

**The experience of vaginal breech birth**  
**A social, cultural and gendered context**

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A thesis submitted in partial fulfilment of the requirements of the University of  
Brighton for the degree of Doctor of Philosophy

July 2015

## **ABSTRACT**

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Breech birth has become a rare phenomenon in England over the last two decades. 3-4% of all babies present bottom or feet first at full term (37-42 weeks gestation) and despite conflicting research about the safest mode of delivery for breech presentation, the vast majority of breech babies will be delivered by planned caesarean section. The small number of qualitative research studies suggest that the experience of breech has complex meanings for childbearing women. This research intended to explore these elements further and to better understand this experience within a social, cultural and gendered context.

A social constructionist theoretical framework with a feminist post-structural position guided the research design. A research case study methodological approach was adopted drawing from different sources to understand the case of vaginal breech birth experience. Participants from the South of England included eleven women who had given birth to breech babies, either at hospital and home, six midwives and two obstetricians who had provided care for women giving birth to breech babies. Thematic content analysis was used during and following the collection of data, which comprised of in-depth interviews as the primary source of data and documentary analysis as secondary contextual data.

Vaginal breech birth is a challenging journey, best understood as three interconnected spaces shaped by the complex social relationships and cultural and gendered context of childbirth. Four themes emerged: Losing the way; Fighting fear and seeking trust; Deciding the right path to follow; and Towards a place of safety. These themes define the experience as one of moving between significant phases of Disrupted space, Uneasy space and Third space. The findings indicate that the prevailing risk paradigm has marginalised breech, disrupting the childbirth journey and creating a deep sense of loss. Vaginal breech birth eludes the narrow polarities of medicalised childbirth and natural birthing, fitting into neither and troubling both. The navigation of these messages is central to the uneasy space, which is a time of pause and consideration with a strong desire to hear different voices to that of a dominant medical view. This provides an opportunity for a less bounded form of birth where individuals seek to prioritise safety in the creation or holding of safe spaces, albeit temporarily and with some compromises. In working to address these challenges, care providers should consider broadening the options available to all women, working together as a team to create safe spaces for the multiple birthing options that women require.



## CONTENTS

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ABSTRACT.....	2
TERMS AND ABBREVIATIONS .....	8
ACKNOWLEDGEMENTS .....	10
DECLARATION .....	11
INTRODUCTION TO THE THESIS.....	12
CHAPTER 1: LITERATURE REVIEW.....	15
1.0 Introduction.....	15
1.1 UK Healthcare and Contemporary childbirth.....	16
1.2 Breech Birth.....	26
1.2.1 Breech birth care, management and skills .....	37
1.2.2 The experience of breech birth .....	40
1.2.3 Researcher's perspective.....	44
1.2.4 Summary .....	46
CHAPTER 2: THEORETICAL PERSPECTIVES .....	48
2.0 Introduction.....	48
2.1 Philosophical position .....	49
2.2 Theoretical Framework.....	50
2.3 Feminist research.....	54
2.4 Summary.....	60
CHAPTER 3: METHODOLOGY.....	61
3.0 Introduction.....	61
3.1 Research design.....	62
3.2 Research questions.....	64
3.3 Introduction to the research methodology approach.....	66
3.3.1 Feminist research and methodological approach .....	67
3.3.2 Research Case Study.....	69
3.3.3 Considerations with using research case study .....	76
3.3.4 Consideration of alternative research methodologies .....	78
3.4 Summary.....	81
CHAPTER 4: METHODS .....	82

4.1 Introduction.....	82
4.2 Data collection.....	82
4.2.1 Feminist approach to data collection.....	82
4.2.2 Site and Populations Selection .....	83
4.2.3 Data Gathering Methods .....	87
4.2.4 Recruitment and consent .....	88
4.2.5 Interviews.....	92
4.2.6 Documents and documentary analysis .....	95
4.3 Data analysis.....	97
4.3.1 Introduction.....	97
4.3.2 Thematic content analysis.....	97
4.3.3 Coding.....	99
4.3.4 Themes and development of findings chapter.....	102
4.3.5 Reflecting and reflexivity .....	103
4.4 Ethical considerations.....	105
4.5 Summary.....	109
CHAPTER 5: RESULTS OF THE ANALYSIS OF THE DATA.....	110
5.1 Introduction.....	110
5.2 Losing the Way .....	113
5.3 Fighting fear and seeking trust .....	122
5.4 Deciding the right path to follow .....	135
5.5 Towards a place of safety .....	147
5.6 Summary.....	162
CHAPTER 6: DISCUSSION.....	165
6.1 Introduction.....	165
6.2 Disrupted Space.....	169
6.3 Uneasy Space.....	182
6.4 Third space.....	198
6.5 Summary.....	209
CHAPTER 7: CONTRIBUTION, REFLECTIONS AND LIMITATIONS.....	211
7.1 Introduction.....	211
7.2 Contribution to knowledge.....	211
7.3 Limitations of the research .....	214
7.4 Personal reflections on the research .....	216

<i>7.5 Implications for practice and further research areas</i> .....	217
7.5.1 Implications for childbearing women .....	218
7.5.2 Implications for health professionals .....	219
7.5.3 Implications for Maternity care provision .....	221
7.5.4 Implications for further research .....	223
<i>7.6 Concluding remarks</i> .....	224
REFERENCES .....	226
APPENDICES.....	242
Appendix 1: Extract from tables .....	243
Appendix 2: Examples from code book.....	245
Appendix 3: Examples of analytical memo .....	246
Appendix 4: Myself and this research.....	248
Appendix 5: Reflexive Diary Extracts .....	250
Appendix 6: Consent Form.....	252
Appendix 7: List of documents included in documentary analysis .....	254
Appendix 8: Letter to Partner/Birthing Partner .....	255
Appendix 9 : Interview Prompt Questions.....	256
Appendix 10: Initial thoughts following interview.....	258
Appendix 11: An extract of the documentary analysis .....	260
Appendix 12: Summary Letter of Approval .....	263
Appendix 13: Information Sheet .....	272
Appendix 14: Overview of locally reported breech births .....	284
Appendix 15: Resources Sheets .....	285
Appendix 16: Poster for NHS Professionals .....	287

## **LIST OF TABLES**

Table 1: Summary of different types of case study. Adapted from (Simons, 2009)..	73
Table 2: Characteristics of participants – women who had given birth to a breech baby .....	91
Table 3: Characteristics of participants – health professionals.....	91
Table 4: Examples of raw data to code, to category, to theme.....	101
Table 5: Examples of raw data to code, to category, to theme.....	102

## **LIST OF FIGURES**

Figure 1: Social constructionism as theoretical framework.....	54
Figure 2: Research design summary.....	63
Figure 3: Categories, Themes and Constitutive Pattern.....	112
Figure 4: Summary Diagram of Findings.....	164

## **TERMS AND ABBREVIATIONS**

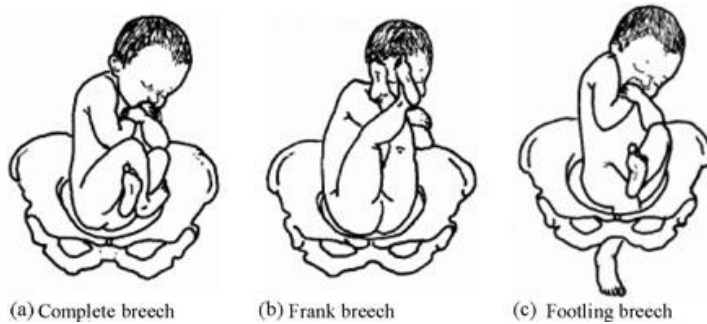
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For the purposes of clarity all terms and abbreviations will be described and explained through footnotes throughout the thesis. Language is intertwined with culture and for consistency a number of terms will be used throughout the thesis that I will introduce at this point.

**Birth** will be the word that I choose to describe childbirth apart from when citing literature that uses the term delivery, or when the descriptive act is one of the delivering of a baby. Birth and birthing is a unique descriptor implying a woman is an active participant in her birth, whereas delivery is a generic passive descriptor (for example, parcels and pizza get delivered) where someone other than a woman controls or facilitates the delivery of her baby. Further, the term **health professional** in this thesis includes both medical, nursing and midwifery staff, sometimes referred to as clinicians in literature. Maternity or health care workers relate to qualified (health professionals) or non-qualified (for example doulas - a birth companion and supporter who assists a woman before, during and/or after childbirth but who has no professional qualifications) staff who provide care.

**Breech** is a descriptor of the presentation of the part of the baby in relation to the mother's pelvis. Most babies enter the maternal pelvis head first (cephalic), but 3-4% of babies at term (37-42 weeks gestation) enter bottom or feet first into the maternal pelvis, known as breech (Goffinet, et al., 2006). There are three types of breech presentation: flexed or complete breech (hips flexed with knees flexed), extended or frank breech (hips flexed, legs extended) and footling breech (hips less flexed or not flexed with feet beneath the baby's bottom). Of these the most common is the frank breech presentation (Steen & Kingdon, 2008). The presentation of the baby may change throughout pregnancy as the baby moves, but by 36 weeks gestation if the baby is found to be breech then the recommendation is to offer women an External Cephalic Version (ECV), which is external manipulation of the baby through the maternal abdomen from breech to cephalic presentation (Royal College of Obstetrics and Gynaecology, 2006). However, this element will not be covered in the scope of this thesis as it is a considerable topic in itself.





(World Health Organisation, 2007)

**Feminism** has a wide variety of definitions and has evolved and diversified. Elements of this substantial and complex body of knowledge will be referred to within and inform this thesis (see Chapter 2.3) but my condensed understanding of feminism refers to a diversity of beliefs, ideas, movements and agendas for action based specifically around what society and culture is like for women. As a feminist, my thesis is underpinned by this broad principle with an intention that this work will help to actively contribute towards social change.

**Gendered** refers to the socially-constructed roles, behaviours, activities, and attributes that a given society considers appropriate for men and women.

## **ACKNOWLEDGEMENTS**

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I would like to express my sincere thanks to my supervisors Dr Val Hall, Dr Kay Aranda and Dr David Crook for their time, patience, guidance and support. It has been a significant and substantial journey for me and I have been very lucky to have benefitted from their expertise, knowledge and pastoral support.

Thanks also to the research support team at the University of Brighton, in particular Glynis Flood and Fiona Sutton for their patience and practical help over the last 6 years.

I would also like to thank my family for their patience, unending support and understanding, especially through the dark times. Thanks to my mum and dad, Clodagh and Richard, for their proofreading, and to my mum for helping me out with the transcribing. I always wanted to make you proud.

Thanks to Caroline Hare for doing the final proof with appreciated speed and diligence.

I would also like to thank my in-laws, Marian and Peter, for their genuine interest, support and tolerance of study time.

My deep gratitude goes to all the people who offered to participate in this study. I am grateful for the generous giving of their time, and for their openness with their stories and thoughts. Their voices are at the center of this research and from them I have learnt so much.

My final thanks are to my tolerant and understanding wife, Justine, who has shown the most patience and love I could have asked for. She has been a rock of support and encouragement and I am indebted to her forever and ever thankful for the help and strength she has offered along the way.

## **DECLARATION**

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I declare that the research contained in this thesis, unless otherwise formally indicated within the text, is the original work of the author. The thesis has not previously been submitted to this or any other university for a degree, and does not incorporate any material already submitted for a degree.

Signed: \_\_\_\_\_

Dated: \_\_\_\_\_

## **INTRODUCTION TO THE THESIS**

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Healthcare is a central element of modern society, and is both the creator and influencer of changes that have a range of macro level (national policy) and individual level consequences. Shaped by numerous evolving ideas and powerful drivers, healthcare mirrors the society within which it is situated, and can shape it in return. As it affects nearly everyone within modern society, healthcare provides an ideal reflection of the complex social, cultural and gendered world that we inhabit. In western countries, healthcare medicine and medical research is a strong determinant in the way that healthcare is provided, managed and valued. Whilst large scale medical research has brought many significant improvements to health and healthcare (for example, the considerable developments in HIV/AIDS prevention and treatment as a result of large randomised controlled trials in Africa (Zani, et al., 2011)), a recent shift towards a more neoliberal philosophy is altering the traditional relationships between healthcare providers and the consumers of healthcare. These changes provide us with opportunities for new insights into the challenges and influences that social relationships have on shaping healthcare provision and individual experiences.

These evolving tensions are being noticed within the field of maternity care, where the complex social phenomena of childbirth and motherhood are still only just beginning to be explored. With much of the current medical research on childbirth focussed on reducing morbidity and mortality through larger scale studies (Walsh, 2010), research that links the wider social, cultural and gender context of health, and provides an understanding of how experiences are shaped and produced, is still in its infancy (Longhurst, 2008). Feminist geographers have contributed to debate on gender and women's healthcare, exploring unequal power relations and acknowledging Judith Butler's (Butler, 1990) work to consider how 'real' bodies occupy 'real' places (Longhurst & Johnston, 2014). This also provides a wider consideration on how women and maternal bodies are represented by and contribute to the social and cultural spaces they inhabit.

Alongside this, the influences of medical litigation, increased technology and a desire for convenience (both for consumers and medics) have driven a more surgically-based birth culture. With this background, obstetric research has focused on finding

the safest way to manage the problem of breech. A single randomised trial (Hannah, et al., 2000) purported to provide the answer that planned caesarean section was safer for breech presenting babies, and this led to changes in clinical management that were adopted in UK maternity services with an unprecedented swiftness in the subsequent years. Despite national guidelines (Royal College of Obstetrics and Gynaecology, 2006) and local clinical protocol, which recommend that breech presenting babies should be born by caesarean section and under obstetric care, a few women continue to birth their breech presenting babies vaginally. Some women make an informed choice during pregnancy to have a vaginal breech birth, but for others the decision is made during labour due to late discovery of the baby's breech presentation. Whether breech birth occurs unexpectedly or as planned, at home or in a maternity unit, with care by a midwife or an obstetrician, this is an uncommon event that challenges concepts of normal birth and the current risk paradigm that is the central tenant of medicalised childbirth.

The specific circumstance of birthing a baby that presents breech, rather than the more common cephalic presentation, provides a unique opportunity for exploring how the social, cultural and gendered context shapes and is shaped by an unusual birth experience.

This thesis tells a story of the experience of breech birth from the perspective of women who have given birth to a breech presenting baby in recent years, and midwives and obstetricians who have provided care for women giving birth to breech presenting babies. The research has been considered and designed to ensure the approach, methodology and methods used were considered to be the most appropriate to address the aims of the research most fully.

The first part of the thesis will provide an introduction to the research, drawing attention to a gap in current knowledge and establishing a rationale for this study. Following this, the theoretical perspective, methodology and methods of the study design will be offered. Finally, the findings from the analysis of the data, a discussion of the new concerns that have emerged from the findings, and considerations of the implications for practice, will provide the concluding chapters.



## **CHAPTER 1: LITERATURE REVIEW**

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### **1.0 Introduction**

This chapter will present a critique of the current relevant literature. It will give context to the subject of this research and establish a gap in the existing literature, providing a rationale for the study. To begin this, the review will establish the broad social<sup>1</sup> and cultural<sup>2</sup> elements of current health care provision and discuss the implications of neoliberalist philosophies on health care and contemporary maternity care. Literature from the field of feminist geography will draw together the concepts of gender, space and place relating to childbirth and maternity care, to offer a spatial perspective on how these profound experiences and the bodies within them are shaped and created. The review will then turn to the specifics of breech, the implications of this on current maternity care provision, and current literature on the experience of breech birth. Finally the chapter will conclude with an overview of the researcher's experiences as a clinical midwife, which provided a professional rationale that was a considerable driver for this study. The literature will be revisited within the discussion section as new concepts arising from the analysis of the data are developed and presented.

A comprehensive review of the literature was undertaken at the beginning of the research and repeated several times throughout the study to ensure emerging research was included. The searching strategy included identifying subject-relevant keywords, keywords identified by other authors, and keywords that emerged through the data collection stage. Boolean logic operators combined keywords to both broaden and narrow the search as required. An e-mail alert was commenced to enable any more research specifically relating to breech birth to be flagged up as it was published, to ensure that new knowledge contribution was included for consideration. The review of the literature was revisited throughout the research as avenues of thought and direction opened and changed during data collection and analysis. The PRISMA checklist was referred to when critiquing randomised

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<sup>1</sup> Characteristics and interactions of groups or populations of humans

<sup>2</sup> Ideas, customs and social behaviours of a society

controlled trials, systematic review or meta-analysis in order to increase the rigour of the literature review (Moher, et al., 2009).

## 1.1 UK Healthcare and Contemporary childbirth

Healthcare has been subject to monumental changes in the last few decades ranging from the economic pressures from the recession (Drummond, 2013), technological improvements and data access (Shah, 2014), organisational failings leading to public enquires (Francis, 2013), wide scale reforms (Dixon, 2011) and increasing regulation and scrutiny (Care Quality Commission, 2010). In essence healthcare can be seen as a reflective microcosm of the wider society. In this challenging landscape, healthcare responds to the shifting requirements, seeking to appease and improve with rising resource demands from an increasingly elderly population and mounting financial deficits. The last fifteen years has seen radical changes to the healthcare market, both in the UK and globally (Gilbert, et al., 2014). Whilst there is still debate about how these changes are affecting both consumers and providers of health care, there appears to be a neoliberal philosophy that is underpinning and driving these events (Sandall et al, 2009; McGregor, 2001). Following a period of technocratic medical dominance, the late 1960's and 1970's brought capitalism to the fore sparking

*“a general lessening of trust in professional authority, an unprecedented decline in respect for medicine, and a growing recognition of the emotional, social and spiritual components of life and healing. This shift found expression in, amongst other things, a birthing consumer movement, which promoted birth as a natural biological process... and made the case for different approaches to childbirth”* (Benoit, et al., 2010, p. 476)

The trend of neoliberalism from the 1980's onwards appears to have '*altered traditional relationships between states, markets, health professionals and their public(s)*' (Sandall , et al., 2009, p. 531) with the UK focussing on the neoliberal concept of consumerism and the promotion of patients' rights to choice and individualised care (Department of Health, 2004). Neoliberalism is not a fixed concept; rather, its meaning has changed over the years, and now it is viewed as a process dependent on a variety of factors and different social and political



geographies (Benoit, et al., 2010). However, within this are some simple concepts of individualism, consumerism and decentralisation (McGregor, 2001) which are often seen to be at odds with persistent medical dominance. Benoit et al's (2010) review of Australian and Canadian maternity care provision reforms suggest that these have not, in fact, substantially altered the position of the medical profession in the provision of services, and in recent times childbirth is increasingly medicalised<sup>3</sup>. Indeed, the ability for the medical profession to utilise the reforms to maintain and increase their dominance is a sign of how deeply embedded and resilient the medical profession is, and how these ideas of birth have become embedded within maternity care and wider society.

