epistemic knowledge of what first-time mothers think. Drawing on reported speech in descriptive talk

has been demonstrated to imply accurate and objective portrayal, and hence bolster the credibility, of claims (Holt, 2000). The implicative nature of a request for an epidural is presented at lines 5-7: “as soon as anyone mentions epidural...she can’t go to the birthing unit.” Through the use of the pronoun “they” (line 6), together with the reported speech (lines 6-7), and the subsequent return to reported speech in line 16 (“people go”), the midwife distances herself from the institutional restriction on MoC that a request for an epidural entails. Here, the use of reported speech serves to bolster the midwife’s positioning of herself as not responsible for the institutional restrictions.

In this sequence then, the midwife draws on her epistemic knowledge of first-time mothers to guide the woman towards a pathway that is presented as less restrictive. The midwife’s claim to deontic authority in instructing the woman what to do (“don’t ever mention the word epidural,” line 15) might be read as at odds with woman-centred care. However, she can also be seen to engage in a form of care that is woman-centred in that her advice works to protect the woman from the restrictions of a standardised medical system (similarly, Teate (2018) showed how some midwives prioritised women’s choices over institutional constraints). This work of advocacy/protection by the midwife is further evidenced by her emotion-focused description of the institutional constraints associated with an epidural request (“I get angry when people are then not able to follow through an area of care because of that” line 21-22).

Extract 2b also illustrates the way in which midwives typically managed the institutional MoC implications associated with epidural requests. It commences four minutes after Extract 2a (during which time the midwife had presented midwifery-led care as the most appropriate

MoC for this “normal” woman). The midwife first introduces epidural plans as relevant to MoC at line 8.

Extract 2b PW#11/MW#2

01 MW: umm so:: (.1) [↑]if you're really straight forward
02 an (.1) <not sick> just young and [[↑]pregnant]
03 PW: [ye:ah]
04 MW: and [↑]normal .hh ah it is quite a nice way to be
05 looked after=[I guess] the only thing is they don't
06 PW: [yeah]
07 MW: really um (.) usually take people who- (.) <are
08 pretty sure that they want an [↓]epidural>
09 (.1)
10 so I don't know if you've thought about any of that
11 [\$yet\$]
12 PW: [yeah] I don't really \$kno:w (.) [if I\$]
13 MW: [\$.hhh:\$]
14 PW: I probably like to avoid that but-
15 MW: yeah so if you [↑]come with an open mind like <you
16 can have the> ga:s, you can have the pethidine
17 [injections] .h >you can have< (.) bi-=have a
18 PW: [yeah]
19 MW: big bath, big shower, they have water
20 bi:rths if you're really interested .h um (.) [↑]an
21 they just keep things kind of normal

22 PW: ye:ah

Here, the midwife elaborates on her previous “normal” categorisation of the woman (see Extract 2a), with the implicative nature of this categorisation emphasised by the upshot marker “so:” (line 1; (Raymond, 2004) and her reiteration of the suitability of a midwifery-led MoC (lines 1-5). The institutional constraint associated with a desire for epidural pain relief is explicitly referenced on lines 5-8. The midwife’s unknowing epistemic stance in relation to the woman’s preference (“I don’t know if you’ve thought about any of that yet,” lines 10-11) positions the woman as holding both epistemic and deontic authority on the matter. The woman’s uncertainty (line 12) is treated by the midwife as insufficient for completion of MoC allocation (line 13), providing further evidence of the woman’s deontic authority in the interaction (i.e., allocation to a care pathway cannot be completed if the woman does not state what she wants). The woman subsequently upgrades her response to indicate a desire to avoid an epidural, albeit tentatively: the use of “probably” and the mitigator “but” both works to downgrade her claim. At this point (line 15), the midwife acknowledges the woman’s response and produces another “so”-formulated turn that involves an “if-then” framing of midwifery-led care as the most appropriate MoC allocation. In this example, then, the midwife relinquishes both epistemic and deontic authority relating to the woman’s plans for an epidural, and aligns with the woman’s stated preferences, thus demonstrating adherence to woman-centred principles.

A variant on how the MoC restrictions associated with a planned epidural were presented to women is shown in Extract 3, below. In this example, the midwife topicalises epidural prior to invoking a “normal” categorisation. The midwife begins by soliciting the woman’s views on an

epidural in labour, and accounts for having presented the question by orienting to the MoC implications of such a request.

Extract 3 PW#32/MW#4

- 01 MW: so (.) when yo:u- were you thinking of wanting
02 an epidura:l in labour? or did you= \downarrow >what did
03 you wanna< do:
04 PW: um (.) \$I have no idea\$ heh heh heh heh .hh
05 MW: cos they've booked \uparrow you to the hi=they've booked
06 you >you're not you're high \downarrow risk,< but you've come
07 back to see the midwives he:re,
08 PW: [\downarrow mm]
09 MW: [\uparrow at] family clinic< which is fi:ne .hh um
10 generally we see women who like you who are
11 \uparrow healthy,>and have no risks< but they (.) <don't
12 want to (.) go to the birthing \downarrow unit> cos they
13 actually wanna go .h and have (.) >they=they um:<
14 want an epidural in \uparrow labour
15 PW: \downarrow mm
16 MW: or they're having an elective section.
17 PW: \downarrow mm
18 MW: now .h >you don't know what you're gonna do in
19 labour< yet,
20 PW: [\$yeah\$]
21 MW: [.h so] (.) <what we: sometimes suggest> is=>an you

22 don't have< ↓to: (.1) is (.2) >put you back to the
23 birth ↑centre<

Here, the midwife issues a yes/no question (line 1-2) to make relevant the implicative nature of requesting an epidural for accessing midwifery-led care. The interrogative is designed to make a response from the patient unavoidable, thus soliciting the required information for the institutional task at hand (Raymond, 2003). The question is syntactically and prosodically complete at line 2, however the midwife expands her request using an open-ended form that provides the woman an opportunity to display her deontic authority (“what did you wanna do”). The woman’s response is one of uncertainty (line 4), and the midwife continues by offering an account (lines 5-15) for having asked about the woman’s plans. It is during this account that the midwife explains the MoC implications of an epidural request. Specifically, the midwife describes what usually happens for women who attend the standard doctor-led (“family clinic”) MoC (“generally we see...,” line 10), setting up a contrast with the presenting woman (“now you,” line 18). In doing so, the midwife categorises the presenting woman as “healthy ... no risks” (line 11), while also orienting explicitly to the woman’s reported lack of knowledge about her labour (line 18).

In this sequence, the midwife repeatedly orients to the woman’s deontic authority on the matter of MoC. The midwife also orients more generally to the deontic authority of women who “don’t want to go to the birthing unit” (lines 11-12). In this way, the midwife makes clear that women can (and do) have the opportunity to choose a MoC. Finally, the midwife’s suggestion to refer the woman to the birth centre is softened in lines 21-22 with the mitigator “you don’t have to,” again orienting to the woman’s ultimate deontic authority to select MoC.

This analytic section has illustrated some ways in which midwives practiced principles of woman-centred care while orienting to institutional constraints on MoC that were associated with accessing epidurals for pain relief in labor. The examples discussed demonstrate how women were positioned as having deontic rights to opt for births that involved use of epidurals for pain relief, despite this choice precluding them from midwifery-led care, which was typically presented as an appropriate MoC by the midwives. Midwives accounted for topicalising the issue of epidurals by describing the MoC implications that an epidural request entailed. In doing so, midwives in our dataset typically distanced themselves from these institutional restrictions on midwifery models of care.

In sum, this analysis has attempted to demonstrate how midwives managed the institutional task of MoC allocation in a setting with a policy of woman-centred care. Midwives routinely and explicitly attended to women's active involvement in decisions about MoC, drawing on their epistemic authority in regard to assessments of women's health/normality to present appropriate care pathways. Midwives also managed the institutional constraint associated with epidural requests on MoC options by presenting appropriate midwifery-led care options while also deferring deontic authority for choosing the MoC to the woman.

5.6 Discussion

A key focus of woman-centredness in antenatal care is the provision of support and information to pregnant women about models of care that will best meet their needs. However, little is known about how such information is presented to women in situ. Despite research demonstrating that women prefer midwifery-led care (McCourt, 2006; Walsh & Devane 2012), most still experience a medical model of antenatal and birth care (Australian Institute of Health and Welfare, 2019). The present examination of naturally-occurring

interactions in an antenatal clinic begins to explore how MoC decisions are accomplished in such settings. Practices for introducing talk about MoC were identified: Midwives routinely categorised women as “normal” in framing their presentation of an appropriate MoC, whilst also attending to institutional restrictions on such choices associated with planned epidurals. This discussion considers some implications of the present analysis for maternity practice, before explicating how the findings contribute to the literature on healthcare decision-making more generally.

5.6.1 Contribution to maternity care research

The presented findings contribute to previous research on the accomplishment of woman-centredness in antenatal care (Nishizaka, 2011; Petraki & Clark, 2016; Pilnick & Zayts, 2016). The analysis has demonstrated ways in which midwives create opportunities for women’s involvement in MoC allocation in the context of routine antenatal consultations. When introducing talk about women’s preferences for epidurals for pain relief during birth, midwives were shown to defer to the woman’s knowledge of self, and her right to choose, in line with woman-centred-care principles. Previous research on maternity care has described women’s feelings of disempowerment under the medical model (McCourt, 2006). Studies have explored the ways in which woman-centred care can be genuinely implemented (Feeley, 2017; Nishizaka, 2010; Pilnick & Zayts, 2016; Teate, 2018). The present study has contributed to this relatively small body of knowledge by examining how midwives remain woman-centred within a hospital setting while also managing institutional constraints regarding women’s plans for pain relief during birth (Davis-Floyd, 2001). Supporting the work of Teate (2018), the present findings illustrate the ways in which women’s choices might be prioritised, in talk and interaction, over institutional processes. The analysis thus contributes

to previous findings about how midwives and pregnant women accomplish institutional work, collaboratively, in realizing a woman-centred philosophy of maternity care.

5.6.2 Contribution to health decision-making research

This study provides empirical evidence about how epistemic and deontic rights and responsibilities are negotiated in the interactional process of presenting choices in healthcare settings (Pilnick, 2008). Previous research has demonstrated how epistemic knowledge is oriented to in healthcare decision-making by professionals and patients/clients (Drew & Heritage, 1992; Heritage & Robinson, 2006; Heritage & Sefi, 1992; Landmark et al., 2015; Lindstrom & Weatherall, 2015). The present study has also contributed to a body of knowledge on how a categorisation of “normal” can be used in healthcare interactions. Within a medical context, the concept of normal has been shown to be a resource for both patients and doctors to pursue social actions, such as constructing identities of “sick” or “well” (Gutzmer & Beach, 2015; Maynard & Heritage, 2005). As Gutzmer and Beach (2015) reported, physicians employed “normal” to accomplish a range of social actions central to cancer care, including invoking normal as a preferred range, treating the absence of normal as indicative of sickness, and countering potentially bad with good news by reassuring patients about normal and not normal depictions of their condition. The present study has contributed to this focus of health research by revealing how midwives constructed the category of normal as a means to present a choice of care pathways for pregnant women.