The UK also experiences similar trends to Australia and Canada, although without the issue of private health care. Sandal et al (2009), describe how obstetrics has adapted by offering specialisation, expertise and diversification into the arenas of fetal medicine and reproductive health (p539). The increasing delineation between the professional boundaries of 'low risk' midwifery care and 'high risk' obstetric care has not diminished professional tensions about jurisdiction. Breech presentation has been caught up in this; from historically being viewed as a variation of normal and well within the care of midwives, breech has been redefined as 'high risk' and under the realms of obstetrics. Current policy concerns about patient safety mean outcomes and performance are highly scrutinised, contributing to the maintenance of high caesarean section rates for breech. More recently, with consumer demand there has been the development of pockets of (self-declared) experts or specialists in breech care (for example: <https://breechmidwife.wordpress.com/clinical-support-at-breech-births>, accessed June 2014). However, there is ongoing debate in clinical settings regarding the definition of expertise, which health professional is allowed and able to be the expert, and indeed how much experience would be required to be deemed competent (Cronk, 1998) (Van Roosmalen & Meguid, 2014).

The social construct of health and sickness offers important links to the relationships between gender, race and class. Women share the reality of occupying, to a greater or lesser extent, subordinate positions to men in most social and cultural settings and have therefore a common shared experience (Harding, 1991). These

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<sup>3</sup>To identify childbirth as being a disorder requiring medical treatment or intervention.

relationships play out in subcultures of healthcare, and maternity services are no different. Reiger's (2008) work on the professional relationships between midwives and obstetricians in Australia exemplifies the ongoing tensions between these two groups and the consequential effect on the women they were providing care for:

*“Midwives wanted doctors to acknowledge and respect them, not just as individuals but professionally. Doctors wanted their specialist training, experience and professional judgment recognized and to be treated as individuals rather than as authoritarian meddlers in normal processes. Yet both groups also reported tensions, distance and antagonistic relationships. A midwife pointed to the power dynamics involved, saying that like many midwives, she was: ‘very much anti-obstetrician, because they were bad, we were good. The women were somewhere in between...there was the tug of war between the power at the top, not the power of the woman (Midwife tertiary unit)’”* Reiger, 2008, p135

Reiger acknowledges that whilst recent neoliberal reforms and the prolonged staff shortages have encouraged more collaborative ways of working, the deeply entrenched institutionalised systems of maternity care provision limits this cooperation, as medicine continues to maintain a powerful hierarchy. She concludes that *‘patterns of medical dominance are reinforced through psychological patterns, underlie interpersonal interactions and are quite literally built into the maternity systems organization of space and time’* (Reiger, 2008, p146). Whilst Australian maternity care is different from that of the UK, as it includes considerable private health care, it is one of the more comparable countries in the world in terms of approach, delivery and complex inter-professional relationships.

In a similar way, there have been some practical attempts in the United Kingdom to empower woman and their choices. For example, midwives being the first and main point of contact for pregnancy, with a manifesto target of increasing midwifery-led units and births at home, and reducing inequalities but providing better experiences and outcomes for marginalised women (Department of Health, 2007). Despite this, there is limited evidence to see the effect of these political changes. Homebirth rates remain low at 2.3% in 2013 (unchanged from 2012, Office for National Statistics,

2014) with no improvement in outcomes for the baby (Health and Social Care Information Centre, 2013. ).

There can be no doubt that the development of technology- and science-driven developments have had some positive influences on the management of disease; for example, the discovery of drugs to significantly lower the transmission rate of HIV from affected mothers to babies whilst in utero and around the time of birth has significantly reduced morbidity rates. However, there are ongoing debates around the overall effects of technology and medicalisation of health on a broader scale (Cahill, 2001) with gender relations being a central consideration for feminist writers. The effects on women and women's health are well-considered through the seminal work of Robyn Davis-Floyd (1987), Ann Oakley (1989) and Sandra Harding (1991), and concerns have been voiced about the disempowering concept of the medical risk narrative<sup>4</sup> on women. Unlike other paradigms which embrace multiple healing modalities, there is a concern that medicine tends to be '*oblivious to anything other but its own direct influence on birth and any perceived resistance to it*' (Lee & Kirkham, 2008, p. 462).

Anne Oakley's important work on women's reactions to childbirth was a formative piece of research that placed birth in a social context and contributed to an understanding of how a women's situation is different from a man's in modern society, and how society and culture completely shapes perceptions, approaches and institutions of pregnancy and childbirth (Oakley, 1980). The study clearly shows that contemporary medicalised childbirth leads to women expressing considerable dissatisfaction and discontent. Oakley's findings were supported by other research that suggests that women lack power within health care settings and may have difficulty getting enough information, and that doctors are often seen as unwilling to let women speak for themselves or have involvement in vital clinical decisions, leaving many women feeling distressed and demeaned (O'Sullivan, 1987). Similarly, Mary Stewart's (2001) research found that in health care women commonly yield to the clinician, complying with the hierarchical relationships that are inherent within health care systems. Mary Stewart's work also confirmed Oakley's work that women

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<sup>4</sup> Model of medically defined risks emphasising the expert clinician, evidence based knowledge, risk prediction and risk control (Lupton, 1999)

had concerns and frustrations about their lack of empowerment and control over their own bodies. This literature does not only highlight issues about the medicalisation of birth, but also supports the notion that birth is an experience within a broader social, cultural and gendered context.

The medical dominance of birth has been a source of critique and challenge from the feminist literature (Crossley, 2007) that acknowledges or pays attention to the complex politics within the current system of maternity care (Department of Health, 1993). Feminist literature postulates that the first step to medicalisation was the definition of the male body as the standard against which all else is judged (Rudolfsdottier, 2000) leading to the medical construction of women's bodies as deviant, substandard, abnormal and pathological (Lee & Kirkham, 2008). Further, feminists proposed that pregnancy and childbirth were being redefined by medicine, being seen as a disease, '*inherently pathological – a clinical crisis worthy of active intervention*' (Cahill, 2001, p. 334). Crossley (2007) proposes that the success of medicalisation of childbirth relied on constructing birth as a situation of inherent risk requiring expert technical management by specialist obstetricians. Feminist literature raises concerns that increasing technology has led to an objectification of women and childbirth as a mechanical process, with the overemphasis on physiology and risk management as justification for further control (Davis-Floyd, 2001). Childbirth statistics represent an increasingly interventional approach to birth, with caesarean section rates steadily rising from 9% in 1980 to 26.3% in 2013/14, with breech presentation making up for 11% of all caesarean sections (NICE, 2014). However the rising number of caesareans for maternal request, now 7%, suggests there may be changes to the demographics of the childbearing population, such as childbearing at a later age and use of assisted conception, that are contributing to the high rates (NICE, 2014). However, it could also be argued that the prevailing medical narrative is becoming increasingly legitimised within society and some women are using it as a form of neoliberal consumerism to plan and control their own birth experiences, in this case by caesarean delivery.

However, the medicalisation of childbirth has been criticised not only for its adverse effects on women's satisfaction with their birth experiences, but also for the social implications of disempowering women and the subordination of other providers of

maternity care (birth workers such as midwives and doulas) who are predominately female (Benoit, et al., 2010). Kirkham (1999) suggests that placing birth in the institution of a hospital which is considered to have been constructed and organised on masculine ideas and ways of seeing the world has led to tense gender relations between health professionals and between maternity care providers and childbearing women. Kirkham adds that, as a consequence, concerns have been raised about the subsequent muting, alienation, concealment and unmet needs and expectations of women (p. 45). Medical science rarely examines these factors and issues and can offer little help in explaining or understanding why individuals differ and respond differently to consultations, treatments or care (Doyal, 1995). Nevertheless, these critical relationships shape social behaviours and culture as well as the places and spaces they inhabit, the study of which is known as social geography.

Social geographers have used the platform of '*the study of people and their environment with particular emphasis on social factors*' (Oxford Dictionary, 2014) to try and gain insights commonly neglected by medical research. The study of social geography provides a lens through which the multitudes of elements (such as gender, class and race) that construct and are constructed by society are considered and the interrelationships between them attempted to be understood. Social geography allows the study of '*social beings evolving around the institutions of society, the production and reproduction of social relations, institutions and practices*' (Massey, 1994, p. 221), but for it to be reflective of that society, it needs to include and study the full breadth of diversity within it. Indeed, social geography offers rich opportunities for this study to consider how childbearing women are produced and re-produced through the places and spaces they inhabit, giving voice to what feminists consider previously-ignored bodies (Longhurst, 2008).

The history of social development and human activity is considered by feminist writers to be defined by the male gender, with authors claiming that this had led to groups such as women being 'hidden from history' (Rowbotham, 1979 *IN* McDowell and Sharp, 1997; p19). Reflective of this is that it has only been in more recent years that women and women's' lives have started to be considered and studied. Gender, within the context of social geography, is now challenging previous held assumptions about how society was seen and presented through a male-gendered methodology

and bias. By exploring social geography through a gendered lens, feminist authors not only consider the daily lives of women but also '*take[...] into account the socially created gender structure of society*' (McDowell & Sharp, 1997, p. 20). Feminist social geography enables a more thorough focus on what it is to be a woman<sup>5</sup>, how cultural understandings of the category 'woman' vary through space and time, and how these understandings relate to the position of women in different societies. More recently feminist social geographers have focused on the gendered body and gender relations, with maternal bodies becoming a core component to this area of research (Johnson, 2008; Manderson 1998). Manderson describes the developing thoughts on maternity and childbirth:

*"feminist scholarship has turned from the initial problem of the role of maternity in defining femaleness to interrogating its place in the social relations between men and women and among women, the meanings with which maternity as experience and status are imbued, and the tensions and accommodations of reproduction and production institutionally and personal in different place and under different systems of production"* (Manderson, 1998, p. 26)

This draws from Judith Butler's influential work on gender in which she argues that it is '*the repeated stylization of the body, a set of repeated acts within a highly rigid frame that congeal over time to produce the appearance of substance*' (Butler, 1990, p. 33). This notion that gender is a constant process of performativity, seen as a production of social interrelationships that embed them within the structures of society, makes gender dynamic and contingent on context. This feminist social geographical lens sees maternity as complex and social, constituted in relations of power inseparable from the spaces and places in which they exist (Longhurst, 2008). Adopting this lens for this research which seeks to explore the social, cultural and gendered context of a specific birth experience is beneficial. This means that the breech birth becomes much more than a biological process, and can be seen as a dynamic process: multiple, fluid, contextual and situated in time and space. The social relations within these childbirth spaces shape structures and systems such as

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<sup>5</sup> It is acknowledged that there is an entire body of work on this subject alone (Longhurst & Johnston, 2014) which will only be explored in a limited way in this research (for further work see Massey, 1994; Belenky et al, 1997; Longhurst, 2008, Low, 2006)

maternity care which then become embedded in societies. Space is certainly '*on the agenda*' (Massey, 1994, p. 249) and provides a useful platform from which to consider and explore the breech birth experience.

The places and spaces where birth occurs are a component of modern childbirth that represent more than the physical location, but also the social and cultural meanings of different places and the subsequent effect on the relationships within them. The move from home to hospital as the main location for birth in the majority of the western world and the exponential rise in the use of technology and intervention was largely without evidence base or evaluation. Whilst perinatal morbidity and mortality<sup>6</sup> have decreased significantly over this time, being widely assumed to be attributable to medical advances, writers have argued that improvements in environmental factors, sanitation and nutrition were possibly far more influential in improving the health and wellbeing of childbearing women and babies (Crossley, 2007). A recent large prospective cohort study, the Birthplace in England Study, suggested place of birth did have some impact on perinatal outcomes. It concluded that healthy multiparous<sup>7</sup> women with low risk pregnancies have an increased likelihood of intervention when giving birth in an obstetric unit (hospital) and healthy nulliparous<sup>8</sup> women with low risk pregnancies have a slightly increased likelihood of adverse perinatal outcomes when planning birth at home (Walton, 2012). However, this study had an overall message that the incidence of perinatal adverse outcomes were low in all birth settings, reopening the discussions about why homebirth rates remain low. Furthermore, this research effectively excludes women with the focus, as with many childbirth researches, on the outcomes for the baby. Exploring the birth experience from a woman's perspective through the elements of society, culture and gender would help to provide context and a fuller understanding to the emerging research in this area and this is where feminist social geography and its spatial frameworks can bring benefit to this research.

How space is conceptualised is one of the ways that we understand and experience the world; lived practices, symbolic meanings and significant places and spaces

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<sup>6</sup> Perinatal mortality relates to the number of stillbirth and deaths in the first week of life (World Health Organisation, 2014). Morbidity relates to a state of ill-health, sickness, injury or disease.

<sup>7</sup> A woman who has previously birth

<sup>8</sup> A woman who has not previously given birth

become more comprehensible (Massey, 1994). Space has many assumed meanings which vary greatly, but for the purposes of this study the following description by McDowell provides clarity:

*“Spatial relations and the layout, the differences between and within places, the nature and form of the built environment, images and representations of this environment and of the ‘natural’ world, ways of writing about it, as well as our bodily place within it, are all part and parcel of the social constitution of gendered social relations and the structure and meaning of place. The spaces in which social practices occur affect the nature of those practices, who is ‘in place’ and who is ‘out of place’ and even who is allowed to be there at all but the spaces themselves in turn are constructed and given meaning through social practices that define men and women as different and unequal”.*

(McDowell & Sharp, 1997, p. 3)

The literature on space, its meaning and construction is considerable and the scope of this research does not allow detailed review, but some basic elements are presented to enable context. Space has been defined historically as closed, limited and simple, as opposed to time, which is dynamic and changing. However, Massey (1994) provides an alternative view: space is not static, nor time spaceless; space is constructed out of interrelations as the simultaneous coexistence of social interrelations and interactions at all spatial scales, from local to global. Furthermore, Massey offers:

*“Space is created out of vast intricacies, complexities and networks of relations at every scale from local to global. Space is not static as it is created by the dynamic social relations. Space by its nature is conceptualised as being created out of social relations, full of power and symbolism, a complex web of relations dominations and subordination of solidarity and co-operation. Space has been referred to as power-geometry. It is not a slice through time, flat or static. It has both order (social phenomena e.g. ways of working in a hospital) and chaos (independent operation and separate determinations with unintended consequences) (Massey, 1994, p. 266)*



Space offers multiplicity: a possibility of pluralities, of overlapping and of reciprocal relations, that are open and indefinite both in social as well as physical geography (Low, 2006). Space, therefore, is best suited to describe the juxtapositions social lives create and are created by (Massey, 1994). Space has also been seen as gendered; with space distinctly divided between the public (masculine) world of work and private (feminine) domestic home setting (Ainley, 1998, p. 66). In a similar way maternity space and places of birth can also be seen as gendered. However, a view of the institution of hospital constructed as essentially masculine, and birth centres and home essentially feminine, is too simplified. Space is not static, but dynamic, created and influenced by social relations and gendered roles (Longhurst, 2008). Supporting this is a substantial body of research supporting the central notion of the importance of relationships on women's birth experiences (Kirkham, 1999; Lundgren and Berg, 2007). Hunter et al, (2008), consider that it is the *quality* of the relationships that hold maternity care together and raises concerns that this evidence is most often ignored when organising maternity care services. They urge further research in this area stating:

*"We urgently need to pay real attention to the significance of relationships, and consider how best these can be developed, nurtured and sustained"*

(Hunter, et al., 2008)

This highlights once again the importance of examining and understanding social relationships and their impact from a macro level, such as maternity services to an individual experience level. Lundgren and Berg's, (2007), secondary analysis of eight qualitative studies delineated the central concepts of the women-midwife relationship, but acknowledged how these were occurring within a wider context with other influences and considerations, such as organisational systems and political drivers, that need further review and researching. This is therefore established as a gap in our current knowledge, and it is this contextual and situated element that is the central focus of my research. This study intends to explore breech childbirth space and explore how it is constructed and shaped by cultural context and social relations.

Next, the current research on the subject of breech birth will be presented and critiqued.

## 1.2 Breech Birth

Breech presentation and breech birth has not always been seen as a high-risk or abnormal event. There are still midwives and obstetricians practicing today who recall breech babies being routinely born vaginally, usually cared for by midwives and not uncommonly at home. However, anxiety around breech has grown; there are thought to be a number of reasons for this. Marjorie Tew outlined in her book on the history of maternity care, the inexorable rise in medicalisation and the dominance of the medical profession that, by the 1980's led to birth taking place almost exclusively in hospital under medical supervision (1990). Under these auspices breech became under the domain of doctors and their scientifically based treatments providing care that *'provided an excellent medium for replacing the mother's trust in the adequacy of her own physiology to achieve safe reproduction, but trust in the powers of obstetric management to achieve a superior outcome'* (Tew, 1990, p. 10). With increased surveillance in pregnancy and more contact with health professionals women and their pregnancies are under increasing scrutiny. In this way, women and health professionals are far more likely now to know their baby is breech in pregnancy leading to both opportunities for intervention to manipulate the baby to the head down (cephalic) position and to recommend an elective caesarean section if the baby remains breech.

Benna Waites (2003), inspired to write a book on breech after her own personal breech birth experience, suggests that there are four main factors that have changed the way breech is viewed. A higher percentage of breech babies are born with congenital abnormalities than cephalic babies (Kierse, 2002), due to their reduced tone limiting their moving to a head down position. In a similar way, premature born babies are also more likely to be breech and there is the concern that, as the premature baby's head is significantly larger than its body, there is a risk of head entrapment (where the body is born but the head is stuck, often behind the cervix). Both factors of congenital abnormalities and prematurity are associated with higher rates of morbidity and mortality regardless of other factors; however, with breech presentation it has been assumed that outcomes may be made worse by the vaginal

birth, but with no evidence or research to prove this is the case (Vidovics, et al., 2014).

Additionally, the care and interventions around the time of birth will have an effect on birth outcomes and there is continued debate over the best practice approach. The most commonly-voiced concerns about vaginal breech birth tend to focus on head entrapment, described above for premature breech babies. This occurrence is less likely for full term babies as their bottoms are a similar size to the babies' flexed heads as they descend through the birth canal. However, where a baby deflexes its head due to loss of tone from hypoxia (lack of oxygen), or when a health professional pulls the baby's body down during poor management of the birth, this can increase the risk of further interventions and subsequent morbidity or mortality. There is no current research to support either a medically-managed, interventional approach (usually including routine epidural, lithotomy position leaving women immobile and clinician's use of manoeuvres or forceps to deliver the baby) or a spontaneous 'hands off' approach (the mother actively birthing her baby in a position of her choice, and the health professionals supporting but not touching the baby) to vaginal breech. Much of the advice and information around the best practice is based on opinion rather than research, and debate continues as to the risks and benefits of these approaches (Waites, 2003, pp. 119-145).

Research into the experience, care and method of delivery for cephalic birth has been considerable and diverse and includes the fields of sociology and psychology (Yajuan & Shuangyun, 2013). On issues such as the safest mode of delivery for cephalic presentation, research studies have been increasingly convergent in terms of findings, with vaginal delivery being the safer mode of delivery for healthy mothers and babies (Josefsson, et al., 2011). In comparison, care and management for pregnancies with breech presenting babies has been dominated by a single randomised controlled trial, Term Breech Trial, which aimed to discover the safest mode of delivery in terms of perinatal mortality and morbidity (Hannah, et al., 2000). It concluded that it was safer for breech presenting babies to be born by planned caesarean section than a planned vaginal birth. Despite considerable criticisms of the study that will be discussed below, the recommendations were swiftly incorporated into clinical practice leading to a situation where very few women with

breech presenting babies give birth vaginally today (Van Roosmalen & Meguid, 2014). Since 2001, recommendations from the Royal College of Obstetrics and Gynaecology (RCOG) (2001) have advised that all breech presenting babies should be delivered by planned caesarean section. Subsequent research findings in this subject area both align with and oppose this opinion (for example; (Kierse, 2002); (Reitberg, et al., 2005); (Goffinet, et al., 2006); (Kotaska, 2007)), but always with the focus on perinatal mortality and morbidity. The next section of the thesis will present and critique the current research on breech including mode of delivery, care and management, and the experience of breech birth, to provide an overview and context to the current evidence based knowledge in order to identify a gap in the literature and to provide a rationale for the subject of this research study.

Approximately 24,000 babies (Gov.UK, 2010) or 3-4% of all pregnancies (Goffinet, et al., 2006) will be breech presenting at full term every year in the UK and 80% of women with breech presenting babies will choose a planned caesarean section even when the option of vaginal breech birth is offered (Guittier, et al., 2011). Breech presentation, but not breech delivery, has been associated with numerous maternal and fetal conditions, including preterm birth, abnormalities in the amniotic fluid levels, hydrocephalus, anencephaly, congenital malformations that affect fetal movement, uterine abnormalities, placenta praevia and multiple pregnancy (Nelson & Ellenberg, 1986). Additionally higher rates of cord prolapse<sup>9</sup> have been reported for some types of breech presentation<sup>10</sup> (Broche, et al., 2005). Vaginal breech birth had been in slow decline even before the Term Breech Trial (Hannah, et al., 2000), despite a lack of compelling evidence to support this changing approach, but increasing litigation and a decline in training opportunities for doctors were thought to be contributing factors (Yamamura, et al., 2007).

In 2000, Hannah et al published research comparing the risk of planned caesarean section versus planned vaginal delivery of term fetus in breech presentation following

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<sup>10</sup> There are 3 types of breech presentation: extended or frank breech (hips flexed, legs extended), flexed or complete breech (hips flexed with knees bent) and footling breech (hips less flexed or not flexed with feet beneath the baby's bottom). Of these the most common is the frank breech presentation (Steen & Kingdon, 2008). Cord prolapse is more common with non-frank presentations (Broche, et al., 2005)

their Term Breech Trial. This was the largest multicentre international randomised controlled trial undertaken in this subject field to date, and concluded that the perinatal morbidity and serious perinatal morbidity for the planned caesarean section group was lower compared to the planned vaginal delivery group, and that this difference did reach statistical significance (relative risk 0.33, 95% confidence interval 0.19-0.56;  $P < 0.0001$ ). Since this research was published, the number of vaginal breech births has declined dramatically on a global scale (Petrovic, et al., 2008). As an example, in The Netherlands alone caesarean section delivery for women with singleton breech baby rose 50% to 80% within 2 months of the publication of the research (Reitberg, et al., 2005). Steen and Kingdon (2008) note that the '*there is no other area of research that has impacted upon clinical practice in such a short period of time*', with the usual time between publication of research data and changes in clinical practice taking years.

Why this occurred is debatable; Reitberg et al, 2004, suggest that the absolute authority of the research forced the Dutch obstetricians to consider a less individualised self-deterministic approach to breech birth and step in line to create a universal opinion based on a high quality research study. Additionally, it may have been the social legitimisation within the medical field of this particular research that made it so powerful; national bodies such as the American College of Obstetrics and Gynaecology, the Royal College of Obstetrics and Gynaecology, and the Dutch Society of Obstetrics and Gynaecology all swiftly adopted the recommendations into national guidelines, that were subsequently adopted into local practices. Certainly, the findings of this randomised controlled trial reinforced the medicalisation aspect of childbirth that has inexorably increased the intervention and caesarean section rate over the last 50 years. Perhaps this explains why, despite significant criticism of the research by Hannah et al (2000) and publication of subsequent research that provided evidence that vaginal breech birth can be a safe option in certain circumstances (for example Whyte, (2004), Goffinet et al, (2006)), the obstetric recommendation for a planned caesarean section for breech presenting babies remains in place 15 years after publication.

The research by Hannah et al (2000) was long awaited by the medical profession. It is still the only randomised controlled trial to be undertaken on breech birth, and

subsequent meta-analyses (Su, et al., 2003) on the data have reinforced the findings; within the scientific research discourse, this makes it a valuable and influential study. It achieved a required sample size for statistical significance and provided a series of sub-analyses to exclude outliers to be able to demonstrate, with statistical significance, that planned caesarean section improved short-term serious morbidity and mortality outcomes for the babies, and with no difference in serious maternal morbidity or mortality. The findings are supported by three subsequent large retrospective studies comprising more than 170,000 breech deliveries (Gilbert, et al., 2003), (Krebs & Langhoff-Roos, 2003); (Reitberg, et al., 2005). All have concluded that elective caesarean section is safer in terms of neonatal morbidity and mortality for term breech babies (Deans & Penn, 2008). Additionally, in order to substantiate the findings of the study, a further piece of research was undertaken by Su et al (including many of the original researchers for the Term Breech Trial) in 2003, where secondary analyses were undertaken to determine factors associated with adverse perinatal outcome. Using the multiple logistic regression analysis enabled the researchers to consider the effect of variables on perinatal outcomes. Although the findings agreed with the conclusions of the previous research, the findings raised further concerns about the original trial, including the impact of the diversity of management and approaches by the different recruitment centres. Use of oxytocin to augment labour ( $P=0.007$ ) and a long second stage of labour ( $P<.001$ ) were both found to contribute to more adverse outcomes, whereas the presence of an experienced clinician ( $P= .004$ ) reduced the risk of adverse outcome. However, these were management decisions made at the time for each individual situation. Despite this, the secondary analysis did provide an element of assurance about the original findings by excluding some of the controversial cases – such as perinatal deaths prior to randomisation, and lethal abnormalities – from its secondary analysis. Even with these omissions, the results still firmly agreed with the original findings with planned pre-labour caesarean section (odds ratio [OR] = 0.13) having fewer adverse perinatal outcomes than with vaginal birth.

Despite this apparent strength there have been numerous criticisms of Hannah et al's (2000) research method and methodology (Robinson, 2005; Yamamura et al, 2007. These include concerns about violation of the inclusion criteria (Banks, 2001), incompatible variations on the standards of care between participating centres

(Kotaska, 2007), perinatal mortality not relating to the mode of delivery (Kierse, 2002), conclusions that were based on varying and very short term outcomes categories of neonatal morbidity (Glezerman, 2006) and the inclusion of problems related to labour, not mode of delivery (Steen & Kingdon, 2008). Kierse (2002) wrote a critical review of the study which prompted a series of letters from the research authors, who complained his commentary had made '*incorrect assumptions*', '*used statistical analysis inappropriately to make his point*' (Hodnett & Hannah, 2002, p. 217), and had '*factual inaccuracies*' and '*unsubstantiated statements*' (Walkinshaw, 2003, p. 70). Kierse defended his original criticisms, and the debate continues along with concerns echoed in other commentaries about the insufficient data or information published by the authors on which to view the conclusions with confidence (Gyte, 2001).

Certainly, the original trial (Hannah, et al., 2000), and the follow up meta-analysis three years later (Su, et al., 2003), raises concerns about the how the variables, suggested management of the labour and births, and perinatal outcome defined in the study were qualified in terms of their parameters. What is clear is that these parameters, the standards against which findings are measured, sit within the medical paradigm of childbirth (for example; short-term outcomes for neonatal morbidity such as APGAR<sup>11</sup> scores, mode of delivery, accepting the use of drugs to stimulate labour or take away pain in labour, and maternal wellbeing defined by pathology). Not only can this lead to a very narrow and medical view of birth, but it can also lead to skewed and limited findings. This certainly appears to be the case when a longer-term follow-up was undertaken on the same study cohort 2 years later. Whyte, along with Hannah and several other collaborators, performed a follow-up study of the original participants at 2 years following birth, (Hannah, et al., 2004); (Whyte, et al., 2004)). Using similar medical parameters to define the outcome criterion for the studies, they concluded that '*planned caesarean delivery is not associated with a reduction in the risk of death or neurodevelopmental delay in children at 2 years of age*' (page 864). It was noted that the study was less powered

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<sup>11</sup> APGAR scores were developed as a method to quickly assess the health of a newborn baby immediately after birth. It is based on the scoring of 5 different criteria: Appearance, Pulse, Grimace, Activity and Respiration, which are given a numerical value when the baby is 1 minute of age and 5 minutes of age. The sum is then their APGAR score. It was designed to show when a newborn may need medical attention, but is not a predictor of long-term morbidity (Apgar, 1953)

than the initial one as not all children were able to be followed up, but the baseline characteristics between the 2 groups were similar to enable comparison. Why the conclusions differed between the short-term and longer-term outcomes is debatable; the authors consider the smaller sample size a significant factor, but acknowledge that despite the poorer short-term outcomes for babies born vaginally, they go on to '*develop normally*' (p870). An alternative view as to the cause of these differing conclusions is to consider how wellbeing is defined around the time of birth; short-term perinatal morbidity measures are only partial indicators. Often predetermined by the views of the researchers as being significant, means outcomes defined in other, more holistic paradigms (for example, delayed time before cord clamping, time and duration of skin to skin contact with mother, and feeding time and duration) are not considered. Additionally, perhaps some of the short-term outcomes chosen are not a good predictive factor for longer-term outcomes; these medically-defined outcomes have limitations as to their interpretable significance; for example, the APGAR score which is used as an indicator for this trial was originally developed as a way of systematically assessing the newborn at birth. However, research suggests it has poor predictive value on longer-term wellbeing, lacks sensitivity and specificity and has low inter-rater reliability (Jepson, et al., 1991).

Interestingly a separate group of researchers, who were involved at a trial centre in the original research, conducted their own follow-up of the participating children at 2 years of age. Molkenboer et al, (2006), followed up 183 children (as opposed to Whyte et al, (2004), who followed up 923 children) with the same questionnaire tool relating to the scoring of development markers and physical wellbeing. The comparative groups were of very different sizes (planned caesarean n=43; planned vaginal birth n=140) leading to large confidence intervals, and also had some characteristic differences that were significant in affecting the ability to compare data, which limited the validity of the study. However, the conclusions of the study were that '*planned vaginal delivery is associated with an increased risk of neurodevelopmental delay at 2 years of age in term children with a birth weight of greater than 3500g*' (p624), the opposite to the conclusion by Whyte et al 2 years earlier. Other than the sample size and group characteristics, there are also concerns about the methodological difference between the studies; Molkenboer reports that the questionnaire tool had a positive predictor of 40%, and that they



were unable to undertake health professional assessments for the children that scored higher, which was done for Whyte et al's study in 2004; this prompts the authors to suggest the results of their study should be interpreted with caution. This is an interesting comparison; data for this type of research must be powered efficiently, and undertaken using an appropriate tool and comparative groups, to provide sufficient validity.

The language used in the abstract conclusions from both of these studies is of interest. The summary conclusion from Whyte et al 2004 study does not mention vaginal birth at all; the headline is that caesarean section infers no long-term benefit. By omitting the alternative way of saying the same thing, that vaginal birth infers no long-term risk, does the author perhaps provide us with a clue as to their own personal perspective and beliefs? In comparison, Molkenboer et al's 2006 summary conclusion is clear that vaginal birth infers an increased long-term risk rather than the alternative of saying caesarean delivery provides long-term risk reduction; a clear statement despite the limitations of the study.

As with other randomised controlled trials there were also concerns with the internal and external validity of both the initial randomised controlled trial by Hannah et al, (2000) and the follow-up studies (Hannah, 2004; Whyte, 2004). There were 121 trial centres in 21 different countries with very different demographics, facilities and clinician skill in facilitating breech birth, making statistical comparisons impossible without dismissing variables and homogenising the populations with imposed medical parameters. Indeed, Kotaska, (2007), argues that the complexity of childbirth, with its infinite number of variables, makes it unsuitable for the randomised controlled trial and instead lauds the '*meticulous and comprehensive*' (p178) data collection of a large-scale retrospective trial called PREMODA (PREsentation et MODE d'Accouchement: presentation and mode of delivery) by Goffinet et al in 2006.

Goffinet et al (2006) used a prospective observational study of over 8000 women with breech presenting babies and reviewed the outcomes for babies born by caesarean section and by vaginal birth – PROMODA study. Their results differed from the previous research by Hannah et al (2000), with the conclusion that, where specific criteria are met before and during labour, planned vaginal delivery remains a

safe option. Critical analysis of this research suggests that they attempted to address some of the concerns highlighted in the Hannah et al (2000) research, including more information on the antenatal and labour management. Reviewing the study guidelines, which were based on French national guidelines (Francais, 2001), for deciding the mode of delivery for women in the study, and the subsequent management of labour and birth, raises some issues, as some may not be common practice in other countries or acceptable practice in the view of other clinicians. For example, the use of pelvimetry to determine the adequacy of pelvic size is not common in the UK and is not supported in national guidelines (National Institute Clinical Excellence, 2007). Additionally, medically inducing labour and/or augmenting it with drugs to increase contractions is not recommended (RCOG, 2006), nor common practice in the UK, due to the lack of research evidence to support the practice. Indeed, the secondary analysis of the Term Breech Trial data found that the use of oxytocin to augment labour ( $P=0.007$ ) was found to contribute to more adverse perinatal outcomes (Su, et al., 2003). The authors Goffinet et al (2006) acknowledge these but compare their stricter guidelines with those of the research by Hannah et al (2000) and suggest that these French guidelines are associated with better outcomes from the data presented from both research studies and thus are justifiable in their inclusion.

This aside, the study was well-designed, with both the study groups (women having a planned vaginal birth, and women having a planned caesarean section) showing similar demographic and obstetric characteristics. The only significant difference was the type of maternity ward the women gave birth in; proportionately more women in the private ward were in the planned caesarean section group (78% v's 22%), thus most women in the public ward were in the planned vaginal birth group (80.6 % v's 19.4%), raising questions about selection criteria, possible clinician bias or difference in obstetric practice or the quality of informed consent given by the participants. As none of the other variables were significant, it may not have an ultimate effect on the data outcome, but more detail within the study design would have been helpful to explain these differences. The retrospective nature of the data collection means that comparability cannot be guaranteed as the analysis cannot control all the confounding factors. However, it can be argued that it is impossible to control the

variables when researching such a complex phenomenon, and attempting to do so nullifies the applicability of research findings to birth situated within real life.

Other research has also presented conflicting and confounding results as to the safest risks mode of delivery for the mother and breech presenting baby. As mentioned previously, Reitberg et al, (2005), published a very large retrospective study of over 33, 000 term infants taking data from a comprehensive computerised registry in the Netherlands. Using similar inclusion and exclusion criteria and outcome measures to the research by Hannah et al (2000), the study found that an increase in planned caesarean sections correlated to a decrease in perinatal mortality (from 0.35% to 0.18% OR 0.53 P 0.007 95% CI), but there was acknowledgement that this comes with an increased risk to the mother, and subsequent pregnancies, from a surgical birth. The study design is simple but relatively well-considered, with a validated computerised system (a national registry that had been tested for computer errors) to extract the data from a significant sample size giving power to the study and a relatively uniform approach to care, in as much as all deliveries were performed by doctors in obstetric departments. However, this study differs from the Goffinet study by giving limited information about guidance for clinicians on details of care and management for labour and birth. This leads to questions on the possible variables that may impact on the outcome criterion, and concerns that the reason for poor outcomes may not be specifically related to presentation alone but to issues with care and management. Additionally, the study lacks detail around these outcome measures; the measures were limited in their description (for example, one outcome was described as 'other trauma' but with no explanatory limiter leading to concerns about what would or not be considered trauma) and, similar to Hannah et al (2000), relied on medically-determined short-term end points that may have little bearing on long-term outcomes (for example, use of APGAR scores), as mentioned previously.

These issues were considered in the design of another study by Poonam et al, (2005), where an analysis of 14,433 singleton term breech babies showed that a small increase in short-term perinatal morbidity and mortality in babies born vaginally or by emergency caesarean section, compared to by elective caesarean sections, was not seen in the comparison of longer-term outcomes of both groups. By using a

single centre this study avoided some of the concerns about validity highlighted in the multicentre randomised controlled trial by Hannah et al (2000). On the other hand, the retrospective nature of the study raises concerns about the increased possibility of selection bias and reliability of longitudinal data input. Despite this, the research provided more details and context in the published paper than most of the others, both in the detailed analysis of the cause of death when it occurred around the time of birth, and the correlations between short- and long-term outcomes. Using outcomes such as mortality rates, defined as death within 28 days of birth in the studies reviewed, prompts questions as to cause and effect. In this study the authors attempted to establish if the mode of delivery was the direct cause of the death or whether there were other factors involved. It found that only 1 death was directly attributable to the mode of delivery, where the baby's arms were in an unusual and difficult position, preventing birth and requiring considerable physical intervention by the clinician. The detailed breakdown is invaluable to providing answers that statistics may pose and to give a more contextual view of the results. Similarly, when comparing the short- and long-term outcomes, the Poonam et al study found that there was a poor correlation, and that the majority of infants who developed long-term needs were born with normal APGAR scores, and that low APGAR scores did not reflect long-term neurological outcomes (Poonam et al, 2005).