5.6.3 Limitations and directions for future research

The findings of this study are based on the talk of a small group of midwives at a public hospital. The particular restrictions around access to midwifery-led care might not apply more generally in the hospital system. Nevertheless, the findings contribute to understanding of the interactional resources that midwives use to facilitate woman-centred care. Video-recordings of the antenatal consultations would have assisted in the understanding of

broader interactional features, for example silences related to record-keeping, and important features such as gesture and gaze. In the present study, only “low-risk” women who were eligible for midwifery-led models of care were involved. Future analyses could seek to shed light on how women who are categorised in other ways (e.g., as “high risk,” or as eligible for Enhanced Recovery Elective Caesarean) are presented with information concerning models of care.

5.6.4 Conclusion

Toerien et al. (2013) called for future studies to “map out the range of ways in which ‘decision-making-in-action’ is managed, and the implications, for patient participation” (p. 887). This study has provided an empirical, interaction-centred look at some ways in which midwives in actual hospital antenatal clinic consultations discussed model of care in ways that prioritised woman-centred principles. The findings demonstrate how midwives managed to create opportunities for woman-centred care in an institutional setting in which logistical constraints imposed limits on women’s choices.

6. CHAPTER SIX: How are decisions made to plan an epidural in labour? Midwife-woman interactions in antenatal consultations.

6.1 Statement of Authorship

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Principal Author

Name of Principal Author (Candidate)	Lindsay Cole		
Contribution to the Paper	I am responsible for the conception and primary authorship of this article. I conducted the literature review, developed the research aims, conducted analysis, and wrote the manuscript. I was identified as the first author when this article was submitted for publication, and I have been responsible for all communications with journal administration including responses to review feedback.		
Overall percentage (%)	85%		
Certification:	This paper reports on original research I conducted during the period of my Higher Degree by Research candidature and is not subject to any obligations or contractual agreements with a third party that would constrain its inclusion in this thesis. I am the primary author of this paper.		
Signature		Date	24/12/2019

Co-Author Contributions

By signing the Statement of Authorship, each author certifies that:

- i. the candidate's stated contribution to the publication is accurate (as detailed above);
- ii. permission is granted for the candidate to include the publication in the thesis; and
- iii. the sum of all co-author contributions is equal to 100% less the candidate's stated contribution.

Name of Co-Author	Professor Hannah Dahlen
Contribution to the Paper	I was involved in the study design and supervision of the research process. I provided comment and feedback on working drafts of the article, and made suggestions on the presentation of material in the article. I also provided advice on responding to comments by the journal reviewers and editor. I hereby give permission for this article to be incorporated in Mrs Cole's submission for the degree of Doctor of Philosophy from the University of Adelaide.
Signature	Date 25/11/19

Name of Co-Author	Professor Deborah Turnbull		
Contribution to the Paper	I was involved in the study design and principal supervision of the research process. I provided comment and feedback on working drafts of the article, and made suggestions on the presentation of material in the article. I also provided advice on responding to comments by the journal reviewers and editor. I hereby give permission for this article to be incorporated in Mrs Cole's submission for the degree of Doctor of Philosophy from the University of Adelaide.		
Signature		Date	7.1.2020.

6.2 Abstract

Objective: The purpose of this study was to examine the ways in the decision to access a planned epidural in labour was topicalised and negotiated between pregnant women and midwives.

Design: This article uses conversation analysis to examine how decision-making unfolds in antenatal consultations in a large metropolitan hospital in South Australia. Data were sampled from naturally-occurring interactions between women and midwives in routine antenatal consultations. Analysis focused on talk about planning to access (or, avoid) an epidural during an upcoming labour.

Findings: This paper illustrates that in the context of woman-centred care, women are held unilaterally responsible for the decision to accept or reject a planned epidural in labour with little or no input from the midwife. Midwives take a step back from involvement in the discussion beyond the solicitation of a decision from the woman. Women wanting a planned epidural took a strong, assertive stance in the interaction and drew on their previous birthing experience, limiting opportunity for the midwife to engage in meaningful discussion about the risks and benefits. On the other hand, women rejecting a planned epidural were less assertive and engaged in more complex interactional work to account for their decision.

Key conclusions: The lack of involvement by midwives may be linked to the non-directive ethos that prevails in maternity care. It is argued that, in this dataset, the institutional imperative for women to know and decide on pain relief while pregnant in order to allocate to a model of care is prioritised over women's aspirations and expectations of childbirth.

Implications for practice: By analysing the ways in which midwives and women interact at the point in time at which decisions were made to plan access to an epidural we can continue to reveal underlying forces that drive the rising rates of medical interventions in childbirth. This

paper also contributes to research evidence on how midwives manage the potentially contradictory dialect between supporting women's childbirth preferences while also managing institutional requirements and evidence-based practice.

6.3 Introduction

Woman-centred care has become a key focus in contemporary maternity healthcare worldwide (Morgan, 2015). Generally, woman-centred care is framed in terms of shared decision-making between women and their care-providers, and the tailoring of care to a woman's individual preferences (Morgan, 2015; O'Malley-Keighran & Lohan, 2016). To achieve this, midwives must adopt a dual stance in relation to the pregnant woman. On the one hand, they strive for shared decision-making that is non-directive and focused on helping women make their own birth choices. On the other hand, they recognise the importance of supporting evidence-based practices (Australian College of Midwives, 2019). Little is known about how this important and potentially contradictory dialectic is enacted in practice. To fill this gap, we analysed recordings of midwife-woman interactions using conversation analysis with the focus on decision-making about the use of epidural for pain relief in labour, which is an important (and contentious) consideration in planning for childbirth in a hospital setting.

A key role of the midwife is to provide information and support in order for women to make their own decisions about childbirth (Australian College of Midwives, 2019). Pain relief in labour has been shown to be a particularly contentious choice with a strong moral dimension (Bayly, 2017), as well as implications for the physiological process of labour (Buckley, 2015; Newnham, McKellar, & Pincombe, 2018). Nonetheless, the basis for using an epidural in this context is steeped in the woman's subjective experience of pain and influenced by the care providers and birth environment surrounding her (Buckley, 2005). Women are encouraged to discuss their preferences for pain relief with a midwife during pregnancy to ensure their

preferences are supported by labour and birth staff. The aim of this study is to examine how women and midwives discuss the option of planning for an epidural in labour in a setting that is promoted as offering woman-centred care.

6.3.1 Epidural use

The use of epidural analgesia is now considered a common pain relief choice for healthy women in labour (Newnham, McKellar, & Pincombe, 2018), and its use is increasing both in Australia and other developed countries. In Australia in 2016, 38% of women used regional analgesia (Australian Institute of Health and Welfare, 2019), compared to 33% of women in 2013 (Australian Institute of Health and Welfare, 2015). The rate of epidural use is much higher in private hospitals. Concerns have been raised about the risks of routine epidural use. In a recent Cochrane review, epidural analgesia was shown to disrupt the birthing process to the extent that it causes increased birth intervention and is correlated with higher rates of instrumental birth (ventouse and forceps) (Anim-Somuah, Smyth, Cyna, & Cuthbert, 2018). Post birth implications have also been observed, such as interruptions in oxytocin production (Buckley, 2005) and decreased breastfeeding rates (Wiklund, Norman, Uvnäs-Moberg, Ransjö-Arvidson, & Andolf, 2009).

In Australia, midwives are usually responsible for routine antenatal care within the hospital system. It is during antenatal consultations that women and midwives prepare and plan for the up-coming birth. Part of that planning typically involves discussing pain relief options available to the pregnant woman. The ways in which midwives approach the provision of information about pharmacological pain relief in antenatal care has been described using two distinct paradigms: the 'working with pain' model; and the 'pain relief' model (Leap, Dodwell, & Newburn, 2010). The 'working with pain' paradigm is grounded in a belief that there are

long-term benefits to promoting normal birth and that pain plays an important role in the physiology of normal birth. Pain is described as providing signals to the woman as labour progresses as well as assisting in the transition to motherhood through the production of natural hormones. In this approach, pain is respected, not feared. In contrast, the 'pain relief' paradigm is characterised by the belief that no woman need suffer the pain of labour and that the offering of pharmacological pain relief is a kindness and a right. In this model, women are offered a 'pain relief menu' including the risks and benefits of each option to enable them to make an informed choice (Leap et al., 2010).

Variance and inconsistencies have been illustrated in research examining the ways in which pain relief options are presented to women in Australian maternity care settings. For example, in an ethnographic study of antenatal education classes, interviews and policies and guidelines, Newnham, McKellar, and Pincombe (2017) found that midwives typically worked within the 'pain relief' model but were not explicit about the effects or risks of epidurals. The researchers found that midwives attempted to espouse the midwifery philosophy of normal birth (for example, urged women to trust their bodies and to think of pain as positive) but that this was moderated by the requirement to disclose institutional requirements (for example, the expectation that the cervix will dilate one centimetre an hour). Downplaying of the effects of medical interventions such as epidural was suggested as an attempt to protect women from feelings of guilt or regret after birth if they were unable to adhere to the institutional timeframes.

Other research has also noted differences in the way in which pain relief is discussed with pregnant women. In an observational study, Cutajar and Cyna (2018) found inconsistency in the ways in which childbirth educators presented information about epidural use. Through

identifying the varying communication techniques (such as negative- and positive-framed information, direct commands, storytelling, and misinformation), the authors made recommendations for improvement in the way information is provided to assist in enabling informed decision-making. Recommendations included using more neutral statements and positive suggestions that focus on the desired outcome. A randomised controlled trial of a birth preparation course in Australia that focused on normalising, explicating and providing tools (such as acupuncture) to help with labour pain found a halving in epidural usage (Levett, Smith, Bensoussan, & Dahlen, 2016).

Midwifery research has demonstrated that the way information is provided can impact on the way women and their partners approach birth (Leap & Hunter, 2016). The many uncertainties related to epidural use highlight the need for effective communication on this matter. This is especially important now that underpinning most maternity services are principles of choice and control on the part of the woman.

6.3.2 Decision-making in healthcare

The ways in which health-related decisions are made has been the focus of previous conversation analysis (CA) research. Findings have highlighted how orientation to epistemic and deontic stances influence choices made (Landmark et al., 2015; Lindstrom & Weatherall, 2015; Pilnick & Zayts, 2016; Stevanovic & Peräkylä, 2012; Stivers et al., 2017). In line with Heritage (2013), we use the term epistemic to refer to “the knowledge claims that interactants assert, contest, and defend in and through turns at talk and sequences of interaction” (p. 370). Deontic orientations, on the other hand, refer to the right to decide on a particular course of action (Stevanovic & Peräkylä, 2012). Thus, in the context of woman-centred care practice, midwives possess professional and institutional epistemic knowledge

to offer recommendations and advice to women about pain relief options, while women hold the experiential epistemic knowledge of their preferences, values and pain thresholds. In keeping with woman-centred care principles, it would seem that women should have the deontic authority to make the final decision. The ways in which midwives and women orient to and negotiate epistemic and deontic rights in talk about pain relief decisions are the focus for the present study.

Previous studies have examined the unfolding of decision-making sequences in medical contexts (Koenig, 2011; Stivers, 2007; Toerien et al. 2013). For example, Stivers (2007) examined interactions between General Practitioners (GPs) and parents who were seeking antibiotics for their children. Parents were shown to use minimal responses (such as pauses or “hmm”) to respond to GP’s recommendations for alternative treatments. Stivers (2007) illustrated how such minimal responses from the parent impacted the unfolding talk – the sequence continued, creating opportunity for other options to be presented by the GP. Similarly, Koenig (2011) illustrated the requirement of patients’ explicit acceptance of a treatment recommendation in primary medical encounters. In the absence of an acceptance, the practitioner oriented to the treatment phase as incomplete, and continued to add weight to the recommendation.