As a reflection of the research available at the time the RCOG 2006 green top guidelines on the management of breech presentation now promote the informed choice approach, enabling women to be given the risks and benefits of mode of delivery and supporting that choice (RCOG, 2006). To date this guideline has not been updated (publication of updated guidelines is expected in 2016) and remains the benchmark for current UK practice. However, the Society of Obstetricians and Gynaecologists of Canada have taken a further step by publishing new guidance in 2009, stating that planned vaginal breech delivery in selected women is reasonable, and providing more detailed recommendations on care and management during labour and birth (Society of Obstetrics and Gynaecology Canada., 2009)

Borbolla Foster et al (2014) considered these management concerns in their retrospective review of breech birth outcomes over 11 years from an Austrian centre that continued to offer a breech service to women. Following strict inclusion criteria

and using a number of assessment technologies such as ultrasound scanning and computerised tomographic pelvimetry (only up until 2004 when it was considered to have minimal supporting evidence) they reviewed 766 cases on an intention to treat basis and with outcome measures of short-term perinatal morbidity and mortality. Unlike the Term Breech Trial (Hannah et al, (2000)), they excluded the identified high-risk cases. However, they did include induction of labour and oxytocin augmentation of labour as part of management as they felt was indicated. Whilst oxytocin augmentation rates were considerably lower than the Term Breech Trial (Hannah, et al., 2000) and PROMODA study (Goffinet, et al., 2006), induction rates were much higher; however, the authors consider that this may be due to differences in definitions of these interventions, and the necessity to consider the geographical area of the clinic where women were required to travel long distances to attend (p228). This is an interesting social factor that is not considered in any of the other research and provides insight into how contextual and situational childbirth is. Whilst the authors conclude that vaginal breech delivery remains an option in carefully-selected women under strict obstetric protocols, it continues to raise questions about management of labour, effects of interventions and the impact of strict medical protocols on women's informed choice and birth experiences which will be presented in the next section.

### **1.2.1 Breech birth care, management and skills**

The study by Poonam et al, (2005) highlighted concerns about suboptimal care during labour and breech births, which was the attributable factor in one of the perinatal deaths described in the findings. The Confidential Enquiry into Stillbirths and Deaths in Infancy 7<sup>th</sup> Annual report published in 2000 highlighted that the single most avoidable factor in causing breech stillbirths and death was suboptimal care in labour, and yet this is poorly represented in the majority of research available. Hannah et al (2000) attempted to address this in their research by specifying that the clinician should be 'experienced', defined as '*someone who considered himself or herself to be skilled and experienced at vaginal breech delivery, with confirmation from the individual's head of department*' (p1376). This loose explanation is open to criticism and raises questions regarding the definitions of 'skilled' and 'experienced' here, and how a head of department can be able to confirm this.

Further to this, Kierce (2002) suggested that as nearly a quarter of the vaginal breech births were attended by midwives or nurses, rather than by obstetricians, within the research by Hannah et al (2000), it would have created a negative bias on the perinatal morbidity and mortality for this group. Although this concern is refuted by the researchers of the trial (Hodnett & Hannah, 2002), it highlights the issue of the experience, skills and care provided by the clinicians, and consideration for the impact this may have on the outcome for mother and baby. The additional argument regards who is best placed to provide care for women birthing their breech babies vaginally; the assumption here and in the majority of the medically-led research is that obstetricians are the optimum care givers, but this is without justification or basis. Basing research on such assumptions may lead to biased or incomplete findings and is unrepresentative of breech birth in the UK where, anecdotally, midwives are often the primary care providers for vaginal breech birth.

Most authors on breech birth and researchers conclude that whilst the debate continues as to what is the optimum mode of delivery for breech babies, the development of care and skills in vaginal breech birth must be valued as there will always be a requirement for them (Banks, 2001). Vaginal breech births will occur through maternal informed choice, and through the discovery of breech presentation in the latter stages of labour where a caesarean section cannot be performed, or in cases where a caesarean is not an option (for example, at home or where there is no theatre availability for surgery).

Research evidence on the optimum care for mother and fetus during vaginal breech birth is limited (Vranjes & Dubravko, 2007). However there have been several discussions and cases written up in midwifery and medical journals that suggest the care approach or management is a significant factor in the outcome for the mother and breech presenting baby (Cronk, 1998); (Reed, 2003); (Odent, 2007). Robinson (2005) noted that when comparing the vaginal births (in the research by Hannah et al (2000)) which were induced, augmented or the mother had an epidural, to those vaginal births which had no intervention, the outcomes for the baby were worse in the intervention group, suggesting a link to care approach and the impact on perinatal outcome.

Other studies have aligned with, or refuted the conclusions of, the Term Breech Trial, continuing the debate. An Irish study by Alarab et al (2004) reviewed 641 breech births comparing short-term perinatal outcomes for pre-labour caesarean section with vaginal births and concluded that:

*“Safe vaginal breech delivery at term can be achieved with a strict selection criteria, adherence to a careful intrapartum protocol and with an experienced obstetrician in attendance”* Alarb et al, 2004.

This study, whilst retrospective analysis, reflected the very strict criteria under which women were allocated to each mode of delivery. This very controlled approach led to low levels of actual vaginal delivery occurring (only 23% of the study group had vaginal delivery). However it is worth noting that the management of labour varied from other studies, and the absence of oxytocin augmentation presented a significant difference to other research studies on breech, which included it as a routine measure when indicated (Hannah et al, 2000; (Uotila, et al., 2005); (Goffinet, et al., 2006); (Abu-Heija & Mohammed Ali, 2001); (Diro, et al., 1999); (Thawaini Al-Inizi, et al., 2005); (Pradhan, et al., 2005)). Research into the risk of oxytocin augmentation on the fetus and mother shows it increases the risk of instrumental delivery and episiotomy (Bernitz, et al., 2014), increases the risk of caesarean section and instrumental deliveries (Bugg, et al., 2006), increases the use of analgesia, increases the risk of caesarean section, instrumental delivery and neonatal morbidity (Buchanan, et al., 2012). In a similar way, the management of labour differed between research studies with many using breech interventional manoeuvres as routine ( (Elli Toivonen, 2012); (Abu-Heija & Mohammed Ali, 2001); (Albrechtsen, et al., 1998); Uotila, et al, 2005; (Alarab, et al., 2004), use of forceps for the after coming head as routine (Abu-Heija & Mohammed Ali, 2001, Albrechtsen et al, 1998), and use of continuous fetal monitoring (Goffinet, et al, 2006; Abu-Heija & Mohammed Ali, 2001; Albrechtsen et al, 1998) which was not seen in the Term Breech Trial (Hannah, et al, 2000). These differing management approaches make comparisons between studies difficult but also raise a question about the impact of them on the outcomes. For example, research suggests that lithotomy position for birth is associated with an increased risk of perineal damage involving the anal sphincter (Hastings-Tolsma, et al., 2007) and yet maternal position was implicitly

lithotomy in the reviewed research due to a high use of epidural, the common use of interventional manoeuvres, the high use of continuous fetal surveillance and the culture of obstetricians to deliver women on their backs (Kitzinger, 2007). Whilst short term morbidity and mortality was the indicator for all these research studies, it did not consider to what extent routine interventions may contribute to this rather than the breech presentation itself. This demonstrates the complexity of research in childbirth where there are multiple factors to consider and a considerable challenge to extract all variables to reach a conclusion.

Goffinet et al (2006) also allude to this with the comment that their research results can only be extrapolated to centres where vaginal breech birth is relatively common, suggesting that clinician knowledge, skill and expertise are one of the influencing factors on outcome. Goffinet et al (2006) also comment in detail on the differences in care provided antenatally and during the labour and birth of vaginal breech births, as compared to the research undertaken by Hannah et al (2000), suggesting these may be factors in the improved outcomes for their vaginal breech babies. These suppositions on other influencing factors lead us onto considering the wider context of breech childbirth: attitudes, decision-making and experiences.

### **1.2.2 The experience of breech birth**

An extensive literature search produced only a few pieces of research that considered and explored women's experiences of breech presentation. Whilst different in their approach, and conducted in four different countries, they provide valuable insight into the qualitative aspects of this birth experience, with some commonalities in their findings.

Guittier et al, (2011), conducted a qualitative study exploring women's perceptions of their experience of the diagnosis of breech presentation and decision-making processes regarding the choice of mode of delivery. Interested in the high rates of elective caesarean section in a population where women are given a choice to have a vaginal delivery, the research was keen to explore this experience and women's coping strategies on dealing with this situation. Using a purposive sample of 12 pregnant women with a singleton fetus, recruited from a maternity unit in Switzerland, participants were interviewed to compare experiences and decision-



making processes when confronted with the choice of vaginal birth versus a caesarean section. The researchers' conclusions clearly outlined the multifactoral and complex nature of this experience, citing that women must '*manage their internal influences such as personality, life history and representations of motherhood but also external influences such as social pressures and medical discourse*' in order to make decisions (p 212). Placing this within the social context the study offers a more in-depth and holistic view of the experience of women, regardless of the mode of delivery, and demonstrates where this experience can be improved. The methodological approach enabled data collection to occur very near to the time of the event; women were interviewed within a week of the consultation about their birth choices leading to an increased chance of accurate recall. However, three of the women gave birth before the interview could take place. Potentially these women's perception could differ considerably from those who were yet to give birth, as the birth itself is such a significant event, altering the nature of the data collected; however, as with many studies around childbirth, unpredictability means these factors should simply be acknowledged rather than attempted to be modified or controlled. The transcript data was initially analysed by 3 different investigators and codes were discussed and agreed to increase validity. However, the researcher also used a computer-aided tool for coding. Concerns have been raised about the use of computer programmes for qualitative analysis, including a sense of being distant from the data (Gibbs, 2007) and the danger of fragmentation and de-contextualising of data during the computer process (Liamputtong, 2009), but fundamentally this could also be considered as a recognised tool to manage data and make data analysis more efficient.

A similar piece of qualitative research was undertaken in Jamaica by Founds (2007) using semi-structured interviews and using computerised tools for data analysis. The Jamaican study also highlighted ethical issues; there was no central ethics committee at the time of the research. However, ethical approval was sought and given from an academic institution. Consent of illiterate female participants was verbal: on one hand, there is an ethical concern of being able to ensure full consent is gained; on the other, the inclusion of all women in this study is of social and moral importance to ensure all voices are heard. The demographics of women in this community and the health care settings are very different from Guittier et al's (2011)

study undertaken in Switzerland, but there were similarities in findings in that women's experiences were affected by meanings of breech '*derived from their own prior personal experiences and the context of their [Jamaican] socio-cultural networks*' (Founds, 2007, p1398). Both studies also acknowledge the influencing factor of the medical and midwifery (or nursing) professionals who were '*instrumental in shaping women's experiences of breech, as women required information from the care providers for defining and interpreting the meaning of breech*' (Founds, 2007, p1398). They emphasise the desire for improved communication '*in particular a greater respect for their [the woman's] ideas and values*' (Guittier et al, 2011, p211).

Toivonen et al (2014) published their research into maternal experiences of vaginal breech delivery based on childbirth experiences in Finland, where choice is offered to women who lack any medical contraindications and who have a desire for a normal birth. The birth is under the jurisdiction of obstetricians and there are restrictions on the mother such as the recommendation of an episiotomy, low threshold for caesarean section and birthing position restricted to semi-recumbent. Unlike the studies by Founds (2007) and Guittier et al (2011) whose participants all have breech deliveries, Toivonen et al (2014) undertook an observational cohort study in order to compare the birth experiences between breech and vertex deliveries. Using a Swedish childbirth experience questionnaire over 308 women who had given birth in the last 5 years were included in the study and results were analysed and presented on an intention to treat basis. All pre-defined parameters of the birth characteristics were comparable except oxytocin augmentation and episiotomy which were both statistically significantly higher in the breech delivery group. Similarly, in the questionnaire responses, the domain of participation - for example, choosing birth position - scored significantly lower in the breech group. When the researchers matched actual mode of delivery rather than intention to treat, they concluded that breech birth experience is as positive as vertex birth experience. This research provides some assurance that whilst breech has come to be associated with being different or abnormal, experiences can be comparable to vertex birth. However, the approach to this research raises some criticism; the tool used to assess the emotional quality of the experience was limited to four pre-determined domains, limiting the scope of the questionnaire. Whilst this provides additional knowledge in this subject area, it does question how effectively this

captures what women themselves consider to be the important components of their own experiences. A further concern was the 57.1% return rate on the questionnaire which may bring into question an over- or under-representation of a particular group of women with a particular type of experience. This retrospective collection of data also raises the issue of recall as women recruited to this study were drawing from their experience of giving birth at some point in the previous five years. This is a persistent and acknowledged issue with research into breech childbirth as it is an infrequent occurrence in the UK. This makes it a challenge to recruit sufficient numbers and a practical necessity to broaden the scope and inclusion criteria when recruiting.

Toivonen et al's (2014) study does raise important issues on the impact of culturally-accepted practices such as high rates of episiotomy and restricting women's birth position on their birth experiences. There is no research to support either of these methods as being necessary for safe breech birth outcomes but they have become routine for many health professionals; indeed there is considerable evidence that both of these interventions have negative physical and psychological disadvantages to women (Priddis, et al., 2012) (Carroli & Mignini, 2009). This perhaps may have influenced the findings of Toivonen et al's (2014) study and suggests a need to explore the diversity of approaches to breech childbirth and the reasons behind them becoming mainstream practice.

A final study was conducted in Norway, exploring the influences on women's choices when faced with breech presentation. Glaso et al's, (2013), study started with the premise that although vaginal breech delivery has declined in Norway, there was still a strong culture of choice and clinicians' skills have been maintained. Whilst women are reviewed and, if meeting the criteria are offered a vaginal breech delivery, some still choose a caesarean section. Unlike Toivonen et al (2014) this study only included women who had breech delivery, but in a similar approach they also conducted a postal questionnaire given to women who had birthed in the previous five years, again bringing up concerns about recall bias. Whilst not presenting the rationale and basis of questionnaire design, the findings showed that age, parity and pre-existing attitudes towards breech presentation were decisive factors when choosing mode of delivery. The researchers concluded that further research was

needed to explore the psychological, socio-cultural and medical factors that influence women's decisions about breech mode of delivery (p1062). This study provides some initial indications on more modern influences, such as seeking web-based information, and demonstrates that control, risk and safety perceptions were essential factors on overall experience.

Although none of these research studies are based in the UK, they do provide some insight into what has been explored so far and where further research should be undertaken. These studies showed the importance of recognising the social and cultural context, and multi-factoral influences, on the experience and perceptions of women who have breech births, and expose some of the tensions between the medical paradigm of childbirth and the social and cultural context of birth for women. In many western countries childbirth has become increasingly medicalised and this has impacted and shaped maternity care provision, society's expectations, childbirth spaces and women's birth experiences dramatically. These are areas of interest as-yet unexplored in this type of birth experience, and will be the areas of focus for this research study.

This review of the current literature has provided context, identified gaps in current knowledge and established a rationale for this research study. However, the passion and drive for this research grew from my own experiences as a midwife and this context will be briefly summarised in the next section.

### **1.2.3 Researcher's perspective**

As a midwife I have been fortunate to provide care for women birthing babies in the breech position, both planned and unplanned and there, and my experiences, sparked an ongoing interest in breech birth. Over the last 20 years I have provided support, care and information for women as they tried to make a decision about how and where they should birth their baby. I have observed and shared a number of breech pregnancy and birth experiences with women which have given me some insight into the particular complexities of having this type of birth experience, which I perceived as being unlike other types of birth. This complexity relates to a situation where, despite the fact that information, advice and recommendations may be offered to women, the ultimate decision about mode of birth may be 'given' to them

in the current climate of support for informed choice. This can be a source of stress and decisional conflict for women (Founds, 2007), representing a point of tension where medical frames of reference, knowledge and expectations and an individual's social, cultural context and personal beliefs and expectations may be in opposition. As the vast majority of women who have breech presenting babies give birth by caesarean section (Guittier, et al., 2011) there are also issues about the extent to which a choice is truly made, and raising suspicions about selective knowledge sharing and coercion by health professionals (Kotaska, 2007). Perhaps also it is a reflection of the construction of choice within a social and cultural context, the legitimisation of medicalisation and technology in society generally, and the position of women in contemporary society. The modern breech birth phenomenon gives a particular example of the dominance of the medical risk paradigm within contemporary maternity care provision, and the experiences of women who choose to challenge or negotiate this with their own uniquely-constructed gendered knowledge, judgement and beliefs.

Reading literature and performing a more comprehensive critique of the available literature in the area of breech birth has been a continual process over many years. As a midwife I am required to provide information to women in order for them to make informed decisions about their pregnancies and births, so searching current and available research is an implicit part of my job. I was also aware that I had questions about my own midwifery experiences of breech birth, and I sought answers through the more academic means of literature searching and attending conferences, but also through professional discussions and informal chats with colleagues and women to try to understand more.

Over many years I have listened to women's and clinician's opinions, beliefs and views, and read a broad spectrum of literature, and my conclusion before the start of this research was that there is considerable passion both in supporting and opposing vaginal breech birth. Experienced midwife Maggie Banks (2001) suggests this is due to a number of factors, including the dominance of medical discourse in maternity care, the inconclusive medical research evidence currently available, personal experiences, beliefs and values, and individual perceptions of risk. Breech birth has a complexity that is beyond the pure physiology or physical outcome. As with most

life experiences, gender, social, political and cultural factors all play a part, and this has not, so far, been explored. Identifying myself as a feminist and wishing to adopt a feminist research approach, this study is driven by a desire to give a voice to women and their experiences, to be able to understand women's breech birth journeys, and to share information with the hope of informing and improving women's breech birth experiences in the future. This research was an opportunity for me to explore the topic of breech from a number of different perspectives, to reflect on my own knowledge, and to consider childbirth through new lenses. I employed a number of strategies to acknowledge and address the potential influence of my experience, background and beliefs, which will be shared during the thesis.

### **1.2.4 Summary**

As reviewed above, current literature in the subject area of breech birth is predominately medical quantitative-based research providing the evidence on which national recommendations are made (Royal College Obstetrics and Gynaecologists, 2006). Despite some strongly-suggested conclusions on the safest mode of delivery for the breech presenting baby, there has also been considerable criticism of the methodologies and methods of the various studies leading to ongoing debate and tensions. The complex and multifactorial nature of birth makes it difficult to conduct randomised controlled trials, eliminating variables and homogenising populations, but existing research does provide areas for further investigation and consideration.

Global health neoliberal reforms have influenced contemporary maternity care provision, but whilst principles of enhancing choice and control for the consumer have had some successes in the UK, deeply embedded hierarchies and institutionalised systems have continued medical dominance, maintaining a tense and complex relationships between obstetricians and midwives, and between health professionals and consumers. The feminist social geography approach provides a lens through which the relationships found in and around maternity space can be explored.

The limited research available about the experience of breech birth suggests that the social and cultural context has a considerable influence on the experience and perceptions of women who have breech presenting babies. This has not been

considered widely in the current medical research but it does expose some of the tensions between the medical paradigm of childbirth and the gendered, social and cultural context of birth for women.

The review of the literature has identified gaps in knowledge about the experience of vaginal breech birth, particularly within the social, cultural and gendered context that forms the rationale for this research study. The following section will discuss the theoretical framework of the research and outline the methodological decisions made to ensure they were the most appropriate and relevant to the study. It will also outline the processes in which the methodological decisions were put into practice during the stages of recruitment, generation and analysis of the data.

## **CHAPTER 2: THEORETICAL PERSPECTIVES**

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### **2.0 Introduction**

The previous chapter provided a rationale for the study by critiquing the existing research and literature and identifying a gap in the existing knowledge. The aim of this chapter is to provide clear reasoning for the study approach, application and process, and to show critical consistency throughout. This chapter will outline the philosophical assumptions of the research and discuss the theoretical framework that underpins the study.

Theoretical perspectives enable us to explain and make sense of what is going on, to account for our observations, and to provide ways of understanding research data (Letherby, 2003). Research paradigms are an interpretative framework, which is guided by "*a set of beliefs and feelings about the world and how it should be understood and studied*" (Denzlin & Lincoln, 2000, p. 27). This includes considering how I, as the researcher, view the nature of reality, and view knowledge - and how I interpret the process of knowing the world and learning new knowledge from it (Denzin, et al., 2003). The explicit incorporation of a researcher's views and beliefs into the research has wide theoretical and philosophical support (Berg 1998, Denzlin and Lincoln, 2000) as it provides a context to the study and enables the researcher to remain critically aware by acknowledging their influence on the approach, method and analysis of the data gathered. With the research aiming to explore the experience of breech birth from a range of different perspectives of those involved in a vaginal breech birth, a flexible and dynamic approach was indicated. In order to capture the detailed personal narratives shared by participants, an appropriate theoretical framework was required that reflected the nature and aims of the research and aligned with the beliefs of the researcher.

To address these methodological concerns, a social constructionist theoretical framework with a feminist research position was considered and adopted for the study. The philosophical position for this research will be presented, followed by a discussion on the feminist research position.



## **2.1 Philosophical position**

On reflection, and following extensive reading, the ontology of relativism appears to best describe my views on the nature of reality, but with some reservations.

Relativism purports there to be no single reality or absolute truths, but multiple constructed realities where truths are relative to theoretical frameworks such as culture and language. This position considers reality to be subjective and influenced by the context of the situation, the individual participant's own experience and perceptions, the social environment and the interactions between them and others. The belief is that there will be multiple meanings of the breech birth experience in the minds of those who experience it, as well as multiple interpretations of the data and thus many equally-valid relative truths (Ponterotto, 2005). This, then, lines up with the aims of this research, which is not to discover a single fact or truth, but to explore the realities of individuals involved in the breech birth experience through the different cultural groups to which they belong, in an attempt to understand the different social causes and drivers that create and shape the experience.

Relativism has challenged the positivist stance that dominates science, and considers 'good' social scientific research as the '*evaluation of hypothetical statements about the cross-case covariation of the variables of interest with the ultimate intent of approximating nomothetic generalisations*' (Jackson, 2015, p. 13). The challenge is that a relativist approach eliminates the validity of reality and that a lack of objectivity limits the progression of knowledge (Jackson, 2015). Sandra Harding counters this by arguing that 'objective' science is always socially situated, since neither the scientists '*nor the knowledge they produce are or could be impartial, disinterested, value neutral*' (1991, p. 11). Furthermore, she argues that approaching study of the world with social-based science provides less distorted descriptions and explanations, recognising that "*“culture” knows a great deal that we individuals do not. The culture remains the ‘authoritative knower’ of all those things for which we neglect or refuse personal and institutional responsibility*' (Harding, 1991, p. 15). Thus, far from excluding culture, culture becomes the context for discovering the multiple truths and enlightening us to the politics and social agendas of science and scientific knowledge. A relativist position also maintains that no

theoretical framework is uniquely privileged over another, and that all points of view are equally valid (Westacott, 2015). This provides a link to feminist research which calls for the decentring of masculinity in society's thoughts and practices, as this provides only partial and distorted understandings (Harding, 1991, p. 13). A relativist position within a feminist research approach will enable breech birth experiences to be contextualised within the social, cultural and gendered context, allowing the multiplicity of truths to emerge from this situational data and providing opportunities for further knowledge and understanding of this complex and unique event.

Criticisms of the relativist philosophical stance include the contradictory nature of making negative judgements about behaviours and practices, whilst maintaining that there are no single realities, and the concern regarding the impossibility of establishing moral principles of right and wrong (Beebe, 2010). Philosopher Harman defends this criticism by asserting that judgements are made through implicit agreements between people with reasoning provided (Harman, 1975). Even when disagreements occur, there is a relativist view that this can lead to a position of faultless disagreement if it is accepted that propositional truth is relative; thus, no one in a disagreement is right or wrong (Kolbel, 2009). Huvenes (2014) builds on this by taking the view that disagreement involves more than beliefs but also personal desires and preferences. These positions are helpful in emphasising the complex and social nature of an individual's realities when researching a childbirth experience such as breech birth, and considering how disagreements and tensions may evolve.

## ***2.2 Theoretical Framework***

The theory of social constructionism aligns with my beliefs on the construction of knowledge and the meaning of this knowledge. The theoretical orientation of social constructionism requires the research to have a critical stance on our taken-for-granted knowledge, enabling a questioning of our observations, perceptions and realities. Unlike traditional understanding that the world can be known objectively and thus can be predicted and controlled, social construction considers that what we believe the world to be depends on how we approach it, and this in turn depends on the social relationships of which we are all part (Gergen, 2009). As we all have unique social relationships based on our culture, race, gender, beliefs, sexuality, education, social background and a plethora of other compounding factors, we will

approach and construct the world and the experiences we have within it differently, but we are influenced by the groups of which we are a part, and some meanings are passed on and shared through socialisation.

Social construction theory enables the argument that claims of objective truth are not possible, but are constructs developed through social interactions and accepted as reality. Burr proposes that knowledge is constructed by people and is socially situated:

*“It is through the daily interactions between people in the course of social life that our versions of knowledge become fabricated. Therefore social interaction of all kinds, and particular language, is of great interest to social constructionists. The goings-on between people in the everyday lives is seen as the practices during which our shared versions of knowledge are constructed... Therefore what we regard as truth, which of course varies historically and cross-culturally, may be thought of as our current accepted ways of understanding the world. These are a product not of objective observations of the world, but of the social processes and interactions in which people are constant engaged”* (Burr, 2003, p. 4)

From this, the development of actions derived from knowledge assertions can be seen; some constructions of the world sustain social actions and exclude others, with breech birth a good example of this. Implicit in this is the creation of power relations where treatment of others, inclusion and exclusion are the result of knowledge assertions (Burr, 2003). Within childbirth, medicine has constructed its own language and knowledge that has established normal and abnormal childbirth definitions that are employed actively in daily clinical practice, limiting options and choices for women despite there often being inadequate or outdated evidence to support it. An example is the practice of artificially inducing labour (induction of labour) in women who go over their due dates, called post term (after 40 weeks gestation). The recommendation of induction of labour (National Institute Clinical Excellence, 2008) for women whose pregnancy goes beyond 41 weeks is based on literature from the 1970's that reported a theory that there was a risk to the baby of placental degradation (Vorherr, 1975). Despite this assertion not being supported by further evidence (Shy, 1991), and no other conclusive evidence being produced to support a

position of benefit of postdate induction, and continued debate around the accuracy on which to establish predicted due date (Menticoglou & Hall, 2002), induction of labour rates have steadily risen and were at 23.3% in 2012-13 (Health and Social Care Information Centre, 2013. ). This raises concerns that the current medical domination of childbirth creates a culture of obstetricians creating knowledge and social authority where interventional models are the accepted normality. This supports the Foucauldian notion of the *'invisible powers that serve as a motivation to adopt or be defined within the standards of the norm'* (Gyllenhammer, 2009, p. 67). These ideas support the focus of the research with the theoretical framework enabling a critique of taken-for-granted assumptions, power relations and knowledge assertions about breech birth, by exploring them in the context of real-life experiences from the perspectives of those people involved. The intention of the approach is to seek to understand how socially-situated language and knowledge are activities that create and produce the social processes and actions of this particular birth experience.

Social construction theory does have its critics. One argument is that it does not address issues such as innate intelligence (or logic), nor the rigidity of mathematical knowledge, as it is purported that neither are socially constructed. Peterson (2012) attempts to address these criticisms, firstly by suggesting that, whilst what numbers refer to and how they are used has significant cultural difference, the *'differences in meaning, familiarity, and application, the structure of natural number doesn't alter from context to context'* (p. 277). He continues to say that whilst mathematics and logic are presented as standing apart from all empirical knowledge, their reference and usage is inherently interconnected with society and relations. He does suggest that whilst some forms of basic numerical thinking are innate, the development of these concepts is determined by whether a culture has an existing domain of knowledge about more complex mathematical knowledge (p. 473). This supports the overriding concept of the considerable influence of relational construction of knowledge.

Further criticism is the concern over the lack of 'self' within the theory: the human elements of personality, attitudes, motivations and personal agency that drive behaviours, and that account for the emotional investments and individual

differences, are not explained by the social constructionist concept (Burr, 1995). Burr suggests that both the idea that society determines the individual and the idea that society arises from, and is based on, the individual are troublesome to the theory, and suggests that a reconceptualising of the relationship between individual and society is required (p. 182). She recommends that thinking about the relationship as a *'dialectical process rather than as a conflict between two pre-existing entities, allows us to think of the person as being both agentic, always actively constructing the social world, and constrained by society (to the extent that we must inevitably live our lives within the institutions and frameworks of meaning handed down to us by previous generations)* (p. 187). This suggests that there is constant flex and change within the individual and society as they inform and shape each other, seen as generations and societies evolve different behaviours and meanings as cultures evolve.

This last criticism is of particular interest when taking a feminist research position, in that there has been a movement away from universalising the experience of 'woman' and acknowledging that there are not a set of principles or understandings of which women from every race, class and culture will approve. Further, Sandra Harding (1987) argues that within each culture, gender experiences vary even to the extent of the differences within women who identify differently at different times (for example as a mother, as a lecturer, as a daughter). The next section will provide an overview of feminist research, some historical context to feminism, and the rationale for adopting a feminist research approach for this research.

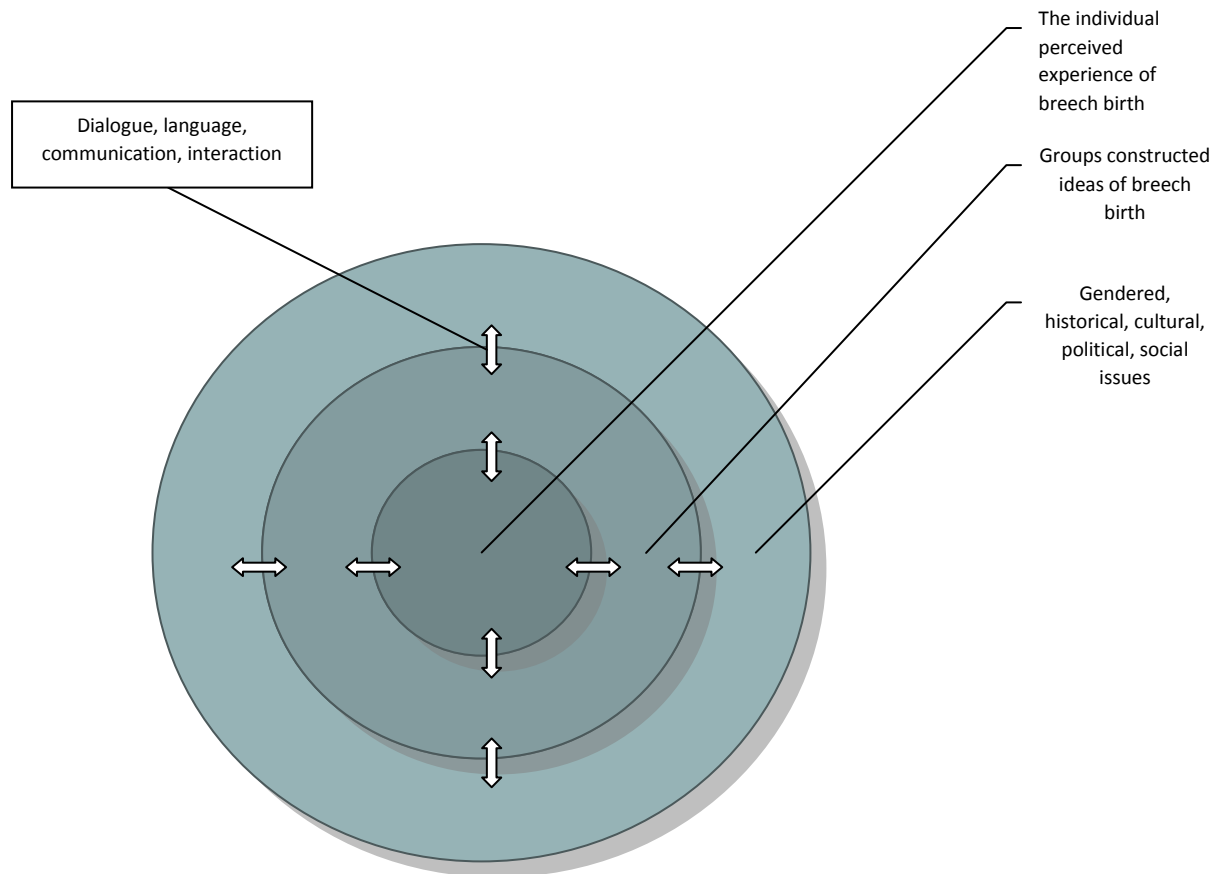


Figure 1: Social constructionism as theoretical framework

### **2.3 Feminist research**

Viewing myself as feminist for many years, it was important to me to adopt a feminist research approach. However, as language and meaning shift between people and across time and context, I will present some literature and my understanding of some common feminist concepts for clarity (Hughes, 2002). Feminism is a broad and substantial movement, theory and ideology that can only be covered in a brief and limited way here, but the intention in this section is to present how this approach aligns with my ontology and epistemology, and to provide the rationale of it being an appropriate lens to meet the aims of this research. Feminist research, understood as practical social research on gendered lives, experiences, relationships and inequalities (Ramazanoglu & Holland, 2005, p. 5), will also inform the decisions

around this research's methodology and methods and entails being explicit and transparent about the influences on this research, as this increases trustworthiness and rigour. For the purpose of this research I will use Ramazanoglu and Holland's (2005, p. 5) definition of gender to include: *sexuality and reproduction; sexual difference, embodiment, the social constitution of male, female, intersexual, other; masculinity and femininity; ideas, discourses, practices, subjectivities and social relationships*. Therefore this research will consider the diversity of gendered lives, perspectives and assumptions through the context of a significant life event, a breech birth.

Historically, knowledge and knowledge claims have been intimately tied to the domination and oppression of women (Letherby, 2003) and feminists have contested that, having being excluded from the development of this knowledge, their experiences and ways of knowing the world are not represented (Ramazanoglu & Holland, 2005). Feminists seek to reconstruct this knowledge - beginning with, and having at its core, women's experiences - to view how women's lives are organised in ways that are different to men's (Maynard, 1994). One of the central constructs of feminism is that of equality. However, rather than the concept of being equal that suggests that women are striving to meet the standard of men's lives, feminism instead suggests that women are different from men and require an equal value placed on women's difference (Hughes, 2002). Further, Sang et al (2012) points out that whilst feminism celebrates difference, '*it also has to balance this with a focus on women as a collective with some common interests and experiences*'. The concept of being equal and different is one of importance for this study, for women are different to men by the nature of giving birth. Yet mothers are more than just the biology of their bodies, but are also produced through cultural practices and spaces within which they are constructed and in turn construct (Longhurst, 2008, p. 2). Whilst this idea can be a source of tension with a relativist ontological position, the claim of different but equal is a valid relative truth.

Taking the principle epistemology that ideas and knowledge are constructed through social relations, the feminist view seeks to deconstruct<sup>12</sup> the authorised knowledge of the patriarchal society, where historically a male-dominated culture used positions of

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<sup>12</sup> Deconstruction sees social life as a series of texts that can be read in a variety of ways (Hughes, 2002, p. 18)

power to define issues, structure, language and theories and create new contextual knowledge from women's experiences (Harding, 1991). Feminist empiricism, feminist standpoint theory and feminist postmodernism and poststructuralism are the main theories that developed from these primary positions. Elements of these theories contributed to this research, as the social constructionist epistemology has arisen from, and has been influenced by, a variety of disciplines and philosophical positions (Burr, 1995). These I will explore briefly here, showing that by paying attention to the main feminist theories, this research blended elements from each, providing a strong position for my research to explore gender dynamics of the experience of vaginal breech birth. This is a central tenet of the feminist researcher as they seek to uncover gendered relations that result in women's voices being less heard, or their opinions and views being marginalised as unreasonable (Simpson & Lewis, 2007).

Feminist empiricism considers, in a similar view of science, that there is a view of a single and universal social world, with truths that can be discovered through research and knowledge (Harding, 1991). The main issue raised by empiricism is that male-dominated science has excluded women though subjects chosen, method and methodological approaches and definitive norms. This has been demonstrated in the review of current research in the subject area of vaginal breech birth, which is dominated by positivist-based research focused on statistical data, outcomes of morbidity and mortality and pre-determined end points. To some degree aligning with the feminist empiricist standpoint, this research will place women at the centre of this research, enabling the issues around breech birth to be re-addressed to consider the women's perspective and discover new social and gendered knowledge.

Where feminist empiricism has gained criticism, and where this research does not align, is in its views that, like science, truths are independent of the knower; that objectivity can be achieved. Although scientific research claims to be objective, value-neutral and protected from political and social values (Harding, 1991), feminists would criticise it on the grounds that science, like all knowledge, is a social product, that scientists are socially-situated human beings and that no scientific method ensures uncovering incontrovertible 'truth' (Chalmers, 1982). The concern for the feminist researcher is that they, too, are not free from their social positions, access to resources, grounded and gendered experiences, and political influences



(Ramazanoglu & Holland, 2005). Indeed, subjectivity is a major aspect of feminist research, which recognises research as a social interaction, and acknowledges the asymmetrical power relationship between researcher and participant that requires consideration throughout the research process (Sang, et al., 2012). It is this awareness that is considered as part of feminist standpoint theory.

Feminist standpoint theory attempts to address some of the issues of objectivity by examining how knowledge and power are connected, and exploring the hidden power relations of knowledge production and the construction of gendered lives (Smith, 1998). Unlike Feminist empiricism, standpoint theory moves from the objectivity and universality of 'truth' to the notion that women speaking their truths results in new knowledge of gendered social lives, grounded in woman's experience (Ramazanoglu & Holland, 2005), believing that experience is the starting point for the production of knowledge (Letherby, 2003). However, they also avoid claiming that this knowledge is 'true', or 'true' for women, as it takes into account the diversity of women's experiences and the interconnecting power relations between women. In addressing the criticisms of feminist empiricism, standpoint theory maintains that, although the researcher will always play a part in the knowledge production, reflexivity enables objectivity to develop, thus enabling the truth to be known as independent to the knower (Harding, 1991). The debate around objectivity, its meaning, relevance and alignment with feminism is complex. Harding (1991) presents concerns that '*objectivism encourages a partial and distorted explanation of why the great moments in the history of the natural and social sciences have occurred*' (p. 143) and instead proposes a concept of 'strong objectivity' as useful in providing a way to consider the gap between how the world is, and how an individual or group wants it to be (p. 161). It is proposed that 'strong objectivity' is achieved by individuals having reflexivity, reflecting on how they are situated in the social matrix and the implications this has on their positions, perspectives and power, that in turn strengthens the standards of good research method (Rosendahl, et al., 2015). The feminist standpoint theory concept and the practice of reflexivity was useful for my own research framework; it required the consideration of individuals' (both the research participant and myself as the researcher) situated lives, and provides a way of examining the relationships within the breech birth experience.