The initiation of treatment decision-making has also been examined. Toerien et al. (2013) evidenced distinct features of ‘recommending’ versus ‘option-listing’ including differences in epistemic orientations, and differences in opportunities for patients to respond (Toerien et al., 2013). ‘Option-listing’ was shown to create greater opportunity for patient participation, relative to ‘recommending’ (Toerien et al., 2013). The focus of this article is on the ways in

which women and midwives orient to epistemic and deontic authority in making plans for pain relief during labour.

6.4 Data and Method

Data were collected in naturally-occurring consultations in a large metropolitan public hospital in South Australia. Six midwives were recruited through a consultative process following approval by the hospital's human research ethics committee. The first author then approached pregnant women while they were waiting for a routine antenatal appointment and asked for consent to audio record the consultation for research purposes. Pregnant women agreeing to participate signed a consent form and were provided with information about the study including contact details of the first author.

Conversation Analysis (CA) (Atkinson & Heritage, 1984; Schegloff, 2007) was used to analyse 48 audio recordings of antenatal consultations between midwives and pregnant women, and consultations were transcribed according to the CA coding system known as the 'Jeffersonian system' (Jefferson, 2004). A transcription key is provided in Appendix 1. Fifteen instances were identified where the option to plan for an epidural was topicalised. The recordings used in this study ranged from 12 to 43 minutes in length and involved four midwives and 15 pregnant women presenting at appointments between 19- and 41-weeks gestation.

Thirteen of the 15 instances involved women presenting at the standard maternity clinic (fragmented and multidisciplinary), while two were attending appointments in the Midwifery Group Practice (MGP) (continuity of care by a named midwife/midwives). The main difference between the two models of care is that the standard clinic is staffed by midwives, overseen by a team of doctors and obstetricians. In contrast, the MGP is run and staffed by

midwives. Most often, epidural talk was made relevant to planning for birth and/or allocation to an appropriate model of care. Model of care implications has been examined in detail in a previous study (Cole, LeCouteur, Feo & Dahlen, 2019). Names in transcriptions are pseudonyms, and written consent was obtained for all recordings.

6.5 Analysis

Analysis focused on sequences of talk around a planned epidural for pain relief in labour.

Fundamental to CA is the assumption that talk is used to perform social actions; that is, talk is designed to achieve something (Schegloff, 1996). The below analysis illustrates precisely how epidural plans were accomplished through talk in interaction.

Initial analysis was conducted by the first author and refined through discussion and data sessions with other researchers. Analytically, the authors sought to identify patterns in how language was used to make plans for epidural. Familiarisation with the data was achieved through repeated reading and listening to instances of epidural talk. During this phase, a pattern was identified that involved women unilaterally making the decision with little, if any, involvement from the midwife. That is, the decision to have an epidural was not treated as a matter for shared-decision making. Rather, the woman claimed all epistemic and deontic authority in the interaction regarding epidural plans, and this authority was never challenged by midwives. Furthermore, midwives typically worked from a 'pain relief' model (Leap et al., 2010), with no evidence of talk about the benefits of working with pain during labour.

In the dataset, antenatal consultations typically involved five broad activities: establishing the reason(s) for visit; physical examination (e.g., listening to the baby's heartbeat, and measuring the woman's uterus and blood pressure); discussion about plans for the birth;

discussion of routine antenatal tests and screenings (including relaying results and presenting available future tests); and closing the consultation.

6.6 Results

The following analysis focuses on the ways in which women and midwives constructed the epidural as a topic for discussion and decision-making. As noted above, midwives, in their framing of epidural talk, typically make no claims at deontic authority to determine whether or not women should plan to have an epidural. This held true regardless of whether women were requesting, rejecting or displayed uncertainty about a planned epidural. Instead, midwives claim institutionally-relevant epistemic knowledge about the implications of women's choices, and provide information to support her decision.

In the fifteen instances of epidural talk: 8 requested a planned epidural; 5 rejected an epidural; and 2 women were unsure whether or not they wanted to plan to have an epidural in labour. An overarching finding in this dataset was that women typically drew on previous birthing experience in accounting for their decision. All those with prior birth experience ($n=5$) requested a planned epidural and all of them made reference to their previous birth. For those with no prior birth experience ($n=10$): 5 rejected a planned epidural; 3 requested a planned epidural; and 2 displayed uncertainty. Generally, women who rejected a planned epidural engaged in more complex interactional work when presenting their decision to the midwife.

The following analysis illustrates how women and midwives make plans to support women's decision to access or avoid an epidural during labour.

6.6.1 Requesting a planned epidural

Women who request a planned epidural typically initiated solid claims to epistemic and deontic authority. This was never challenged by midwives in this dataset. In all extracts presented, MW is used to represent the midwife's turn at talk, PW represents pregnant woman and SP represents support person. Extract (1) illustrates a typical way in which a woman orients to her right to access an epidural and makes relevant her experiential knowledge of pain. The extract is taken from a consultation with a woman at 34-weeks gestation with her second child and comes directly after the midwife has explained that a second labour is often shorter and more intense. The woman's response is as follows:

Extract (1)

01 PW: as long as I get the epidural I don't

02 care

03 MW: ↓.hh ri:ght [.hhh]

04 PW: [heh]heh heh heh

05 MW: ↓yeah so have you written that down

06 (.) >wants epi:[dural]<

07 PW: [yahs] not wants

08 needs

In this case, it is the woman who first initiates talk about planning an epidural. As the talk comes straight after comparing first and subsequent childbirth experiences the woman takes a knowing epistemic stance founded in her experience of having given birth before. She takes this position to claim the epistemic knowledge to her rights and responsibilities to plan for an epidural. The drawing on a membership of having given birth previously was a routine feature in sequences in which women requested to plan an epidural. A *statement-formulation-elaboration* sequence is identified above, which has been shown to be used

frequently in news interviews (Heritage, 1985), but also in doctor-patient interactions (Gafaranga & Britten, 2004). CA work has routinely identified that such formulations are used by interactants to display their understandings of the talk (Gafaranga & Britten, 2004). These sequences are used to summarise talk, and to action a plan (identified in the case above with the midwife's imperative to *write it down* (line 5)). The woman makes considerable effort in this interaction to assert her rights and responsibilities. This is evidenced in her reformulation of the midwife's action-formulation, in lines 7-8 with the extreme-case formulation "not wants, needs". Extreme-case formulation has been shown to be used interactionally to defend against or counter potential challenges to justifications, and to portray the circumstances that precipitate actions as external to, or independent of, the speaker (Pomerantz, 1986; Whitehead, 2015). Here, we see the description working to defend against any potential undermining of the claim that the woman plans to have an epidural. The woman's assertion to have an epidural in this case evokes an action-accepting compliance token (Stevanovic & Peräkylä, 2012) from the midwife in the response particle "right" (line 3). It is clear then from the woman's talk that she understands her rights to access an epidural for pain relief in labour, and her responsibility to communicate her preferences with the midwife prior to labour. The midwife upholds woman-centred care principles through acknowledging the woman's involvement and avoiding challenging the decision. The woman's assertive claim to epistemic and deontic authority provided little room for engaging in discussion about the risks and benefits of, and alternatives to, epidural use.

A second extract is presented to again illustrate the common features of requesting a planned epidural. The following extract (2) is taken from a woman pregnant with her second child. It also follows a conversation about her previous birth experience (as in extract 1).

Extract (2)

- 01 MW: did you have an epidural with
02 ↑that one?
03 PW: yep
04 MW: ↑yeah? A:and you're going to have
05 one this time?
06 PW: yahhess=it's the most amazing
07 [thing ever]
08 MW: [mm of course] They are pretty
09 good, aren't they. Perfect.
10 PW: don't know how people get
11 through childbirth without it
12 MW: heh heh heh heh heh heh

Similar to extract (1), the woman takes a strong epistemic stance to base her decision to plan an epidural on her previous birth experience. Both the woman and midwife orient to the decision as entirely the responsibility of the woman. Again, we identify a *statement-formulation-elaboration* sequence (lines 6-11) used to demonstrate a collaborative understanding and affiliation with the decision. The midwife's response in lines 8-9 ("of course they are pretty good aren't they") is used here also to validate and acknowledge the woman's involvement in the decision. Following the woman's declaration of her decision the midwife attempts to close the sequence ("Perfect.", line 9), indicating the accomplishment of the decision-making goal is achieved. Epistemic and deontic claims rest entirely with the woman, unchallenged.

We will now turn to examine how women who plan *not* to have an epidural in labour respond to the imperative to communicate their preferences.

6.6.2 Rejecting a planned epidural

Just as women who plan to have an epidural orient to their responsibility to communicate their plans, so too do women who plan *not* to have an epidural. However, in contrast to planning an epidural, women who plan not to have an epidural are identified as engaging in more complex accounting for their choices. The following two extracts illustrate how midwives' responses to women's rejection of epidural plans solicit an expansion of the sequence leading to extended accounting work on the part of the woman. Extract (3) illustrates a typical way that women worked to assert their plans. The extract is taken from a consultation with a woman who is 19-weeks pregnant with her first child. She responds to the midwife's question about the woman's thoughts on what she wants for labour and birth by offering her plan to avoid an epidural.

Extract (3)

01 MW: so .hh have you ha=have you got a
02 bit of an idea of (.) what you
03 >wanted< have you thought abo:ut
04 (.) y'know through your pregnancy
05 and labour and that sortof thing
06 PW: (.) .hh a lill bi:t
07 MW: yeah
08 PW: ummm (.) I'm >pretty keen to try
09 an' avoid an epidural< if I can
10 MW: sure

11 PW: umm but (.) I'm not against (.)
12 <other forms of pain relief>
13 MW: right
14 PW: I jus= I chatted with a fe:w women
15 that have had ongoing back pain
16 from having an [epidural]
17 MW: [hmm hmmm]
18 PW: and I'm just <keen to avoid that
19 if I can but>
20 MW: [which the anaesthetist]
21 PW: [<yeah other than tha:at>]
22 MW: will argue with them and say \$they
23 would have got it anyway\$
24 MW: [but who knows]yeah\$
25 PW: [yeah yeah]
26 PW: umm >but other than that(.)I
27 dunno I'm pretty just sortof go
28 with the flow [>see what happens<]
29 MW: [yeah I think that's]
30 actually the best way to be

Extract (3) illustrates the potentially difficult task of a woman with no previous birth experience claiming epistemic knowledge to decide on the management of pain during labour. Relative to women requesting a planned epidural, instances of rejecting an epidural seemed more difficult in interaction. Here, the woman hedges her responses with hesitation

(lines 6 and 8) which has been shown in CA literature to display uncertainty, or to pre-empt a dis-preferred response (Pilnick & Zayts, 2014). The midwife offers an information receipt “yeah” (line 7) to validate the woman’s claim to assert birth preferences, and to encourage her to continue her turn at talk. Despite claiming deontic authority to assert her preference it is softened with hedgers and the mitigators “pretty sure” and “if I can”. The woman also offers the disclaimer “I’m not against other forms of pain relief”, possibly countering any potential negative reaction to rejecting pharmacological pain relief. Typical of cases in which women reject plans for an epidural, the woman above engages in significant accounting for her decision (lines 14-6) as she describes chatting to women who attribute back pain to having had an epidural. In this case the midwife uses an expert-footed indirect form of reported speech of an anaesthetist to challenge the woman’s account. Framing the challenge through reported speech serves to neutralise the midwife’s stance and avoids directly challenging the woman’s decision of not wanting an epidural. Thus, woman-centred care principles of choice are upheld. At the end of the extract presented the woman downgrades her assertion to planning to ‘go with the flow’, softened with “pretty just sort of” (lines 27-28), for which she is praised by the midwife who offers the affiliative formulation “yeah I think that’s actually the best way to be” (lines 29-30). Affiliation has been previously identified in CA work in antenatal contexts to be accomplished through agreements (Petraki & Clark, 2016). Affiliation is evident here in the midwife’s responses “yeah”, subsequently upgraded to a high-end agreement in lines 29-30 as noted.