Feminist postmodernism develops feminist thinking further: it posits that there are no overarching truths, no answers, and no objectivity and universal theories (Burr, 1995). Feminist postmodernists consider women and women's experiences as diverse and complex, where there is no shared single reality, defying the possibility of any form of authorised knowledge (Ramazanoglu & Holland, 2005). This position emphasises the co-existence of multiplicity and situational-dependent ways of life, with no overarching systems of knowledge or underlying sociological structures that can be 'discovered' (Burr, 1995). Postmodernists aim to challenge and deconstruct widely-held objective 'truths', present alternative accounts, question and challenge society norms and values, and develop an understanding of power in relations (Nash, 1994). This means social interactions and relationships are a central part of enabling an understanding of how 'truths' come to be accepted and how this then shapes individual and their lives. As described in the introduction of this section, the definition of gender is diverse; it can be relational, discursive, behavioural and functional. However, historically, it has tended to be categorised as a binary of sexual difference, simplified to male and its opposite, female (Butler, 1990). By acknowledging this, feminist research can explore how lives are produced and affected by the tensions between ascribed binary definitions, definitions that ignore the social, cultural and political pluralities (Butler, 1990, p. 19. 31) and the complex realities of individual experiences. This has not been widely considered within research related to childbirth, where medical science's focus is on the physical body (Longhurst, 2008), and considered very little in the area of breech birth, so including this element of feminist postmodernism theory offers an opportunity for a noteworthy contribution to existing knowledge.

Feminist poststructuralism furthers this to consider the way these truths are constituted through language and behaviours with the core theory of gender subjectification; suggesting how, in patriarchal societies, knowledge and power work systematically to marginalise women (Weedon, 1997). By considering the historical processes of discourses and regulatory frameworks through which gendered individuals and social contexts are constructed, there is an opportunity to show how power relations are developed and maintained (Foucault, 1980), a central component to social construction epistemology. This concept of power relations is a critical factor in the experience of birth where far from being a natural experience,

*'motherhood is a complex social phenomenon: it varies over time and space, and is intricately bound up with normative ideas about femininity'* (Holloway, 1999, p. 91), and will be an important part of this research and the experiences will be considered within a social, cultural and gendered context.

The element of post-structural theory that purports there are no objective truths, and that shared gender does not necessarily mean shared experiences because women are positioned differently within society (due to differences such as class, race, age, disability, sexuality), was adopted for this feminist research approach in order to be open to all experiences, perspectives and assumptions. However, I do believe that there are common realities that women share, such as childbirth - but not all women, and not all in the same way. Doyal (1995) suggests we should not deny the possibility of women having beliefs, values and interests in common, whilst at the same time considering the complex social, economic and cultural variety of women's lives. Further, feminist post-structural theory considers that women do not share a single unseamed reality but may have a commonality in the themes of inequality and oppression (Stanley & Wise, 1990) (see Chapter 3 and Chapter 4). Including these elements within the feminist research approach adopted for this study enables a strong platform for exploring a momentous event in women's lives; vaginal breech birth is a common reality that will have shared threads that this research intends to explore in a way that is open to the diversity and complexity of lives and experiences. Contextualising these experiences within a social, cultural and gendered context, and investigating similarities and differences, provides an opportunity for a potentially rich and radical new knowledge in this area.

By drawing on important aspects of these main feminist theories, a feminist research approach was developed for this research that will align with my ontology and epistemology, but also will guide and shape the methodology, method and research questions. These elements are central to providing a focus during the research process, with the intention of enabling new knowledge to emerge in a way that has not been done in this subject area previously.

## **2.4 Summary**

This chapter has presented the philosophical positioning and theoretical perspective of the research, outlining the interpretive social constructionist theoretical framework employed. It has also presented a background and rationale for adopting a feminist research approach that has been developed by blending different elements of feminist theory to create a strong platform for the research to develop. This framework was integral to defining an appropriate methodology for conducting this research, and this will be presented in the following chapter.

## **CHAPTER 3: METHODOLOGY**

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### ***3.0 Introduction***

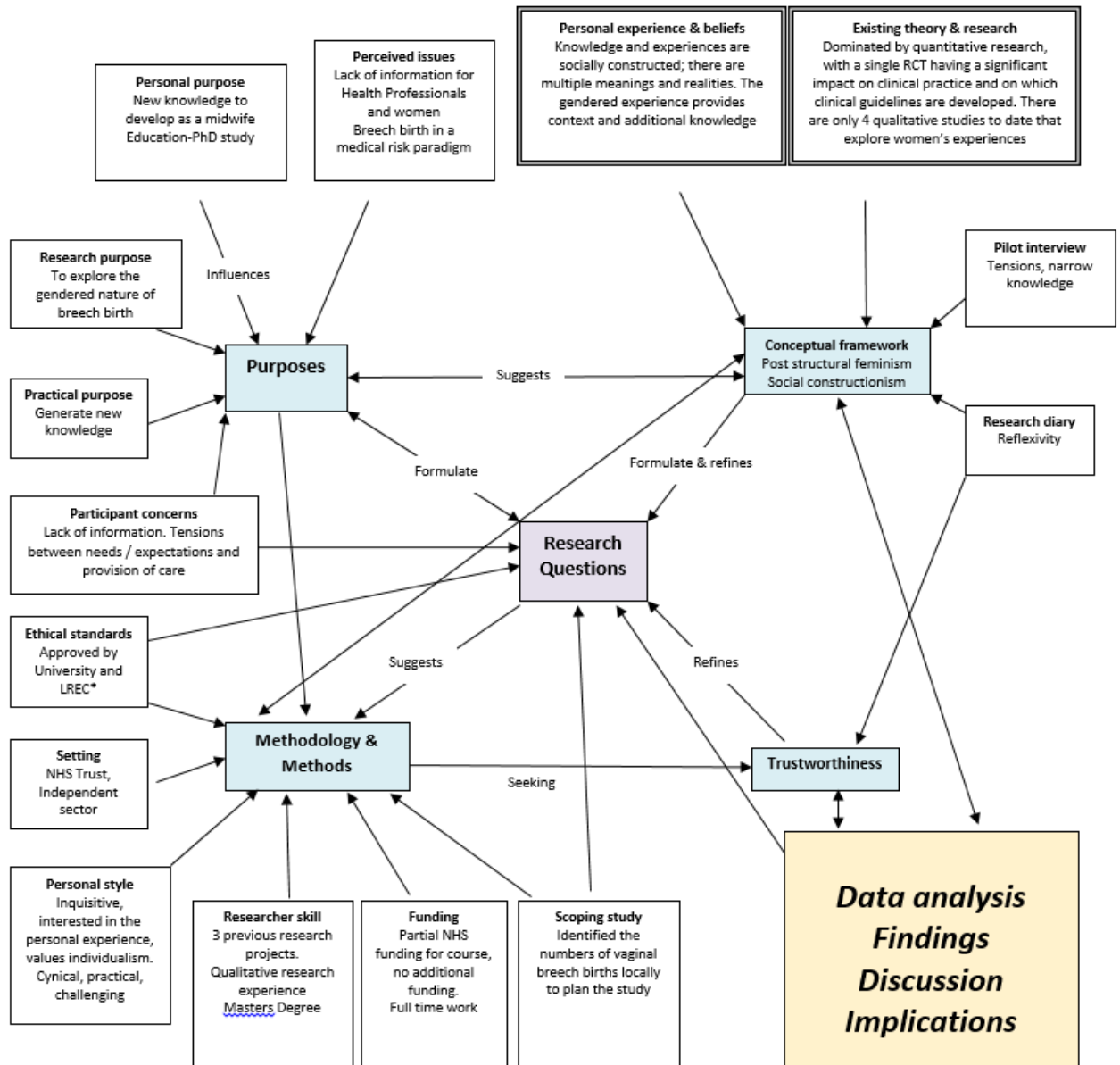
This chapter will present the methodological approaches that informed the data collection and data analysis. Research design, methodology and methods both shaped and were shaped by the research questions developed from the purpose of the study and conceptual framework described in the previous chapter. This coming chapter will include the rationale for using a case study approach and a review of other options considered as part of determining the study design.

Overall, the research seeks to answer questions that focus on the experience of breech childbirth, to conceptualise this within a gendered social framework and to gain a further understanding and new knowledge in this area. Using a feminist research approach considers the importance of giving a voice to women and their experiences, whilst being aware of the diversity of women's realities and acknowledging the social relations between the researcher and researched (Ramazanoglu & Holland, 2005). For this reason, the research methodology had to be able to capture the data that would best seek to answer these questions within the feminist research paradigm, but that also meet the practical limitations of the research (such as time, distance and funding).

In order to address the gaps in knowledge identified in the review of the literature outlined in chapter 1, an appropriate methodology was required to be flexible enough to reflect the varied experiences and perspectives of the women and health professionals who participated in the research. Whilst acknowledging childbearing women are at the core of the birthing experience, the social construction theoretical framework required that this was not seen in isolation to others who were involved, and influenced and were influenced by this experience. A methodology was adopted that reflected and incorporated the social, cultural and gendered context of the breech birth experience being studied. Finally, with the aim of informing future care providers and childbearing women, a research methodology was sought that produced a better understanding of this unique birth experience.

### ***3.1 Research design***

The research design was based on a number of factors including the purpose of the research, the conceptual framework, the methods and the validity of the study. The purpose of the research and conceptual framework were interlinked as both informed the other. Without considering the beliefs and assumptions on which the research was based, as well as the existing research evidence, the purpose of the research could not be ascertained. Similarly, personal and professional impetus develops the drive for undertaking investigation that both shapes and challenges existing knowledge. These informed and refined the research questions, which, along with the purpose and conceptual framework, suggested the methodological approach. The methodology and methods chosen were subject to a number of considerations, including practical and ethical issues that will be explored within the sections below.



\* LREC = Local Research Ethics Committee

**Figure 2: Research design summary**

### **3.2 Research questions**

The research questions were created following reflection on the aims and purpose of the study. The questions were further shaped by the development of a conceptual framework that considered the lens through which the study will be approached, the initial review of the literature which identified gaps in knowledge and a context to the study, and a consideration for the ethical underpinning of the research and methodological approach that ensured the research was achievable, practicable and appropriate to undertake.

The conceptual framework - the system of concepts, assumptions, expectations, beliefs and theories - informed and refined the research design and questions (Miles & Huberman, 1994). The framework ensured the research design, approach, methodology and methods were explicit and congruent.

Broadly, the purpose of the research was to explore the phenomenon of breech childbirth, how the experience of breech birth is constructed by those involved, and to conceptualise breech birth within a social context. The focus of the research objectives are to describe and examine how gender, culture and social relations shape the current breech childbirth experience for women in the UK today.

The research aims are:

1. To add to the existing research and knowledge in a way that is explicit, exploring the experience of vaginal breech birth within the social context in which it occurs.
2. To provide insight into the gendered nature of the breech birth experience.
3. To provide an understanding of the specific cultural and social context of the vaginal breech birth experience, within the wider context of birth.
4. To produce new knowledge about women for women that can improve, in some way, the issues women face.



In light of these aims the primary research question is:

***What is the experience of vaginal breech birth within a social, cultural and gendered context?***

The secondary research questions are:

1. How is the experience of breech birth constructed within a gendered and social context?
2. In what ways do social, cultural and political constructs impact and influence the experience of vaginal breech birth for women?
3. How do issues around gendered interrelationships between those involved in the birth shape the experience of vaginal breech birth for women?
4. How do the places and contexts of care provision impact and influence experience of vaginal breech birth for women?

### ***3.3 Introduction to the research methodology approach***

Birth is an inherently gendered experience and central to the context of the research, so attention was given to feminist theory that informed a feminist research approach combined with a methodology that would enable sensitivity to the gendered nature of the experience. The development of a blended feminist research approach ensured women's experiences were central to the research and provided a starting place to explore a unique experience in a way that research in this area had previously not addressed.

When aligned with feminist research, the case study methodological approach chosen for this research not only considers the power relationship between researcher and participant, acknowledging the perspectives of different participants and engaging them in the research process, but also pays attention to the gendered context of the experience being studied. The strength of this combination of a feminist research approach and case study methodology is that it enables a comprehensive and contextual review of the breech birth experience and the data in a way not previously achieved. The research questions posed can be best answered using the combined feminist research and research case study approach as it allows for an in-depth contextual exploration from multiple perspectives of complex and unique events, which for this study is breech birth. This approach will enable the research to be both responsive to the issues identified by participants and make it accessible to multiple audiences (Stake, 1995). Whilst the research case study allows both quantitative and qualitative methodologies to be used, for this study a predominately qualitative approach was undertaken. This approach enables the intention to situate and contextualise a situation, attempting to make sense of a phenomenon in terms of the meanings people bring to them (Denzlin & Lincoln, 2008) in the hope of getting a better understanding of the subject of breech birth.

This chapter will introduce the feminist research and methodological approach for this study, providing rationale and transparent considerations for the decisions made.

### 3.3.1 Feminist research and methodological approach

A methodology is a theory and analysis of how research does or should proceed (Harding, 1987). Fundamentally, all and any methodology and method can be used in feminist research, but the way of approaching the research and the analyses of feminist enquiry differs significantly to the traditional scientific approach due to fundamental epistemological differences.

Feminist research asks questions that have women and women's issues at the core in order to challenge, develop and grow women's positions and causes. Whilst the study of women is not new, it is research on *and with* women, from the perspective of their own experience that makes feminist research distinct. Further, it is the feminist research consideration of the plurality of women as a culturally and socially diverse group that is a significant difference to traditional science methodological theories, which tend to homogenise women into a single group when conducting experiments or trials. The case study methodology adopted for this study addresses this through considering multiple perspectives by not only interviewing the women who have had a breech birth, but also intending to consider those who may be significant to them in this experience: their birth partners, wives/husbands, mothers, or midwives, for example.

It may be argued that there are methodological difficulties with developing knowledge based on women's experiences, in that experiences cannot be expressed independently from the specific culture, period and location within which the individual woman is situated, making it a poor or limited source of direct general knowledge of social realities (Ramazanoglu & Holland, 2005). Despite these difficulties, accounts of experience provide knowledge that does not or would not otherwise exist, with feminist research strongly arguing that taking account of women's lives and experiences is a necessary component of the knowledge of gendered lives and power relations (Ramazanoglu & Holland, 2005). In this way, the intention of this research is to explore not just 'what' the experience is of vaginal breech childbirth but also 'why' the experiences are as they are, and how they are shaped by the political, social and cultural aspects of the world they exist in. For this, a methodology is required that ensures the breadth as well as depth of experience is considered, in order to fully consider these questions.

Additionally, feminist research puts the social construction of gender at the centre of the inquiry, seeing gender as a basic organising principle which profoundly shapes our lives and experiences (Lather, 1991). This presents a distinct difference to traditional scientific research that rarely considers gender as the default, which is always to the patriarchal dominant norm. In order to capture the diverse and complex experiences of women, a case study method was employed that considered the way information was gathered and analysed by the researcher. Smart, (2009) raised concerns about the importance of researching 'talk' as well as 'text' to really hear how people interpret and define social interaction and life events. The feminist research approach strives to present the complex layers of social and cultural life in ways that value the emotion and feelings of the people involved, through presenting verbatim quotations to illustrate points and introduce authenticity, and this was applied when presenting the findings chapter. Berg (1998) insists that these illustrations need to be given context and interpretive meaning by the researcher as it is they that chose to use them, their length and the detail in them and where and when to insert them within the writing. Without this, context and meanings can be misinterpreted and deeper latent understanding missed. The case study methodological approach for this study was chosen to allow the perspectives of participants interviewed to become the main data source, being guided by the data generated to review secondary sources of data, such as documents, in order to provide context to the primary data. By using interviewing as the main approach to data collection, women's experiences were able to be shared in their own words, capturing the nuances and emphasis and emotions with the stories as part of the analytic process, acknowledging their importance and significance.

The role of the feminist researcher was also considered during methodological decision-making. Sandra Harding (1987), considered it vital to recognise that the cultural beliefs and behaviours of feminist researchers shape the results of their analyses no less than those of the traditional science researchers; the difference being the openness of this element within the research process. Indeed Stake (1995) and Merriam (1998), key authors of research case study, acknowledge and welcome this by asserting that knowledge transformation and creation are made possible through the process and interactions between the researcher and the participants (Grunbaum, 2007). These two positions are convergent in their acknowledgement of

the social nature of the research process, and in making it explicit rather than hidden or ignored.

In a similar way the concerns about relational power between the researcher and interviewees were carefully considered. Where health professionals also research those to whom they provide care, there needs to be more thought towards ensuring safeguards against coercion during the recruitment or consent processes. These were reflected in the research design. Feminist research calls attention to gendered power issues and what can be done about them as a distinctive concern; there is diversity in how this is experienced by different women in different contexts (Ramazanoglu & Holland, 2005). It is acknowledged that my approach, or conceptualisation of the research issue, is from my own self-engendered premise of working for nearly twenty years within an NHS maternity care system that has a powerful hierarchy of medical dominance. Being aware of this, and considering it during the research process through a reflective diary and researcher reflexivity, enabled transparency and increased trustworthiness as well as personal insight.

The foundation of feminist research lies in the centrality of gendered issues, the consideration of women's experiences and the acknowledgement of the plurality of women as a socially-diverse group, and with these in mind the research case study approach provided the most appropriate methodology to achieve these aims.

### **3.3.2 Research Case Study**

There has been ongoing debate about what is research case study, in terms of defining both the purpose, application and the approach (Merriam, 1998). Whilst this lack of clear definition has led to this methodological approach being misunderstood or misleading (Sandelowski, 2011), to attempt to provide clarity for the purpose of this research I will next summarise my understanding of the approach. In view of the complexities in definition and language, I shall keep to the terms research case study and research case study approach.