Extract (4) below is presented to further illustrate the additional accounting work that first time mothers engage in when rejecting a planned epidural. The extract comes from a consultation with a woman who is 38-weeks pregnant with her first child. Similar to extract

(3), the woman below claims the deontic authority to assert her decision regarding the use of an epidural.

Extract (4)

01 MW: ehh happy about your >knowledge
02 about< having an ↑epidura:l
03 PW: (.) yeah I wasn't going to have one
04 MW: not gonna have ↓o:ne
05 PW: yep (.) \$hopefully\$
06 MW: okay heh heh heh heh
07 SP: what do you mean knowledge
08 MW: eh well usually <often times when
09 women that get> eh get seen in
10 ou:r um clinic he:re <are opting
11 for an epidural> and so that's why
12 they're exempt from going to our
13 birth centre
14 PW: ↓mm
15 MW: and by knowledge I me:an <we can
16 provide you with um> discussion
17 about it <an also some written
18 material> as well
19 PW: yeah no <I looked it up it
20 doesn't look nice> so I'll just
21 try and (.) \$avoid it <I'm not a
22 huge fan of needles or anything

23 like that so>\$ I'm like <yeah ↓no
24 that's one I don't really wanna
25 do> heh heh heh heh
26 MW: heh heh heh \$yeah no that's all
27 good. that's oka:y \$that's alri:ght\$

In this extract, epistemic authority is initially claimed by the midwife as the bearer of information. However, she accepts her diminished epistemic stance in the interaction and despite reformulating the woman's response (line 4), she does not challenge the woman's choice. In this way, the midwife takes a step back from any involvement in the decision-making process beyond the offering of information.

As illustrated in extract (3) we observe similar features in the above extract (4). A hesitation prior to responding (pause at line 3), followed by subsequent mitigators and down-grading of claims to deontic authority as her position is softened with smile-talk (line 5), laughter (line 25), and the softened terms "hopefully" (line 5) and "try" (line 21). These terms are in contrast to her first declaration "I wasn't going to have one" (line 3). Notably, similar to extract (3), is the subsequent accounting work that is enacted on the part of the woman to justify her choice in rejecting an epidural (lines 19-25). While the midwife never challenges the woman's right to decide, reformulating the woman's claim in line 4 and her laughter after "okay" in line 6 prompts the woman to expand on her decision to which she obliges (lines 19-25). As in all cases, the midwife is identified as affiliating with the woman's choice by offering praise and validation, seen in the above extract in lines 26-27 as a technique to close the sequence.

In the final section of this analysis we turn to instances where women display uncertainty about the use of an epidural in labour.

6.6.3 Unknowing epistemic stance

Cases of uncertainty were identified in two of fifteen examples of epidural talk throughout the dataset. Common features of these two women's unknowing stances involved orientation to a lack of experiential epistemic knowledge and laughter. Extract (5) illustrates these typical features. The extract is taken from a consultation with a woman at 23-weeks gestation with her first child. The midwife has recommended midwifery-led care as appropriate for the woman, and now presents a barrier to accessing that care in the form of a planned epidural.

Extract (5)

01 MW: <I guess the only thing is> they
02 don't really um usually take
03 people who (.)are pretty sure that
04 they want an epidural
05 (.)
06 so I don't know if you've thought
07 about any of that yet
08 PW: yeah I don't really \$kno:w if I\$
09 MW: \$.hhh\$
10 PW: I'd probably like to avoid that
11 but=
12 MW: yeah so if you come with an open
13 mind <you can have the> ga:s you
14 can have pethidine injections

15 they have a big shower they have
16 water bi:rths if you're real
17 interested um (.) an they just
18 keep things kind of normal ↑okay?
19 PW: yea:h

The midwife in extract (5) frames the issue of planning an epidural around its implications on model of care choices. The midwife here orients to an institutional pronoun “they” (line 1) to neutralise her responsibility in the exclusion of women who plan epidurals, and to avoid offering an unsolicited recommendation. As noted above, this was a general pattern across the data: midwives take an unknowing epistemic stance regarding women’s preferences and hence take a step back from involvement in the decision-making process or deferring to the organisation’s rules. However, the issue of planning for an epidural in extract (5) is formulated with a preference orientation for the woman to reject the epidural in favour of midwifery-led care, given the midwife’s recommendation for midwifery care. A lack of response from the woman in line 5 prompts the midwife to continue her turn at talk with a neutral framing (*I don’t know*, line 6) to inquire about the woman’s thoughts on having an epidural. Typical of these cases, the woman demonstrates her knowledge that a decision is required with “yeah” followed by an unknowing epistemic stance involving extreme-case formulation (*I really don’t know*, line 8). Through hesitation and laughter women were identified as demonstrating knowledge of their responsibility to assert a decision regarding epidural plans. The smile-laughter talk in the woman’s undecided response in line 8 indicates some delicacy about not having an appropriate response. The midwife affiliates with laughter – possibly also orienting to the woman’s responsibility to know what she wants. Subsequently

in line 10, the woman offers the preferred response with some hesitation, her stance softened with “probably” and “but”. Despite the obvious hesitation, midwife cuts the woman off (line 11-12), offering affiliation and praise for having an “open mind” (lines 12-3). In this way midwives avoids any explicit recommendations regarding epidural plans, instead deferring all epistemic and deontic authority to women. This is one way in which midwives work in interaction to accomplish woman-centred care but stop short of the ‘working with pain model’.

In all of the above extracts, midwives supported women’s choices about planning for an epidural in labour regardless of whether they were rejecting or requesting the epidural. While this support may be viewed as is in line with woman-centred care principles, the institutional imperative to know, and to plan for, an epidural may be viewed as prioritised over supporting women’s aspirations and preferences (for example, extract 1 line 7 the woman declares “not wants, needs”). Women generally recognised their role and responsibility in knowing their decision and the requirement to advise the midwife of their plans. These solid claims to epistemic and deontic authority provided little scope for midwives to engage in discussion about the risks and benefits of epidural-use, nor the opportunity to offer alternative forms of pain management.

6.7 Discussion

This study has examined how decisions about the planning for epidural use in labour are solicited by midwives and responded to by pregnant women. The present study has sought to clarify how such decisions were initiated, and responded to, in a ‘woman-centred care’ antenatal clinic. The study both supports and augments prior work on shared decision making in healthcare. It supports prior research by highlighting the unique nature of

decisions made in maternity care when compared to research on health-related decision-making in other medical settings. Similar to other research on decisions in antenatal clinics, our findings highlight a range of interactional strategies women and midwives enacted to engage in shared-decision making. Women typically oriented to knowledge that it was their responsibility to make decisions about their care, while midwives stepped back from offering unsolicited advice (Petraki & Clark, 2016; Pilnick & Zayts, 2016). As the midwives in Pilnick and Zayts' study were guided by the level of 'worry' women reported, midwives in the present study relied on women's descriptions of previous experience of giving birth to guide the decision-making process.

Patient claims to deontic authority in healthcare has also been observed in medical encounters. In a seminal work, Kleinman (1978) suggested that non-compliance in medical consultations arises from conflicting explanatory models of disease and illness. That is, traditional clinical disease models do not take into account social and cultural factors that influence patients' behaviours and experiences of illness. More recently, a cultural shift to patient-centred models of healthcare promote the rights and responsibilities of patients to take an active role in accepting and rejecting medical advice. Emerging interactional research is shedding light on the specific ways in which patients resist traditional medical authority. For example, through withholding acceptance (Koenig, 2011; Stivers, 2007) and mobilising their own medical knowledge (Lindstrom, 2015).

Pain relief in the present dataset was oriented to by midwives as entirely a matter of women's preference, rather than treated as a medical treatment. One possibility for this may be attributed to women's perception of pregnancy as a normal physiological experience, rather than a medical condition (Bryant, 2009). It may also reflect the different ways in which

patients respond to invasive versus non-invasive treatments. For example, Landmark (2015) showed that patients oriented to objective medical knowledge as a prerequisite for agreeing to invasive treatment.

In this sense, decisions about the management of pregnancy, labour and birth are more personal than medical, privileging experiential epistemic knowledge of the woman over the professional knowledge of the practitioner. Women are more inclined then to claim deontic authority in interactions to guide the decision-making process even when initiated by the midwife, and with systematic implications for on-going care. Our main observation is that both midwives and women oriented to the knowledge that the decision to use an epidural in labour, or not, was a decision made more or less entirely by the woman, rather than as a shared decision between midwife and woman. Further, the delicacy of women with no experience of giving birth rejecting the use of epidural was noted, evidenced by the additional interactional work enacted to justify and account for their choice. The unique position of the first-time mother as 'dealing with the unknown' due to having a limited point of reference to inform decisions has been written about (Dahlen, Barclay, & Homer, 2010). While the first-time mother is a 'novice', those mothers with a prior birth experience have more lived experience to inform their decisions (Dahlen, Barclay, & Homer, 2008). This was very evident in these interactions. The concept of 'going with the flow', particularly for first time mothers, has also been reported previously and was evident in this study. Going with the flow can lead to reduced disappointment when expectations are not met but it can also mean women are more vulnerable to the institutional priorities and particular medicalised cultures they enact (Borrelli et al., 2018; Dahlen et al., 2011; Newnham, McKellar & Pincombe, 2018).

Midwives in this study typically worked from a 'pain relief' model whereby pharmacological pain relief was treated as a routine choice and access to an epidural was oriented to as a woman's right (Leap et al., 2010). The placement of these decision-making sequences within the consultation may provide some insight into this finding. The systemic implications of planning for an epidural (i.e., restricted access to some models of care) meant that the discussion was steeped in an institutional requirement to allocate a woman to an appropriate model of care. A discussion more genuinely focussed on women's birthing preferences without the institutional element may provide the opportunity for a more in-depth discussion about supporting the birth experience that women want to achieve. One could also argue this dual allegiance to woman and system by midwives challenges the concept of woman centred care. Leap (2000) states that woman-centred care, "Focuses on the **woman's individual** needs, aspirations and expectations, rather than the needs of the institution or professionals". It was clear that institutional needs regarding entrance requirements to certain models of midwifery led care pivoted on the decision about wanting an epidural.

In this study, all women that had prior birthing experience requested a planned epidural for their up-coming birth. A potential reason for this may be that women who had experienced an epidural-free birth may already have been allocated to a midwifery-led model of care and did not appear in our dataset. Many of these women may have given birth previously in the same organisation and hence met with the same approach when it came to pain relief options. The qualitative nature of this study means that we cannot infer generalisability. However, the present examination is reflective of these individual experiences and highlights an important area of future investigation given that pain relief is a common (Leap, 2010), and sometimes contentious (Bayly, 2017) topic for discussion in maternity care.

This study further clarifies the dimensions of health-related decision-making. In responding to a call by Toerien et al. (2013) to examine the ways in which health-related decisions unfold, this study has contributed to work on patient participation, choice and medical authority in the context of an antenatal clinic. In this context, midwives were found to orient to women's superior epistemic status as "owners" of their experience (Peräkylä & Silverman, 1991), including women's superior knowledge of their preferences for pain management. The requirements of the institution however were also present in the decision-making challenging in part the woman-centred approach. A completely different interaction may have been seen if the women were in a continuity of midwifery care model as discourse around issues such as pain relief are seen to be more in-depth and the ongoing relationship with a known care provider enables an evolving conversation as the relationship grows (Teate, 2018). It is apparent when the midwives giving antenatal care are also the ones at the birth and providing postnatal care to women they know that they engage in different conversations around issues such as epidural (Teate, 2018).

It is generally considered good practice in qualitative research to acknowledge that the researcher is an active participant in determining what data is generated and how it is analysed (Finlay, 2002). Therefore, reflection on the position of the authors is warranted as a form of transparency and quality control. The first author has had personal experience as a recipient of maternity services three times (in two different settings – an obstetric unit and at home) and formed an opinion about the constrained opportunity to enact control over giving birth within a hospital setting. This led to the decision to undertake post-graduate studies researching the opportunities for women's involvement in childbirth-related decisions. As such, this study forms part of a larger work that will be submitted as a doctoral thesis. The

remaining two authors form the first author's supervisory panel. One is a well-known accomplished midwifery researcher, and the other an academic professor in psychology with an extensive publication history in maternity services. Acknowledging the research team's biases, we engaged in deep reflexivity throughout the study, often checking to ensure that claims were objectively supported by data. A series of data session enabled debate and discussion, eventually resulting in consensus. This process increases credibility of rigorous research practices and analyses. Having the different perspectives of midwifery and psychology also brought perspective and reflexivity to the study.

6.7.1 Conclusion

We approached woman centred care as accomplished discursively and interactionally, rather than adopting a more conventional view of the application of a set of guiding principles. CA has helped to bring to light the complexity of empowering women's involvement with fulfilling institutional imperatives. This study offers new and fresh insight into the specific set of skills that midwives' employ to accomplish their antenatal work. The findings from this study can be used as a spring-board for future CA work examining how decision-making sequences unfold and the nuances in talk that enable, or hinder, women's involvement in their maternity care.

7. CHAPTER SEVEN: Discussion

In this chapter, I synthesise the main findings of the thesis. I begin by summarising the results of each study. Then, I discuss how my work contributes to interactional literature on shared decision-making in institutional contexts. I then outline the potential methodological and practical implications of the present findings. Finally, I consider the limitations of the study and areas for future research.

7.1 Overview of findings

This thesis offers the first elaborate discursive study of women's involvement in childbirth-related decisions for 'low-risk' pregnancies, and is one of the few studies in the area that uses naturally-occurring data. The aim of this research was to gain a better understanding of the ways in which childbirth-related decisions are made and accounted for in the Australian hospital system. This is important because despite current policies that document women's rights to be actively involved in decisions about their maternity care, research evidence consistently shows that most women do not achieve the birth experiences they want. A number of reports and strategic plans for maternity services indicate an intent for the woman's experiences to be identified as a principle focus of care and meeting the women's needs has become a core aim of maternity care services, beginning with antenatal care (Bryant, 2009; Cumberledge, 1993). In 2009, an Australian National Review of Maternity Services conducted by the Australian Government Department of Health and Ageing sought submissions from women, service providers and other stakeholders about important issues in maternity services. The most prevalent issues raised by women included: a desire for greater options in models of care that reflected their birthing choices; more access to information; respect for personal perceptions of risk; and a desire for birth to be understood as a natural

process rather than a medical procedure (Bryant, 2009). A National Guidance on Collaborative Maternity Care was subsequently released by the Australian Government in 2010 in response to the review. The guidance encourages a woman-centred care approach and promotes women's rights to services that support the psychosocial, emotional, cultural, spiritual and physical needs of pregnant women (National Health and Medical Research Council, 2010). In 2017, the Australian Health Ministers Advisory Council (AHMAC) started the process to develop a National Strategic Approach to Maternity Services (NSAMA). A strategy document 'Woman-centred care: Strategic directions of Australian maternity services' has been produced to provide overarching national strategic directions to enable improvements in line with contemporary practice, evidence and international developments. The document is currently progressing through the AHMAC approval processes before being released (Australian Department of Health, 2019).

Despite governmental moves to support the empowerment of women in maternity services, research continues to find that women have limited opportunity to enact any real control over hospitalised birth. For example, women's documented natural birth plans have been repeatedly reported to have had little impact on the lived experience of hospital-based birth (Happel-Parkins & Azim, 2015; Malacrida & Boulton, 2014). Other studies have highlighted the challenges women face resisting the dominant medical discourse (see for example, Edwards, 2004; Coxon, Sandall & Fulop, 2013; Snowden, Martin, Jomeen & Martin, 2011; Petrovska et al., 2016).

To understand more about this apparent disjuncture between what women report to want in childbirth and what actually happens, I designed a discursive psychological study, framed by ethnomethodology, to identify and describe aspects of language used to negotiate and

communicate childbirth decisions in the context of woman-centred care. Three fundamental aspects of ethnomethodology with particular relevance to childbirth underpinned analyses: accountability, epistemic and deontic orientations, and morality (see chapter 3, sections 3.1.3 to 3.1.5). I first focussed on unsolicited birth narratives to examine precisely how women accounted for the introduction of medical interventions. I then turned to focus on midwife-woman interactions in antenatal appointments to observe how decisions unfolded in situ.

Overall, studies one to three identify and describe aspects of language used to communicate childbirth decisions in the context of woman-centred care where women are encouraged to be involved in decisions about their care. The first study highlighted routine ways in which women attributed accountability for medical interventions in online birth narratives. In keeping with a discursive psychological approach, the aim of the study was not to question whether or not medical interventions were appropriate. Rather, I explored how narratives drew on particular linguistic constructions to account for the use of medical intervention. The main finding of study one was that, in these publicly available retrospective accounts of hospital-based childbirth, medical interventions were positioned as unwanted, but unavoidable. That is, women typically reported having held a preference for a more natural birth, but that they were unable to avoid interventions in a hospital setting.

In this first study, I identified two dominant themes in women's accounts of being unable to avoid unwanted interventions: avoiding stress or distress on the part of the woman or baby; and adherence to institutional requirements (hospital policy and/or routine practice). The latter provided important insight into women's accounts that positioned the place of birth as impacting on the birth experience. I illustrated how women described medical interventions as unavoidable but also as unnecessary. In narratives in this theme, women typically referred

to a fundamental belief in their physiological ability to give birth naturally, but were unable to achieve this due to an institutional requirement to adhere to hospital policy/practice. For example, one woman described how doctors “insisted” on a caesarean section due to a breech positioning. Another woman described being ‘warned’ that it was “hospital policy not to let women push for more than two hours” and this resulted in an epidural and an assisted birth (forceps). Unlike descriptions of interventions as unavoidable that were framed in terms of medical ‘concern’ and invoked ‘stress’ as a warrant, descriptions of intervention that invoked compliance with hospital policy/practice typically constructed medical intervention as unnecessary.

A robust feature of women’s online birth narratives, and which informed the analyses undertaken in subsequent studies, was the routine orientation to a normative or moral order around natural childbirth. This finding is in line with evidence from previous research that indicates natural birth continues to be valourised in contemporary society (Bayly, 2017; D’Cruz & Lee, 2014; Malacrida & Boulton, 2014; Mazzoni et al., 2011; Tully & Ball, 2013). However, despite this consistent finding, some form of obstetric intervention is introduced in the majority of births in Australia (Australian Institute of Health and Welfare, 2019; Dahlen et al., 2014), though this varies depending on setting or provider. As described above, this is interesting in the context of current policy directives that emphasise the importance of women’s involvement in decision-making around birth. Women’s rights to take an active role in maternity care have been formalised in the development of woman-centred care frameworks. Woman-centred care is designed to place the focus of maternity care “on the woman’s individual needs, aspirations and expectations, rather than the needs of the institution or professionals” (Leap, 2000). This disjuncture between the natural birth that

women say they want, and what typically occurs provided the basis for examination of actual interactions between women and their midwives in planning and preparing for childbirth. I wanted to explore the ways in which decisions were made and communicated at the point in time in which they occur. My aim was to shed light on potential explanations for why it appears that women are not achieving the birth they aspire to in a hospital setting that promotes woman-centred care.

Studies two and three therefore, focused on how decisions about aspects of maternity care are made in real life interactions between midwives and women as they occur. In these two studies I used conversation analysis (CA) to examine the ways in which midwives and pregnant women orient to epistemic and deontic authority in and through talk to negotiate and communicate decisions related to planning for childbirth in hospital. Building on the findings of study 1, and using previous conversation analytic literature, I offered a nuanced and in-depth understanding of how childbirth-related decisions are made in situ.

Study two examined how patterns in language were used to accomplish the institutional imperative to allocate pregnant women to a model of care. As described above, a valorisation of natural birth persists in contemporary society. To support women opting for a natural birth in the hospital under examination, midwifery-led care may be offered to 'low-risk' women. Midwifery-led care aims to prioritise physiological processes of childbirth. The midwifery-led model was presented to women as an alternative to the 'default' medical doctor-led care, which is where the data was sourced and where all pregnant women accessing maternity care in this hospital are initially screened. I showed how midwives typically presented recommendations for midwifery-led care in ways that worked to downplay their deontic authority, thus deferring authority to decide to the pregnant woman and orienting to the

woman-centred nature of the interaction. Downplaying deontic authority was achieved by the use of terms such as “if you like” and “you don’t have to”.

Of particular interest to the overarching research aims of this thesis, was that model of care allocation was inextricably linked to plans for accessing pain relief during labour. The implication of requesting a planned epidural in the hospital under study was that women could *only* be allocated to the standard doctor-led model of care. I illustrated the ways in which midwives worked to remain woman-centred while managing institutional restrictions that limited women’s choices of model of care. I demonstrated how midwives distanced themselves from the institutional restrictions on access to model of care through the use of pronouns such as “they” (for example, “they don’t usually take people who are pretty sure they want an epidural”).

The institutional requirement for a woman who wants an epidural to labour on the standard doctor-led maternity ward was described as important to ensure that woman’s pain relief choices are respected and supported. This may be understood as in line with woman-centred care principles. However, through detailed examination of midwife-woman interactions, my analysis has revealed a consequence in the form of restrictions imposed on access to midwifery-led care. This is a concerning finding because previous research has overwhelmingly shown that midwifery-led care is more closely aligned with women’s birth preferences (Madden, Turnbull, Cyna, Adelson, & Wilkinson, 2013), is associated with lower rates of medical intervention (Sandall et al., 2016; Tracy et al., 2014) and increased rates of satisfaction with birth (Cluett & Burns, 2013). In the present data, the institutional imperative to decide during pregnancy whether or not to plan for an epidural in labour restricted access to such midwifery-led care. In the third and final study of this dissertation, I sought to

examine the ways in which those implicative decisions to plan access to an epidural in labour were topicalised and negotiated in and through talk.