Research case study can be defined according to its different purposes (Simons, 2009). Research case study has been described as a research design (Merriam, 1998), as an empirical enquiry (Yin, 1994), as a generic term for the investigation of an individual, group or phenomenon (Sturman, 1994), as the examination of an instance in action (MacDonald and Walker, 1975 in Bassey, 1999), as a method (Simons, 2009) and as the '*study of the particularity and complexity of a single case, coming to understand its activity within important circumstances*' (Stake, 1995) to name a few. This final description by Stake is the most coherent with the epistemological paradigm of this research as the research case study approach will enable the complex case of the breech birth experience to be understood as a particular activity within context. In this way the personal, cultural, social, political and gendered circumstances within which the breech birth experience is situated will be considered.

Although the range of these definitions and descriptions can lead to confusion over the nature of a research case study and caution over its rigour as a research approach, the flexible and responsive nature of a research case study approach enables it to reflect the evolving, changeable and complex nature of the phenomena it seeks to explore. This is ideal for such a diverse and complex experience as childbirth. Like many methods and methodologies, research case study has developed over time with key authors bringing their own epistemology to interpret and develop understanding. Yin (2009), a leading exponent in case study, described the key as the enquiry in a real life context but also suggested case study could reveal a '*single objective reality*' (p64) a view predominately opposed by several others such as Stake, who sits within an interpretivist paradigm. The advantages of research case study, and the position of most research case study authors, is it that it is embedded in reality, recognises the complexity of social context and focuses on the subtlety and complexity of a specific case to illuminate a general issue (Bassey, 1999). Whilst this research aims to explore breech birth experience in a real-life context by interviewing women about their birth experiences and those around them (birthing partners, family members and health professionals who provide context and perspective to that experience) it will not attempt to find nor believe there to be a single answer as to what this experience is, or means, that can be applied universally. This research therefore will not seek to discover a single generalisable

'truth' about the experience of breech birth for women but, in alignment with my feminist post-structural theoretical framework, will seek to understand the holistic nature of the breech birth experience and the relationship between the people, events, contexts and processes that make up the component parts of that experience.

Using experience as a source for gathering new knowledge is central to feminist research and is common to the research case study approach. A consideration is how this new knowledge can be used and generalised. Cohen and Manion (1980) state that the aim of research case study research is to establish generalisation about the population which the case represents. Conversely, Simons (2009) asserts that research case study broadly aims to understand the case itself rather than generalise to a whole population, with Stake (1995) warning against making assertions from interpretations, leaping to conclusions and making grand generalisations. Instead, he proposes '*naturalistic generalisations*' referring to '*the learning processes through which we individually acquire concepts and information and steadily generalise them to other situations as we learn more*' (Bassey, 1999, p33). Similarly Bassey himself suggests that there may be scope for '*fuzzy generalisability*' where what was found with the phenomenon explored in the case may be found in similar situations elsewhere (p12). This research both acknowledges the necessity of grounding new knowledge in the uniqueness of women's childbirth experiences within the feminist paradigm, and also seeks to avoid the dangers of treating experiential knowledge as simply true and transferable. By taking Stake's advice the research will aim to be '*patient, reflective and willing to see another view of the case*' (1995, p. 12) through reflexivity and recognising similarities and differences to cases or situations, seeking to understand rather than to explain (Simons, 2009, p. 164).

Whilst definitions of research case study as a whole are challenging to pin down, there are also different categorisations of research case study based on what it seeks to achieve, or its theoretical intention (Bassey, 1999) and by the nature of how it is written up (Merriam, 1988).

Stake (1995) defined 3 types of research case study: intrinsic, instrumental and collective. The intrinsic case study is also considered to be a 'descriptive' case study

(Yin, 2009) where a case is studied and theoretical insight can be gained but in a discursive way. This was not the approach used in this research as it will not enable the aims of an in-depth theoretical insight and analysis required of the research question. When considering the research question and the epistemology of the research, a collective case study approach was considered, with cases defined by the type of care provided (private independent care or public sector care) and by which health professional (midwives or obstetricians) and in a different setting (home or hospital birth). However, this approach was discounted for a number of reasons. Firstly, this categorisation is constructed by the health care professional or science, rather than by how women see their births, and it is the aim of the study to explore the experience of vaginal breech birth without predefined categories. Secondly, the course of childbirth is rarely simply defined in the categories above. Women have combined care with both the NHS and private independent midwives or have care from both obstetricians and midwives, so categories will be blurred. Finally, the research does not seek to compare individual women's experience of vaginal breech birth, but rather to conceptualise the experience of vaginal breech birth - through the perspectives of women giving birth, and through the perspectives of those who share those experiences, taking into consideration how the social world and personal interactions shape and influence these people.

Stake's (1995) second descriptor of instrumental case study was also considered but rejected. This is described thus: '*a case is chosen to explore an issue or research question determined on some other ground, that is, the case is chosen to gain insight or to understand something else*' (Simons, 2009). This type of case study would not fulfil the research aims as it is the case itself – the experience of breech birth – that I wish to explore, rather than some other related issue. The final descriptor used by Stake, the collective, is also not suitable to be able to gain an understanding of the single case study. Had the research aims been to explore the experience of a number of higher-risk conditions in pregnancy, for example, this would have been more appropriate, but the single case means a more focussed approach is required.



Type of Research Case Study	Indicated by	Summary Descriptor
Intrinsic	(Stake, 1995)	The case is studied for the intrinsic interest of the case itself
Instrumental	(Stake, 1995)	A case is chosen to explore an issue or research question determined on some other ground; the case is chose to gain insight or to understand something else
Collective	(Stake, 1995)	Several cases are studied to form a collective understanding of the issue or question
Theory-seeking	(Bassegy, 1999)	The case is considered to develop new theory
Theory-testing	(Bassegy, 1999)	The case is considered to test existing theory
Story-telling	(Bassegy, 1999)	The case is considered to share the story it tells
Picture-drawing	(Bassegy, 1999)	The case is considered and shared through visual pictures
Evaluative	(Bassegy, 1999)	The case is evaluated through its study
Descriptive	(Merriam, 1998)	The case is written up in a descriptive way
Interpretative	(Merriam, 1998)	The case is written up in an interpretative way
Evaluative	(Merriam, 1998)	The case is written up in an evaluative way
Explanatory	Yin (1994)	The case is used to explain the causal links in complex real-life interventions
Descriptive	Yin (1994)	The case is used to describe real life interventions
Illustrative	Yin (1994)	The case is used to illustrate real life interventions
Exploratory	Yin (1994)	The case is used to explore real life interventions
Meta-evaluation	Yin (1994)	Many cases are used to evaluate a real life intervention
Theory-led	(Simons, 2009)	Exploring or exemplifying a case through a particular theoretical perspective
Theory-generating	(Simons, 2009)	Generating theory from the data itself through an interpretative lens
Ethnographic	(Simons, 2009)	Uses qualitative methods to gain close up descriptions of the context to understand the case in relation to a theory or theories of culture

**Table 1: Summary of different types of case study. Adapted from (Simons, 2009)**

The aims of this research fit more with the Simons 'theory-led' case study approach, which means exploring or exemplifying a case through a particular theoretical perspective (Simons, 2009). For this research a strong theoretical framework of feminism and a feminist research approach provide the theoretical perspective from which the case of vaginal breech birth experience can be explored in context. However, as Simons warns (p. 22), this approach is not so much a question of testing the theory of feminism, but more using the framework to elicit new concepts relating to this specific experience.

This research will also be interpreting the data generated, and therefore will have elements of an interpretive case study, described above by Merriam. However, interpretative research case studies use rich descriptive data to

*"...develop conceptual categories or it illustrate support or challenge theoretical assumptions held prior to data gathering... A case study researcher gathers as much information about the problem as possible within the intent of interpreting or theorizing about the phenomenon"* (Merriam, 1988, p. 28).

Therefore, this would not be the approach most beneficial for this research, as the intention is not to be able to illustrate or challenge the theoretical framework to be used, but to use it to enable different knowledge to be discovered. Additionally, the research does not intend to develop new theory, but to be open to new concepts that provide a better understanding of a complex subject. It is the intention of this research to be led by the theoretical platforms of feminist research, to be open to the what the outcome of the findings may be, but with the focus being on the social, cultural and gendered relations and context that will bring about a different conceptualisation of a particular event, or instance, the breech birth experience.

Research case study involves the study of an instance in action within a 'bounded system' where a particular case is studied so that a tolerably-full understanding of the case is possible (Bassegy, 1999). For many case study researchers this involves direct observation in natural settings in order to get as close to the research subject as possible. However, research case study is not limited to this alone and its flexibility enables a wider reach for data relevant to inform the case (Sandelowski,

2011). As it would be virtually impossible for the scope of this research to observe vaginal breech childbirth as it occurs, due to its infrequency and the possible influence of the researcher on the process, data was collected retrospectively. To achieve this, there were defined timeframes from which the data was taken. Taking data from births occurring within the previous 5 years was a practical decision due to the small number of vaginal breech births that occur, but also within a period of time where practice and attitudes had changed minimally, from my perspective as a clinician and from the literature review (no significant changes in national clinical guidelines have been published in this time). This differs from the historical or archival methodologies which study issues over longer periods of time, where society, culture, politics, knowledge and clinical practices will have all been different. However, it is acknowledged that the current knowledge is informed from, and by, history and cannot be seen as a separate entity.

Research case studies focus on cases decided and defined by the researcher, although these may be redefined or 're-cased' (Sandelowski, 2011, p. 155) as the research continues its flexible and responsive journey. For the purpose of the research the case will be defined as '**the experience of vaginal breech childbirth**'. This will enable the research to understand and theorise about the phenomenon of vaginal breech birth including the current care provision for vaginal breech birth, the experience of women who have breech childbirth and the factors that shape women's breech birth experiences. The research case study approach provides understanding and meaning of an event from a multi-person perspective within the context of where the experience occurs (Simons, 2009). From a feminist research and social geography approach this concept can be expanded to consider that women's experiences are all related to others, places, times and space. These experiences are both socially-constructed and relational, meaning that the individual perspective will be built from multiple interactions and thus shaped by many people's perspectives to create new ones. In this way, the research case study approach supports the feminist and spatial lens and creates contextual meaning through understanding how perspectives are always shaped by how we interact with the world, and the people within it.

Data was collected from a variety of different sources (for example, people present at the time of the birth, information given to or found by the mothers, and clinical protocols used by health professionals to guide practice), perspectives (for example, the woman who gave birth, and the health professionals providing care) and locations (for example, birthing units, women's homes and obstetric-led maternity units). In this way, the case can be known in the context within which it exists.

### **3.3.3 Considerations with using research case study**

Research case study is not held in wide esteem by the scientific community and holds a low position in terms of the hierarchy of research evidence (Centre for Reviews and Dissemination, 1996). This is possibly due to misunderstanding about the true nature of the methodological approach. Patient or clinical case studies are often used in medical and nursing teaching strategies to learn about pathology and their management (Bryar, 2000) and the similar names can cause confusion. Additionally, the conflicting definition of what constitutes a 'case study' methodology or approach, as discussed above, can mean the robustness of the approach is challenged. Sandelowski (2011), argues that research case study is not a methodology but is '*the intensive study (however accomplished) of one or more cases for some explicit purpose*' (p154). Further, she argues that research case study is a matter of positioning, a way for the researcher to '*signal to an audience they wish to reach*' (p154) as well as being a way to provide the study with appeal and make it acceptable in terms of credible findings. This suggests that the flexible nature of the research case study approach is its best feature; it enables the flow of data to be determined by the data rather than by pre-determined and rigid frameworks. In addition, it can be argued that the evolving and flexible definitions reflect the reality of the world being studied and enable rich data to be collected, as it responds to the emerging themes and is directed by the data rather than the researcher. This would imply that rather than being in decline, the case study approach is maturing as an established methodological design.

However, the flexible nature of the case study approach is considered in the literature as both a strength and weakness (Meyer, 2001). Whilst allowing the study

to be tailored around the research questions, this flexibility can also lead to concerns about the trustworthiness of the case study approach (Zucker, 2001); (Pegram, 2000)). In order to address the concerns, the following criteria were contemplated: truth, applicability, consistency and neutrality (Lincoln & Guba, 2000). In consideration of this, the findings were reviewed by my research supervisors to ensure the findings were based on the data produced rather than my own imagination (Strauss & Corbin, 1990). I also kept a reflexive journal throughout the research. This also adds to the credibility of the study with reflective writings used as a way of pausing to consider the subjectivity of the research process and findings. The nature of the case study approach also enables some degree of validation through member checking, with data produced being reviewed by some participants. The original intention was that all the participants would be involved in reviewing the data during a second interview. However, this became practically challenging due to the unpredicted distance and time required for travel and subsequent financial burden of travel. Subsequently, only 2 second interviews were undertaken and this is an acknowledged limitation to the study. Nevertheless, it was also noted that these secondary interviews did not add further to the information gathered from the primary ones; thus, it is my opinion that this did not substantially affect the rigour of the research.

The applicability of the research was considered, but Simons (2009) argues that single case studies are not intended to be representative of the whole population. Whilst it is extensively agreed that findings should not aim to be applied to broad populations, it is considered that they can be widely applicable to the generalisation of concepts and theories, which can then be considered more widely (McGloin, 2008).

In an age where randomised controlled trials and systemic reviews have been constructed by science to be considered as the gold standard of health-related research, all other research, and particularly qualitative research like this study, is relegated to the lower levels in the hierarchy of evidence (Strauss, et al., 2011). Although quantitative research and randomised controlled trials are appropriate to answer particular types of questions, other research questions and inquiries are more suited to research approaches and methodologies that are more qualitative

and flexible. With increasing interest in pragmatic research there is a drive for research to focus more on the perspectives of stakeholders and patient-centred outcomes with real world context rather than ideologies (Glasgow, 2013). This new thought on how research can be more relevant and effective in changing and improving practice moves research to a more socially-based starting point, with relationships and context a key element in research design and approach. Glasgow (2013) supports this shift in research, suggesting it will provide more relevant and rapid answers that will help integrate practice and research. This widening of thought on what constitutes effective and relevant research may help break down the hierarchy of evidence to present a more inclusive acknowledgement of what each type of research methodology can contribute to knowledge. In this way, I believe that case study methodology will continue to evolve and mature into a more mainstream research approach as it is able to add to knowledge in its own unique way.

### **3.3.4 Consideration of alternative research methodologies**

The exploratory nature of the research question means that the data collected will not require control or manipulation, methods best suited to an experimental or survey. Instead, it seeks to explore links and themes, rather than frequencies or incidence, and aims to '*illustrate an idea, to explain the process of development over time..., to explore uncharted issues... and to pose provocative questions*': core features of the research case study approach (Reinharz, 1992, p. 167). Unlike the randomised controlled trial experimental approach that aims to establish a causal relationship between controlled variables, the research case study method goal is to investigate the relationships between component parts (Sturman, 1994). In this context the method favoured will allow the research to provide an insight into vaginal breech birth experience from a multi-person perspective, within the context of where the experience occurs (home, midwifery led unit or hospital environment). The approach aims to 'preserve and understand the wholeness and unity' (Punch, 2005) of the breech childbirth phenomenon, encompassing important contextual conditions and variables (Yin, 2009). For these reasons, reductionist quantitative approaches were considered to be not appropriate in being able to answer the research questions posed by this study.

Other research methodologies were considered as less appropriate in order to be able to answer the research questions. An ethnographic approach of collecting data as it occurs, in the context in which it occurs, was considered unachievable due to the unpredictable nature of birth and the small potential sample size. It also would rely more on observations of events, rather than allowing the woman's voice to be heard, distilling the meaning of the experience from the individual's perspective. Action research was considered inappropriate for the aims of this research, as it does not seek to solve problems or provide practical solutions through the research itself (Punch, 2005).

A grounded theory methodology was seriously considered, and may indeed have been an appropriate methodological approach. Grounded theory is a methodology that studies humans in a real setting and develops theory from a constant comparative process, and is one of the most widely-used qualitative interpretive frameworks in social sciences (Thomas & James, 2006). There are many similarities between research case study and grounded theory methodology; both can include qualitative and quantitative data, but are predominately qualitative. Additionally, both approaches seek to explore real-life situations with a focus on contextual, social and cultural constructions of the world (McCann & Clark, 2003). Strauss and Corbins (1990) approach to grounded theory draws on the same theoretical frameworks as for this research; social constructionism and post structuralism with a focus on considering the contextual social and culturally-constructed macro and micro worlds of the participants (McCann & Clark, 2003). However, Glaser's approach to grounded theory has a more positivist stance based on critical realism and a post-positivist paradigm. This approach places the researcher as independent from that which is being researched and objectivist epistemology that would not be in alignment with this research.

Whilst being a popular and well-established research methodology, grounded theory also has its critics. The formulaic structured approach has limitations and has drawn concerns, which vary from it highlighting the immediate and apparent at the expense of more complex social situations (Layder, 1993) to criticism that the elaborate sampling procedures divert attention from the data (Bassey, 1999). Additionally, the popularity of the structured grounded theory approach may even undermine the

other, more open and creative, qualitative methodologies. It is suggested that the desire for structure represents old tenets of the positivist ways of knowing, reliance on a system and measurement, or perhaps '*a tacitly held desire to response to those foundationalist impulses*' (Thomas & James, 2006, p. 780). In this way the grounded theory approach, whilst offering an established and well-considered process to follow, was found to be limited in the possibilities that the research findings may bring. In comparison, the research case study approach offered a more flexible, broad and responsive approach.

One of the other main issues when considering grounded theory as a methodological approach was the requirement to either not undertake (Glaser) or only undertake a preliminary literature review (Strauss & Corbin, 1990) prior to the data collection being undertaken, in order not to taint or constrain the emerging theory. This was practically difficult: a detailed and thorough literature review had already been undertaken, not only for the purposes of my previous research into breech birth, but also since as a lecturer I delivered frequent evidence-based sessions for health professionals and students on the subject of breech. I was already saturated with the current research and wider literature on the subject which would, in terms of grounded theory methodology, have been a strong influence in my preconceived notion on the subject and issues, and reduce theoretical sensitivity (McCann & Clark, 2003). There was also concern about the availability of participants. For grounded theory there is a requirement for theoretical sampling. However, my own clinical knowledge and a preliminary scoping survey suggested only a limited number of possible participants, due to the scarcity of vaginal breech birth forcing a more pragmatic approach to sampling.

The other consideration was that, unlike grounded theory and ethnography, case study is open to the use of theory or concepts that can guide the research and analysis. For this research the study was already framed by feminist theory and concepts of medicalised childbirth, from my professional knowledge of working in maternity services for many years and my previous research in this subject area. Being unable to remove this basic pre-research understanding, I considered this another reason to not employ grounded theory or ethnography methodology.



After much deliberation the flexible and contextual nature of the theory-led research case study was considered a more suitable fit for the research approach.

### **3.4 Summary**

In summary, the theory-led research case study approach that has been used for this research into the experience of vaginal breech birth has been considered as the most suitable for aligning with the social construction theoretical framework and feminist research approach that informs the research design. This chapter has presented the rationale and explanation for this choice, with consideration for the current concerns and alternative methodologies that may have been suitable. The case has been presented as 'the experience of vaginal breech birth' and this will form the core of the research case study.