Study three therefore provided a closer examination of the ways in which the decision to plan for an epidural in labour was worked up in interactions between pregnant women and their midwives in preparation for childbirth. In the context of woman-centred care, the tailoring of care to a woman's individual preferences should be achieved through shared decision making between women and their care providers (Morgan, 2015). My aim in the third study was to build on existing healthcare interactional research on shared decision-making to understand the ways in which women and midwives negotiated plans for pharmacological pain relief. Discussions about pain relief were common in antenatal consultations, and as study two illustrated, this was most often associated with allocation to a model of care.

The overarching finding of study two was that women unilaterally made the decision about whether or not to plan for an epidural in labour with little, if any, involvement from the midwife. That is, the decision to have an epidural was not treated as a matter for shared decision-making. Rather, women claimed all epistemic and deontic authority in the interaction, and this authority was never challenged by midwives. Another broad pattern identified in the data was that midwives typically used language consistent with a 'pain relief' model of talk, rather than a 'working with pain' model (Leap et al., 2010). In other words, women were presented with a pain relief menu with little (or no) discussion about risks associated with epidural use, nor the physiological role of pain during labour. In this context, women routinely drew on their experience (or lack thereof) of giving birth to account for the decision that was elicited.

There were differences observed between women who requested a planned epidural and women who rejected a planned epidural. Generally, women who rejected a planned epidural engaged in more complex interactional work when presenting their decision to the midwife. In contrast, women who requested an epidural made strong epistemic and deontic claims, leaving little room in the interaction for midwives to engage in a discussion about risks and benefits of epidural use.

Topicalising the need for a decision as an institutional imperative limited the opportunity for midwives to initiate a discussion about supporting the physiological processes of labour without pharmacological intervention. For women requesting a planned epidural, their assertiveness indicated knowledge that the decision was theirs to make and of their responsibility to communicate that decision. My analysis showed that midwives quickly took a step back from involvement in the decision, offering praise and support for women's involvement. In this way, epistemic and deontic authority rested entirely with women and any challenge by midwives was avoided.

For women rejecting a planned epidural, the sequences of talk were typically longer and more complex. Women engaged in more accounting for their decisions and most often down-graded their stance throughout the sequence. This more complex accounting work may reflect the delicacy of rejecting medical intervention in a clinical context (Lindstrom & Weatherall, 2015). The finding that it appears harder for women to reject an epidural than it is to plan for one in interaction-based data, may also go some way to explaining the disjuncture between Australian women's reported preferences for avoiding pharmacological pain relief (Henry & Nand, 2004; Madden et al., 2013) and the declining rates of pain-relief-free childbirth (Australian Institute of Health and Welfare, 2019). Regardless of the woman's

choice, midwives in the present data avoided directly challenging the decision. Rather, support was provided in terms of facilitating systems in place to ensure women received the pain relief if it was requested. In this way, support for the systematic processes of the institution were shown to be prioritised in midwife-woman interactions over support for the physiological processes of labour.

Together, these three studies provide much needed contribution to research evidence in the field of health-interactions and maternity care practice. Findings have demonstrated that while a general valourisation of natural birth seems to persist, there may be challenges in overcoming the institutional barriers to achieving a normal birth. This overarching finding has been further strengthened by the triangulation of findings between two separate data sets and methodologies. Midwives working within a medical institution may be challenged to attend to both the needs of the system, and the birth preferences of women. In other words, close examination of the language used to negotiate and communicate childbirth decisions have illustrated that systematic processes within institutions privilege access to medical interventions over providing support for the physiological process of normal labour and birth.

7.2 Contributions to patient participation research

The findings outlined in the previous section have contributed to literature on the involvement of patients in decisions relating to their healthcare. Two distinct methodologies, framed by discursive psychology, have been employed to provide triangulated research evidence on the opportunities afforded to women to participate in decisions related to giving birth in Australia: thematic analysis and conversation analysis.

7.2.1 Contribution to sparsely investigated settings

In study one, I took a discursive psychological approach to analyse naturally-occurring women's accounts of childbirth. A large body of research exists on women's retrospective accounts of childbirth and generally describe women's disempowerment in birthing in the hospital system (Happel-Parkins & Azim, 2015; Malacrida & Boulton, 2014). However, most previous qualitative studies of this nature use interview and focus group data which are associated with particular limitations such as treating accounts as a matter of factual reflection rather than as a form of accounting designed to achieve particular functions in a research-orientated interaction (Potter & Hepburn, 2005). Few studies use naturally occurring data to examine how childbirth experiences are described, and those that are available focus on atypical birth experiences such as planning vaginal birth after a previous caesarean (Dahlen & Homer, 2011) and breech births (Petrovska et al., 2017) which focus specifically on how women account for resisting medical advice. In contrast, through the examination of publicly available birth stories, and of interactions between midwives and women planning for a normal birth, my studies have shown that even for women with no reported risk factors, women still faced challenges in enacting real agency over their birth experience.

In study one, I explicate a number of key similarities in respect of other analyses of women's retrospective accounts of child birthing experiences, particularly in terms of attribution of accountability for interventions and orientation to the normative or moral order around natural childbirth. I demonstrate that similarities arise in terms of a reported disempowerment in hospital systems, despite recent policy directives that mandate women's opportunity for control over birth. I illustrate how my findings further this knowledge by explicating the range of linguistic practices used to manage stake and interest in descriptions

such as defensive detailing, extreme case formulation and vague descriptive categories.

While findings support previous research that indicate that women prefer to avoid medical intervention during birth, my analyses show precisely how attribution of accountability is worked up in naturally occurring accounts of childbirth. In the context of woman-centred care in a hospital environment, the present findings provide further insights into what is often a difficult, complex and contested experience for women.

Moreover, studies two and three contribute to institutional CA research with investigations from a setting that has previously received little attention, both in regards to geographical placement and institutional context. Whereas the vast majority of health-related CA research has studied medical interactions from the UK and USA, this study has investigated maternity care interactions from an Australian public hospital, broadening knowledge of midwife-woman interactions in this context. In a study of problem presentation in antenatal consultations in Japan, Nishizaka (2010) highlighted a fundamental difference medical interactions and routine antenatal consultations lies in the reason for visit: antenatal visits are not problem-driven, rather they are routine-surveillance orientated. The present study contributes to specifying the dynamics involved when providing opportunities for women to participate in decisions about how and where to give birth. These decisions may be understood as less burdensome than medical decisions which could impose responsibility for arguably more severe adverse outcomes.

The CA component of this thesis contributes to the literature on decision making sequences in healthcare interactions during which patients (in this case, pregnant women) are expected to be more actively involved than through a mere acceptance or rejection of a recommendation. This departs from the recommendation-acceptance structure taken for

granted in most shared decision-making research as being equivalent to the phase during which physicians and patients plan what to do next (Toerien et al., 2013). This thesis provides a nuanced examination of how woman-centred care is accomplished discursively and interactionally in order to explicate and expand our understanding of how decision-making sequences unfold and the nuances in talk that enable, or hinder, women's involvement in their maternity care.

7.2.2 Patient involvement in healthcare

The discursive approach adopted in this thesis has enabled descriptions of what actions participants carry out, the working of resources participants use, as well as the interactional consequences (Pomerantz, 1990). This inductive approach investigating naturally-occurring communication presents a different starting point to other approaches examining patient involvement in healthcare that focus on what shared decision-making *should* look like (Garrard, Ridd, Narayan, & Montgomery, 2015; Makoul & Clayman, 2006). In contrast, I argue that it is essential to know how patient involvement is described and enacted by women and midwives in naturally occurring settings. A central argument in this thesis is thus that the specific knowledge about how patient involvement works in practice, including the identification of what practitioners are already doing can inform future policy reform initiatives. This may be particularly significant in maternity care where women are increasingly being held accountable for their birth choices and are responsible for consenting to the care and interventions used.

All three studies in this thesis describe how women (and in studies two and three, midwives) orient to the terms for women's involvement in decisions related to hospital-based childbirth. Across all the studies, the constraints of women's involvement are oriented to.

This is in line with previous research in maternity care that has highlighted the constraints on women's choices related to giving birth (Happel-Parkins & Azim, 2015; Malacrida & Boulton, 2014; McCourt, 2006; Pilnick, Fraser, & James, 2004). Previous research examining midwife-woman interactions has shown how asymmetrical positions of power limit the capacity for women to actively engage in her care (Kirkham, 2009; Leap & Edwards, 2007; Levy, 1999). Research in this area has consistently found that decisions women make around their maternity care can depend on the way information is presented, as well as the relationship they have with their midwife (Catling-Paull, 2013; Teate, 2018; Wright, Pincombe, & McKellar, 2018). The approach used in the present study extends this line of research by explicating how women's and midwives' actions in *actual interactions* provide a source for investigating participants' orientations to preferences for participation. The discursive approach of this thesis sheds light on subtle negotiations about preferences, whilst distributing epistemic and deontic rights and responsibilities.

7.3 Implications for maternity care

Woman-centred care represents a professional standard for midwifery. The relationship a woman has with her midwife is fundamental to woman-centred care. It has been argued that much like other regularly assessed core skills such as reading cardiotocography output or cardiopulmonary resuscitation, communication training should be incorporated into ongoing professional development and review processes (Wright et al., 2018). Understanding how antenatal consultations unfold enables reflection on opportunities for women to be involved in decisions about her care.

A complicating factor in the enablement of women's rights to be involved in decisions about her care is that midwives are increasingly managing routine antenatal care in hospital

institutions which impose restrictions on the scope for women's choices. As described in chapter 2.3, midwifery philosophies are fundamentally different from a medicalised model in that they seek to facilitate healthy pregnancies, rather than the medical focus of the management of risks. Some authors have questioned the capacity for hospital-based maternity services to provide the level of personalised and flexible care consistent with woman-centred care principles due to the authoritarian environment associated with the medical institution (Hastie, 2006; Stapleton, Kirkham, Curtis, & Thomas, 2002). The second and third studies of this thesis aimed to uncover how midwives managed the potentially contradictory position of supporting women's birth preferences while also managing the needs of the institution and using evidence-based practice.

Critique of the industrial nature of maternity institutions is not new. A growing number of studies are showing that acute medical settings can be detrimental to normal birth practices and outcomes (Davis-Floyd, 2001; Dixon & Foureur, 2010; Fisher et al., 2006; Goer, 2002; Kitzinger, 2006; Newnham, McKellar, & Pincombe, 2017). Studies have consistently shown that women, birth and midwifery care are largely constrained within a medical model of care due to the dominance of a medical discourse in Australia. Newnham (2014) used Foucault's theory of knowledge/power to illustrate how midwifery is constructed as a subjugated profession by a dominant medical discourse. Medicine was shown to negotiate the boundaries of its discourse in order to maintain power/knowledge over birth (Newnham, 2014). In more recent work, Newnham et al. (2017) coined the phrase 'paradox of the institution' to describe how institutional surveillance leads to an institutional momentum that in its attempt to keep women safe actually introduces new areas of risk. The findings of the

current thesis add weight to these claims, showing that institutional requirements are routinely oriented to as limiting or restricting women's birth choices.

My findings have supported other Australian examinations of antenatal care that focussed on how midwifery care is enacted in public hospitals. For example, Wright et al. (2018) used both interview and observational data to gain insight into the professional interpretation of woman-centred practice in a hospital setting. Acknowledging the competing priorities of woman-centredness and the institution, midwives were shown to either choose, or be directed by their employers, to adopt particular routines as a way of providing safe care and minimising risk (Cartwright & Thomas, 2001). My research has illustrated the ways in which adoption of institutional routines are enacted in and through talk. Specifically, I showed how midwives drew on particular categorisations to topicalise model of care choices and oriented to the implicative nature of pain relief choices, while also fulfilling institutional requirements to allocate women to a model of care and to solicit pain relief plans during pregnancy. An understanding of the specific ways in which midwifery is enacted within a medical institution can identify areas of competing priorities and opportunities for improvement in the application of woman-centred care.

The ways in which women are involved in decisions about how they give birth has important implications on satisfaction with their birth experience. Much previous research evidence has shown that a sense of control is strongly associated with a more positive birth experience, and can facilitate a smoother transition into satisfied mothering (Catling-Paull, 2013; Cook & Loomis, 2012; Geerts et al., 2014; Hauck, Fenwick, Downie, & Butt, 2007; McCourt, 2006; Spinelli et al., 2016). However, until now little has been known about how a 'sense of control' is enacted in maternity care practice. Interaction-based research that has considered

women's involvement in child birthing choices have typically considered decisions about routine screening (Pilnick, 2008) and the ways in which midwives work to establish rapport with women (Petraki & Clark, 2016). The present thesis illustrates how women retrospectively describe their involvement in birthing choices as well as how up-coming births are planned for during antenatal consultations. My research can help guide and inform on the ways in which midwives accomplish woman-centred care discursively in practice.

It has been argued that specific education and guidance on how to actually implement woman-centred care is limited (Wright et al., 2018). This thesis has illustrated that 'best practice' needs to be founded upon information about the interactional consequences of adopting a given practice. Conversation analysis has been used to build a communication skills training method known as Conversation Analytic Role-play Method (or CARM) (Stokoe, 2014). In CARM, training participants 'live through' segments of real interactions, and reflect upon alternative ways of managing specific interactional tasks. An advantage of using authentic interactional data, is that it has the potential of increasing professionals' interactional awareness; on how subtle details in talk work, and how they may affect communicative trajectories. This method of feeding back CA findings to inform on training has been used in workshops for helpline call-takers (Hepburn, Wilkinson, & Butler, 2014). Sections of recorded helpline interactions were used to illustrate where 'choice points' occurred in which call-takers were faced with options, for example to leave a silence, offer a sympathetic response, work towards advice-giving and so on. Playing recordings and stopping at key points of choice allowed for discussion and consideration about what their next turn would be and also *how* they could deliver it. The exercise is reported to have offered a platform for demonstrating skills and commenting on those of others (Hepburn et

al., 2014). More recently, CARM has been used in professional development of early childhood educators (Church & Bateman, 2019). CARM workshops were shown to be helpful in assisting educators to identify opportunities for engaging children in problem-solving and collaborative play. As Church and Bateman (2019) describe, “a methodological strength of CA that resonates in professional development, is an ambition to find how institutional practices are done, what resources speakers use, and how these are applied in predictable ways” (p. 251). Recognising the context-specific environment of the interaction, CARM may present an opportunity for the tailoring of talk in antenatal consultations that can facilitate greater scope for women’s involvement in her care.

Another implication to be drawn from this doctoral work is that woman-centred care (or indeed, patient-centred care more generally) cannot be mandated purely from the political realm, for instance, through the National Guidance on Collaborative Maternity Care. If the goal of woman-centred care is to be realised in practice, more research is needed that aims to bridge the gaps between juridical and political goals and practice. The CA approach in this doctoral thesis contributes to a different kind of evidence than what is common in studies of patient participation. Common methods for understanding women’s experiences of enacting agency in maternity care included various forms of self-reports such as interviews, focus groups or questionnaires (Coxon et al., 2013; Happel-Parkins & Azim, 2015; Malacrida & Boulton, 2014). This thesis has addressed a gap about how participants’ actions in actual interactions provide a source for investigating participants’ orientations to preferences and agency. The findings from this research can be used to inform hospital processes and guideline development on issues such as allocation to a model of care.

7.4 Limitations and recommendations for future research

There are several limitations to the research presented in this thesis which are important to highlight. A limitation of the dataset involving online birth stories is that while the data collection period fell within the timeframe that woman-centred care was widely practiced in Australia, it is not always clear when the births that were described occurred. However, given the data collection period began seven years after the National Review of Maternity Services in 2009, and that the selected websites update their featured stories, we can assume that at least most would have accessed maternity care in a hospital that purports to promote woman-centred care. In any case, the shift from a paternalistic approach in healthcare towards a more person-centred one has been occurring over many decades, empowering patients to be involved in their healthcare services (Beisecker & Beisecker, 1993). Another limitation I faced in the analysis of the first study was ambiguity around the term 'natural'. For example, 'natural' childbirth might refer simply to 'vaginal' birth, whereas other women might use 'natural' to mean no medical intervention or even no medical management. For this reason, I focussed on identifying instances where women described the use of specific interventions that they claimed to want to avoid, or where they reported negative feeling associated with the use of particular medical interventions. A further limitation may be that women who share their birthing stories online may be more invested in their identity as a 'birthing woman'. As such, it may be the case that there are any number of women experiencing birth interventions without feelings as if these were unnecessary.

A limitation of the dataset involving midwife-woman interactions is that all the interactions occurred within one public hospital. It is unclear whether the particular restrictions around access to midwifery-led care, or the requirement to decide on pain relief during pregnancy apply more generally in the hospital system. Furthermore, it is unclear whether there are

different institutional restrictions and requirements relevant to the private hospital system compared to the public system under examination. Further research is needed to examine decision-making in different maternity systems. Nevertheless, the findings reported here contribute to the understanding of the interactional resources that midwives use to facilitate woman-centred care while attending to institutional requirements, as well as women's own orientations to their expectations of agency in childbirth related decisions. Video-recordings of the consultations may have assisted in the understanding of broader interactional features, for example silences related to record-keeping and important features such as gesture and gaze. The use of video-recorded data should be considered in future research aiming to examine the ways in which language is used to negotiate childbirth-related decisions.

Further research could be carried out to further investigate notions and practices of what constitutes 'woman-centred care'. Although there have been recent attempts to describe it (for example, Fontein-Kuipers, de Groot & van Staa, 2018; Brady, Lee, Gibbons & Bogossian, 2019), woman-centred care continues to seem a variable conceptual framework. More ethnomethodological studies are needed to realise the range of ways in which decision-making is managed in maternity care, and the implications for woman-centred care policies.

A further limitation involves the inclusion criteria of the studies. The online dataset did not include narratives that described home or unassisted birth, or those that described planned caesarean section births. In the midwife-woman interactional dataset, only women who did not present as having any complicating or high-risk factors were examined. Future analyses could seek to shed light on how women giving birth in different settings and in different

circumstances (for example, those considered 'high risk') are afforded the opportunity to be involved in decision-making and planning for their up-coming birth.

Despite these limitations, the findings of the current research add to the literature by empirically exploring the ways in which language is used to describe, establish and negotiate opportunities for women to participate in childbirth-related decisions. Exploring the patterns and variations in how agency is constructed in naturally occurring contexts adds another layer of understanding to research on childbirth. Making visible the ways in which woman-centred care is constructed discursively helps to illuminate the opportunities and barriers women face in enacting any real power and control over their experience of giving birth in a hospital setting. Moreover, the current findings offer insights into the crucial role of maternity care providers in women's birth experiences and highlight particular barriers to informed decision-making and where there may be opportunities for improvement.

7.5 Concluding remarks

This thesis has documented midwives' and women's own orientations to agency and authority in naturally occurring contexts when making (or describing) decisions about giving birth in hospital. Two distinct datasets have been derived to triangulate the findings and in doing so, bolster the reliability of the conclusions. The first dataset involved 106 publicly available online birth narratives and were examined for attributions of accountability for medical interventions. The second dataset involved 49 midwife-woman interactions in real antenatal encounters in a South Australian public hospital. Three areas of childbirth-related decisions have been explored: (1) introducing unwanted medical intervention (2) allocation to a model of care (3) planning to access an epidural for pain relief. These articles have added

to knowledge about how agency and power is accounted for (article 1) and enacted (articles 2 and 3) in decisions made about births.

In sum, these studies show that women and midwives alike orient to a restricted form of woman-centred care in a hospital setting. Study 1 illustrates attribution of accountability for unwanted medical interventions as introduced to address 'stress' or to comply with 'institutional practice / policies. Studies 2 and 3 document particular ways in which midwives set terms for women's involvement, while also orienting to women's rights to enact control in her maternity care. Although midwives in studies 2 and 3 explicitly hold women accountable for making certain choices about care, they also simultaneously employ strategies to uphold the institutional restrictions that acted to constrain the scope of women's choices. This finding was also reflected in the first study where women described being unable to avoid medical interventions due to certain hospital policies and/or the practices of particular practitioners. In studies 2 and 3 midwives typically took a step back from decisions about model of care and pain relief, as well as distancing themselves from institutional restrictions (e.g., by using institutional pronouns such as '*they* won't allow x'). Midwife activities like topicalising the need for a decision, as well as pursuing a committed response and describing the implicative nature of a choice can thus work towards both institutional goals (i.e., the institutional imperative to know and plan for pharmacological pain relief, and allocation to a particular model of care) and to achieve a form of woman-centred care, which is promoted in current guidelines, policies and legal rights. Furthermore, the three studies together demonstrate that the achievement and terms of woman-centred care is established and negotiated by women and their care-givers. Finally, institutional

systems, as oriented to in interactions and unsolicited narratives, may not correspond with current maternity care guidelines of women centred care.

This thesis is the first elaborate study of women's involvement in decisions related to 'low risk' pregnancies and births, and is one of the few studies that uses naturally-occurring data to examine how attributions of accountability are worked up retrospectively, as well as *in situ* orientations to epistemic and deontic authority. The findings of this thesis contribute to much needed empirical detail and specification of how women are involved in actual childbirth-related decision-making and should be used as a basis for refining and developing recommendations for practice and policy making in the future.

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Appendix 1

Conversation Analysis transcription key

[yeah]	
[okay]	Overlapping talk
(.)	Brief pause
(1.2)	Time (in seconds) between the end of a word and the beginning of next
wo:rd	Colon indicates prolonged vowel or consonant
↑word	
↓word	Marked shift in pitch up (↑) or down (↓)
°Word°	Degree sign indicates syllables or words distinctly quieter than surrounding speech
>word<	Increased speaking rate
<word>	Decreased speaking rate
.hh	In-breath
\$word\$	Dollar sign indicates smiley voice
<u>word</u>	Underlining denotes emphasis
word=word	Equals signs indicate that speech is linked and runs on

Appendix 2

Midwife participant information sheet

Midwife-Participant Information Sheet

Lyell McEwin Hospital

Title	<i>Talk about Birth: Interaction in Antenatal Consultations</i>
Short Title	<i>Talk About Birth</i>
Coordinating Principal Investigator/ Principal Investigator	Lindsay Cole
Associate Investigator(s)	<i>Associate Professor Amanda LeCouteur (The University of Adelaide) Professor Hannah Dahlen (The University of Western Sydney)</i>
Location	<i>Lyell McEwin Hospital</i>

Part 1 What does my participation involve?

1 Introduction

You are invited to take part in this research project, which is called *Talk about Birth*. You have been invited because you facilitate antenatal consultations with pregnant women during which childbirth is discussed.

This Participant Information Sheet/Consent Form tells you about the research project. It explains the processes involved in taking part. Knowing what is involved will help you decide if you want to take part in the research.

Please read this information carefully. Ask questions about anything that you don't understand or want to know more about. Before deciding whether or not to take part, you might want to talk about it with a relative, friend or colleague.

Participation in this research is voluntary. If you don't wish to take part, you don't have to.

If you decide you want to take part in the research project, you will be asked to sign the consent section. By signing it you are telling us that you:

- Understand what you have read
- Consent to take part in the research project
- Consent to be involved in the research described

You will be given a copy of this Participant Information and Consent Form to keep.

2 What is the purpose of this research?

The study is part of research towards a PhD being undertaken by Ms Lindsay Cole at The University of Adelaide that is designed to increase knowledge about how childbirth is planned and experienced in Australia.

This research aims to add to our understanding of the use of maternity services by women. Specifically, it involves looking at how women and midwives talk about various issues to do with childbirth.

3 What does participation in this research involve?

If you agree to participate, you will be asked to sign a consent form agreeing to the audio-recording of a 32-36 week antenatal consultation with consenting pregnant women. Nothing else will be required from you. Please note that whether or not you decide to participate will not affect your employment at the clinic in any way. The recording of the appointment will be transcribed by Lindsay Cole, and included in a collection of such recordings, which will then be analysed for patterns and similarities in how women talk about their childbirth preferences. Once the research team has analysed all the data, a report of the findings will form part of Lindsay's PhD thesis. Results from this study may be used in publications and presentations.

This research project has been designed to make sure the researchers interpret the results in a fair and appropriate way.

There are no costs associated with participating in this research project, nor will you be paid.

4 Do I have to take part in this research project?

Participation in any research project is voluntary. If you do not wish to take part, you do not have to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage.

If you do decide to take part, you will be given this Participant Information and Consent Form to sign and you will be given a copy to keep.

Your decision whether to take part or not to take part, or to take part and then withdraw, will not affect your employment, your relationship with professional staff or your relationship with the clinic.

5 What are the possible benefits of taking part?

There will be no clear benefit to you from your participation in this research.

6 What if I withdraw from this research project?

If you do consent to participate, you may withdraw at any time. If you decide to withdraw from the project, please notify a member of the research team before you withdraw. If you do withdraw, you will be asked to complete and sign a 'Withdrawal of Consent' form, which will be provided to you by the research team.

7 What happens when the research project ends?

Once the study is complete, a paper will be prepared for publication. If you would like a copy of the article, or a summary of results, please contact Lindsay Cole, who will send it to you.

Part 2 How is the research project being conducted?

8 What will happen to information about me?

By signing the consent form you agree to the research team collecting and using personal information about you for the research project. Any information obtained in connection with this research project that can identify you will remain confidential. Personal information collected will be used to describe the women participating in the study. Personal details will not be linked to the recording of your appointment. Details, such as names of people or locations that might occur in the recordings, will be replaced by pseudonyms in the transcription, analysis and reporting stages of the research.

Your information will only be used for the purpose of this research project and it will only be disclosed with your permission. The only personal information that the research team will collect and use is your years of midwifery experience.

It is anticipated that the results of this research project will be published and/or presented in a variety of forums. In any publication and/or presentation, information will be provided in such a way that you cannot be identified.

Any information obtained for the purpose of this research project that can identify you will be treated as confidential and securely stored. It will be disclosed only with your permission.

9 Who is organising and funding the research?

This research project is being conducted by The University of Adelaide in collaboration with the Northern Adelaide Local Healthcare Network (NALHN).

10 Who has reviewed the research project?

All research in Australia involving humans is reviewed by an independent group of people called a Human Research Ethics Committee (HREC).

The ethical aspects of this research project have been approved by the HREC of The Lyell McEwin Hospital.

This project will be carried out according to the *National Statement on Ethical Conduct in Human Research (2007)*. This statement has been developed to protect the interests of people who agree to participate in human research studies.

11 Further information and who to contact

If you want any further information concerning this project or if you have any problems which may be related to your involvement in the project, you can contact the researcher on 0417 882 072 or any of the following people:

Research contact person

Name	Lindsay Cole
Position	PhD Candidate/principal researcher
Telephone	
Email	lindsay.cole@adelaide.edu.au

For matters relating to research at the site at which you are participating, the details of the local site complaints person are:

Complaints contact person

Name	Vanessa Owen
Position	Executive Director of Nursing & Midwifery
Telephone	
Email	Vanessa.owen@health.sa.gov.au

If you have any complaints about any aspect of the project, the way it is being conducted or any questions about being a research participant in general, then you may contact:

Reviewing HREC approving this research and HREC Executive Officer details

Reviewing HREC name	TQEH/LMH/MH Human Research Ethics Committee
HREC Executive Officer	Heather O'Dea
Telephone	
Email	Qeh.ethics@health.sa.gov.au

Appendix 3

Woman participant information sheet

Woman-Participant Information Sheet

Lyell McEwin Hospital

Title	<i>Talk about Birth: Interaction in Antenatal Consultations</i>
Short Title	<i>Talk About Birth</i>
Coordinating Principal Investigator/ Principal Investigator	<i>Ms Lindsay Cole</i>
Associate Investigator(s)	<i>Associate Professor Amanda LeCouteur (University of Adelaide) Professor Hannah Dahlen (University of Western Sydney)</i>
Location	<i>Lyell McEwin Hospital</i>

Part 1 What does my participation involve?

1 Introduction

You are invited to take part in this research project, which is called *Talk about Birth*. You have been invited because you are currently scheduled to attend a 32-36 week antenatal consultation where you will be invited to discuss the up-coming birth. Your contact details were obtained from your midwife.

This Participant Information Sheet/Consent Form tells you about the research project. It explains the processes involved in taking part. Knowing what is involved will help you decide if you want to take part in the research.

Please read this information carefully. Ask questions about anything that you don't understand or want to know more about. Before deciding whether or not to take part, you might want to talk about it with a relative, friend or local health worker.

Participation in this research is voluntary. If you don't wish to take part, you don't have to.

If you decide you want to take part in the research project, you will be asked to sign the consent section. By signing it you are telling us that you:

- Understand what you have read
- Consent to take part in the research project
- Consent to be involved in the research described
- Consent to the use of your personal and health information as described.

You will be given a copy of this Participant Information and Consent Form to keep.

2 What is the purpose of this research?

The study is part of research towards a PhD being undertaken by Ms Lindsay Cole at The University of Adelaide that is designed to increase knowledge about how childbirth is planned and experienced in Australia.

This research aims to add to our understanding of the use of maternity services by women. Specifically, it involves looking at how women and midwives talk about various issues to do with childbirth.

3 What does participation in this research involve?

If you agree to participate, you will be asked to sign a consent form agreeing to the audio-recording of your appointment today. Nothing else will be required from you. Please note that whether or not you decide to participate will not affect the care or services provided to you at the clinic in any way. The recording of your appointment will be transcribed by Lindsay Cole, and included in a collection of such recordings, which will then be analysed for patterns and similarities in how women talk about their childbirth preferences. Once the research team has analysed all the data, a report of the findings will form part of Lindsay's PhD thesis. Results from this study may be used in publications and presentations.

This research project has been designed to make sure the researchers interpret the results in a fair and appropriate way.

There are no costs associated with participating in this research project, nor will you be paid.

4 Do I have to take part in this research project?

Participation in any research project is voluntary. If you do not wish to take part, you do not have to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage.

If you do decide to take part, you will be given this Participant Information and Consent Form to sign, and you will be given a copy to keep.

Your decision whether to take part or not to take part, or to take part and then withdraw, will not affect your routine care, your relationship with professional staff or your relationship with the clinic.

5 What are the possible benefits of taking part?

There will be no clear benefit to you from your participation in this research.

6 What if I withdraw from this research project?

If you do consent to participate, you may withdraw at any time. If you decide to withdraw from the project, please notify a member of the research team before you withdraw. If you do withdraw, you will be asked to complete and sign a 'Withdrawal of Consent' form, which will be provided to you by the research team.

7 What happens when the research project ends?

Once the study is complete, a paper will be prepared for publication. If you would like a copy of the article, or a summary of results, please contact Lindsay Cole, who will send it to you.

Part 2 How is the research project being conducted?

8 What will happen to information about me?

By signing the consent form you agree to the research team collecting and using personal information about you for the research project. Any information obtained in connection with this research project that can identify you will remain confidential. Personal information collected will be used to describe the women participating in the study. Personal details will not be linked to the recording of your appointment. Details such as names of people or locations that might occur in the recordings will be replaced by pseudonyms in the transcription, analysis and reporting stages of the research.

Your information will only be used for the purpose of this research project and it will only be disclosed with your permission. The personal information that the research team will collect and use involves the age-range and number of previous births of women who participate.

It is anticipated that the results of this research project will be published and/or presented in a variety of forums. In any publication and/or presentation, information will be provided in such a way that you cannot be identified.

Any information obtained for the purpose of this research project that can identify you will be treated as confidential and securely stored. It will be disclosed only with your permission.

9 Who is organising and funding the research?

This research project is being conducted by The University of Adelaide in collaboration with the Northern Adelaide Local Healthcare Network (NALHN).

10 Who has reviewed the research project?

All research in Australia involving humans is reviewed by an independent group of people called a Human Research Ethics Committee (HREC).

The ethical aspects of this research project have been approved by the HREC of The Lyell McEwin Hospital.

This project will be carried out according to the *National Statement on Ethical Conduct in Human Research (2007)*. This statement has been developed to protect the interests of people who agree to participate in human research studies.

11 Further information and who to contact

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Research contact person

Name	Lindsay Cole
Position	PhD Candidate/principal researcher
Telephone	
Email	lindsay.cole@adelaide.edu.au

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Reviewing HREC approving this research and HREC Executive Officer details

Reviewing HREC name	TQEH/LMH/MH Human Research Ethics Committee
HREC Executive Officer	Heather O'Dea
Telephone	
Email	Qeh.ethics@health.sa.gov.au

Appendix 4

Consent form

**THE UNIVERSITY OF ADELAIDE HUMAN RESEARCH ETHICS COMMITTEE
STANDARD CONSENT FORM
FOR PEOPLE WHO ARE SUBJECTS IN A RESEARCH PROJECT**

1. I,, consent to take part in the research project entitled 'Talk about Birth'
2. I acknowledge I have read the Information Sheet entitled 'Talk about Birth'
3. I have had the project, so far as it affects me, fully explained to my satisfaction by the research worker. My consent is given freely.
4. Although I understand that the purpose of this research project is to improve the quality of medical care, it has also been explained that my involvement may not be of any benefit to me.
5. I have been given the opportunity to have a member of my family or friend present while the project was explained to me.
6. I have been informed that, while information gained during the study may be published, I will not be identified and my personal results will not be divulged.
7. I understand that I am free to withdraw from the project at any time and that this will not affect medical advice in the management of my health, now or in the future.
8. I am aware that I should retain a copy of this Consent Form, when completed, and the attached Information Sheet.

.....
Signature

.....
date

WITNESS

I have described to the nature of the procedures to be carried out. In my opinion she understood the explanation.

Status in Project.....

Name.....

Signature

date