The next chapter will provide a detailed description of the method and data collection approach.

## **CHAPTER 4: METHODS**

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### ***4.1 Introduction***

This chapter will outline the methods used for this research study and the timelines indicating key stages. It will present the description and rationale for the data-collection process, including how this was shaped by the feminist research approach. It will outline the recruitment strategy, data-gathering methods and data-analysis approach. This chapter will conclude with the outline of the ethical considerations for this research.

### ***4.2 Data collection***

The breadth and depth of the data collected ensured that this phenomenon of vaginal breech birth was viewed holistically, comprehensively and in context (Punch, 2005).

The focus and case of the research was determined as the vaginal breech birth experience, and multiple sources of interrelated data were gathered from people directly involved in the childbirth experience (such as the mother, midwife and obstetrician). Data was also being gathered from relevant documents, reference documents, leaflets and sources accessed by the research participants, and identified by them as being significant to their experience.

#### **4.2.1 Feminist approach to data collection**

Feminist researchers use any and all methods available for data collection (Harding, 1987), but what creates a feminist approach to the methods employed is largely in the smaller and yet vital details to data-collection approach. Interviewing women

about their breech childbirth experiences is core to the collection of data for this research: using women's experiences to explore how breech birth is constructed, influenced and shaped to develop new knowledge is inherently gendered. Other people significant to the birth experience will also be interviewed, such as midwives and obstetricians. It was considered that there may be elements of oppression and domination with these participants' experiences and perceptions, due to the social and political nature of the current childbirth care system.

Within this feminist research approach there were elements of the study that were guided by the participants rather than being pre-imposed by the researcher. The data itself was shaped to some degree by the participants themselves. Documents that were mentioned or considered significant by the women interviewed were then followed up as secondary sources for documentary analysis.

During data collection there was careful consideration for the potential practical requirements for this group. Participants were offered choice of location, times, dates and were reassured I could work around or with their daily social lives. This flexible participant-centred approach assured that their needs were considered and valued, and the impact of the research was limited only to the potential inconvenience of their time during the interview/s. Being flexible and willing to adapt to their situational context, rather than inviting them to my place of study or work, ensured consideration and an attempt to address the power paradigm in the traditional researcher and participant relationship; a key element of feminist research (Punch, 2005)

#### **4.2.2 Site and Populations Selection**

The initial plan was to have 2 NHS sites for recruitment, again due to the potentially-low numbers of women giving birth vaginally to breech presenting babies (this had been identified in the initial scoping review). However, one site was unable to provide the required data from their computer system and could not therefore identify potential participants. The NHS trust informed me of this just prior to data collection commencing (eight months after initial agreement). After discussion, it was decided to go ahead with the one NHS trust and inclusion of Independent midwives and their client group, and see how many women could be recruited. Whilst recruitment was

achieved in terms of anticipated numbers of participants, the data-collection period was longer than expected, delaying the planned timeframe of the research and limiting opportunities for second interviews and member checking.

As a result of this, data was collected from two 'sites': one NHS Trust in the south of England, and from women who had been provided care by Independent midwives and Independent midwives themselves. The potential participants lived and worked mainly in the south of England. The NHS Trust site used was one I had not worked in or had any connection with, and I have never worked as an independent midwife, thus this reduced the risk of influence or coercion during the research process. The inclusion of independent midwives was considered to be important. Through my work as a midwife I know that a significant number of women chose to have their breech births with Independent midwives, and so it was important to reflect what occurs in real life and accurately document the experience from all the contexts within which it occurs. As breech presentation and birth can occur for women of any race, age, culture, socio-economic group, and in women having first or subsequent babies, the population was only limited by self-selection by agreeing to participate in the study; all the women who had had a vaginal breech birth in the previous five years were invited to take part from the sites.

It was also a pragmatic approach. Breech birth is relatively uncommon and to be able to get enough data I had to ensure that I included the sites where breech birth occurred. By limiting the sites to a geographical locality around where I lived, the intention was to ensure that travel and time costs were kept within reasonable limits, as it was all self-funded and in my own time. However, due to the diverse locations of the independent midwives and the women for whom they provided care, this was not always achievable. The nearest participant was a 15-minute walk from my home, and the furthest 105 miles away, a day's round trip. Whilst the participants who agreed to be interviewed lived much further away than anticipated, women who had given birth vaginally to a breech baby were low in number and this was my primary group for data collection. I therefore felt it important to include all the women who volunteered. This meant considerable pressure on my time and financial resources, and limited my ability to conduct second interviews as I had originally planned. To mitigate this, some second interviews or member checks were undertaken by phone,

but this did impact on my initial intentions of undertaking a secondary face-to-face interview where clarification or further information was sought. Whilst this may have limited the quality of the interaction and was not comprehensive, the secondary interviews provided little further information, so I felt the consistency of the study was maintained (Lincoln & Guba, 2000).

An exercise was undertaken to attempt to define the numbers of vaginal breech birth in the South-East of England to aid decisions regarding data collection. This involved reviewing locally-reported data regarding the number of reported vaginal breech births in an NHS Trust in the previous three years. This enabled a degree of benchmarking of expected numbers which provided a guide to the research in terms of expectations and scope (see [Appendix 14](#) for summary).

There are two elements that were carefully considered during the research design and during the data collection phase; the recall of experiences and the effect of the researcher on data provided by the participants. Few studies have investigated women's recall of their birth experiences and how these may be affected by time, and concerns may be raised as to the temporal effects on perceptions and accuracy of recall. Due to the limited number of participants potentially available for the research, it was a conscious decision to extend the period by recruiting participants whose experiences of breech birth (as health professional or childbearing women) had occurred in the previous five years.

The majority of data was generated from interviews with the participants. Self-reporting in this way can lead to the possibility of the participants giving answers which they think I, as a researcher or as a midwife, may want to hear (Polit & Hungler, 1998). With this in mind, I attempted to address these: firstly, by having clear verbal and written information sources for participants around the time of the interviews and reiterating to them my desire to hear their story/ies from their perspective. Secondly, I attempted to establish a good rapport with the participants, using my professional and personal skills to create a relationship quickly and put the participants at ease. Interviews were undertaken in places of participant's choice. I used several techniques in order to gain the participants' trust. These included the clothes that I wore, my body language, the use of sensitive humour and finding things in common. This purposefully-informal approach was designed to reduce the

apprehension phase and move to a place of co-operation and participation (DiCicco-Bloom & Crabtree, 2006). I remained reflexive through the use of the reflective diary and discussions with my supervisors.

Whilst I feel that I managed to maintain my researcher role during the data collection, there were challenges when on two occasions where I moved into the midwife role and this called for pause and reflection. Responding to distress or direct questions during interviewing required an immediate and compassionate response, and consideration of the effect of this on the research and individuals involved. Whilst I felt my actions were appropriate, it did raise the issue of how involved I should, and can, become in these circumstances, and how this may affect the participants and the research, a struggle recognised by others. My experiences mirror those of Anderson (1991) in her study about Chinese and Anglo-Canadian women with diabetes, which led to her being asked for clinical information by the participants based on their understanding that she was a nurse as well as a researcher. This is seen as a positive reciprocal arrangement that aligns with the feminist research approach of acknowledging social roles, and encourages attempts to minimise power differentials through reciprocity and co-construction of knowledge (DiCicco-Bloom & Crabtree, 2006).

Whilst the scoping exercise provided the information about the group and type of participants, there was consideration for requiring people to recall events from a few years before and how this may affect the study. There are limited studies in this area and they are not conclusive. Waldenstrom (2003) concluded that memories of birth experiences became more negative over time. However, Stadlmayer et al, (2006) suggest some aspects of experiences become more positive with time. Takehara et al (2014) recently published a large-scale study on recall over a 5-year period and concluded that women can remember their childbirth experience clearly at 5 years after the birth. This suggests the experience of birth has a powerful effect on women and aligns with psychological studies which suggest/show that emotional events are more likely to be vividly and accurately remembered (Takehara et al, 2014).

An inclusion and exclusion criteria was developed to ensure the purpose of the research was accomplished, to provide guidance to participants, to address practical factors (such as language barriers and costs) and to maintain ethical integrity.

### **Inclusion criteria:**

- Childbearing woman who had given birth (vaginally) to a singleton breech baby (live birth) in the last 5 years
- Currently-registered health professional who had provided care for a women during a vaginal breech birth in the last 5 years
- Speaks and understands English
- Lives in South East of England (this was widened when recruitment was initially poor)

### **Exclusion criteria:**

- Women that have been provided care by the researcher
- Health professionals who had been taught by the researcher in the previous 5 years
- Health professionals undergoing any form of supervisory review/investigation

## **4.2.3 Data Gathering Methods**

Qualitative case studies gather data from interviews, observations and documents (Merriam, 1988). I used one primary and one secondary method of data collection in order to exploit the strengths of each and allow the secondary sources to provide context to the primary one. The primary data source was interviewing women who had experienced vaginal breech birth and midwives and obstetricians who had provided care for women having vaginal breech birth. During the interviews other documents or sources of information mentioned or identified by the participants were noted and later sourced as secondary data, as part of the data collection process. The following documents were identified during the data collection process: protocols, which provided guidance and standards for clinical care, and information leaflets, books and websites given to and used by the participants in their search for information about breech birth (see [Appendix 7](#) for list of documents included in documentary analysis).

#### **4.2.4 Recruitment and consent**

A purposeful convenience sampling approach was used, as the number of potential participants was known to be low. Whilst acknowledging the risk of bias with this approach, it was also practical and pragmatic given the time and resource limitations of the research. The table below shows the characteristic of the participants. The social, educational, cultural and political backgrounds of the participants were not included in the data collection as this was not considered at the time to be relevant. However, on reflection it may have been useful to review these additional characteristics in order to assess potential bias and over- or under-representation in a more transparent way. As the research was not intending to be representative of a population or group, but an exploration of a specific bounded case, this would not be of significant bearing on the findings, but may be considered for future research in this subject area. All the women who participated had given birth to a breech baby in the 5 years previously and all spoke English (as translation facilities were not within my resource ability). All the health professionals recruited had been practicing for more than ten years and whilst many had experiences of breech births from many years previously, they were asked to recall their experiences from breech births within the last five years. The health professional experiences of breech births varied from providing care for one breech birth to nearly a hundred breech births. Again, in retrospect, this characteristic data could have been captured more fully at the time to provide more context, and this will be considered for future research.

Recruiting women who had had vaginal breech births was achieved by using gatekeepers who identified potential appropriate participants through birth registers from the Independent Midwives Association and NHS Trust. Women were initially approached by letter and phone by the gatekeepers to invite participation in the research. Gatekeepers were recruited following communication with the Head of Midwifery and the secretary for the Independent Midwife Association, who kindly identified a person who was willing to be a gatekeeper, and I maintained regular contact with them during the data-collection phase.



During the interviews with women who had given birth, if their partners/birth partners were mentioned specifically as being a significant part in the birth experience, then they were left a letter for them to consider passing onto their partner/birth partner, inviting them to be part of the research. In practice, however this element only came up during three interviews with women and none of their partners/birthing partners came forward using this recruitment strategy (see [Appendix 8](#) for letter). The lack of success of this method of recruitment has been considered. Possible reasons are that women chose not to pass on the letter of invite, or the research being of low interest to the partners or simple practicalities of lack of time. However, this lack of interest was not followed up so is only supposition. The reflexive approach to the research produced some thoughts on the implications of the absence of this group in the research, and to make it explicit within the research. Initially considered a position of indifference to the research, further reflection led to a consideration of a number of elements. This included deliberation on how my position as a woman, as a researcher and as a midwife may have influenced responses of partners/birth partners and their contribution to it. In essence, there is a possibility that *who* I was impacted on their decision to not participate. Research around fathers' experiences of birth suggest common responses of feeling helpless, anxious and useless (Genesoni & Tallandini, 2009), and where birth was difficult fathers felt that the midwife should have guided them more (Vehvilainen-Julknen & Liukkonen, 1998). Reflecting on this, the partners/birth partners may have felt this research triggered some anxieties or complex feelings towards the birth, and that perhaps it was the midwifery profession that may have contributed to their reluctance to participate. Whilst this is an unknown element, it does raise questions and ideas for further exploration in future research.

Health professionals were recruited through voluntary basis. Posters were displayed in staff areas (NHS Trust) or shared on group e-mail communication (Independent Midwives Association). The gatekeepers gained consent from interested potential participants to pass on their information to me. I would then phone them, provide further information about the study, answer any questions the participant had and gain verbal consent from them to be recruited. An initial interview would be arranged at a mutually-convenient time and at this meeting I offered further verbal information and went through the consent form, answering any further questions the participant

might have had. Verbal and written consent was gained from all participants (see [Appendix 6](#) for consent form).

Decisions about the 'right' number of participants was driven by ensuring that all relevant categories, in this case the different participants in a breech birth experience, were included to provide enough data to answer the research questions. Masons describes qualitative sample size as being '*large enough to make meaningful comparisons in relation to your research questions, but not so large as to become so diffuse that a detailed and nuanced focus on something in particular becomes impossible*' (Mason, 2002, p. 136). Whilst the ultimate intention was to continue to recruit participants until no new knowledge was being produced, the tentative expectation was to recruit 8-10 women, 4-5 people who were significant to the women (identified by women in their interviews and subsequently invited to participate), four or five midwives and four or five obstetricians. These figures represent the view of the centrality of women's childbirth experiences to this research, but acknowledgement of how other key people were involved and influenced the breech birth experience. There was also a concern for the time and resource limitations of the study, which was a practical consideration. In actuality, 11 women were recruited, 6 midwives and 2 obstetricians. The data collected from these interviews was rich and provided the ability for meaning to be constructed from it, which will be presented in the next chapter.

The characteristics of the women who had given birth are described in the table below. This was a purposeful sampling approach and participation was completely voluntary, with the option to withdraw at any time.

Pseudonym	Lead professional for birth	Location of birth	Parity at time of birth	Known (planned) or unknown breech
Lucy	Independent Midwife	Home	0	Known
Sam	Independent Midwife	Home	1	Unknown
Kay	Independent Midwife	Home	1	Known
Orla	Independent Midwife	Home	0	Unknown
Sara	NHS Midwife	Hospital	0	Known
Carla	Independent Midwife	Home	0	Unknown
Lara	Obstetrician	Hospital	0	Unknown
Amy	Independent Midwife	Home	1	Known
Jessica	Obstetrician	Hospital	0	Unknown
Hannah	Obstetrician	Hospital	0	Unknown
Kerry	NHS Midwife	Hospital	1	Known

**Table 2: Characteristics of participants – women who had given birth to a breech baby**

Pseudonym	Role
Helen	Independent Midwife
Rose	Independent Midwife
Liz	Independent Midwife
Erin	Independent Midwife
Katie	NHS Midwife
Rhian	NHS Midwife
Betty	Obstetrician
Jan	Obstetrician

**Table 3: Characteristics of participants – health professionals**

#### 4.2.5 Interviews

Interviews were chosen as the main method of data collection as it comfortably aligned with my ontological position that suggests that people's knowledge, views, understandings, experiences and perceptions are meaningful constructions of the social reality that this research seeks to explore (Mason, 2002). With the research framework of social constructionism, the recognition is that interviews will provide a reconstructed view of participant's birth experiences through the interactive dialogue of the interview itself (Gergen, 2009). The advantage of interviewing, particularly the unstructured and semi-structured approach used, is that the data will enable the research to achieve the depth and roundness of understanding required to explain something about the social meaning, context and complexity of the breech birth experience. This is an advantage over the structured interview or survey that provides more of a superficial analysis and a broad understanding of surface patterns (Mason, 2002).

The majority of interview time was spent in an unstructured mode (i.e. asking interviewees to share their experiences without prompts or questions so their story is as they wish to tell) to enable fresh insights, and to increase the likelihood of generating a fairer and fuller representation of the interviewee's perspective. However, prompt questions were prepared and used at times where it was perceived that interaction would prompt participants to share more aspects of their experiences, so this part of the interview was more semi-structured (see [Appendix 9](#) for prompt questions). A pilot interview was undertaken as it had been four years since my previous research study and I was keen to refresh my skills. This interview enabled time for reflection and to identify where my techniques needed to improve. This also helped the development of the prompt questions which were devised in collaboration with the pilot interviewee, a woman for whom I had provided care during her breech birth (which was an exclusion criteria for participation in the study). It is acknowledged that all dialogue is subject to bias and the influence of myself as the interviewer on the generated data cannot be eradicated. Instead, I have been reflexive throughout the research process and remain thoughtfully self-aware (Doyle, 2012) (see [Appendix 5](#) as example extract of reflexive diary and Chapter 7, Section

7.2.7 on reflection). Practically, it would have been difficult to collect this data in any other way in order to address the research questions. Birth can be observed and documented clinically, but people's birth experiences can only be captured through them telling their story, and verbal storytelling is the most accessible form of communication for most people.

The interviews lasted about an hour and all interviews were audio-tape recorded with the participant's consent. Any documents identified by the participant during the interview that may have contained information/data relevant to the research were sourced where practicable. All documents and data sources were subject to determination of their authenticity and accuracy as part of the research process (see section on documentary analysis below).

Data collection and initial analysis was undertaken simultaneously where possible. Certainly, my initial thoughts on what was emerging from the data were shared with participants at the end of the interviews, to check my understanding. Realistically, there was often a longer-than-intended gap between the data collection and initial analysis due to time constraints and the ebb and flow nature of interviews (at times I had several interviews in one week and others were months apart). Because of this I always generated a reflective account of the interview as soon as possible to capture initial thoughts and responses to the interviews, which were then referred to during the initial data analysis phase (see [Appendix 10](#) for example of initial thoughts following interview). Emerging insights, hunches and tentative hypotheses influenced the next phase of data collection in a continuous cycle (Merriam, 1988).

Challenges arose around technical difficulties of recording the interviews and my limited typing skills. The quality of sound recordings were good on the whole, but interviewing women with small babies and young children brought practical issues. The tape recorder was a source of fascination for small children and if left unattended (even for a split second) the recorder was in danger of being chewed or used as a toy. Babies/children needed changing and feeding so interviews and recordings were frequently paused and the most common challenge was trying to ensure the women's stories were heard above the general noises that small children and babies make. To mitigate these challenges the tape recorder was placed in the least tempting-to-children place but within recording distance. I became familiar with

interviewing around the needs of a young family and accommodated frequent stoppages, and used written notes when noise levels endangered quality recordings. My limited typing skills and speed was a source of frustration, and took considerable time. Whilst I transcribed the vast majority of interviews in order to maintain immersion in the data, time limits meant I employed a transcriber for some of the later interviews. To compensate for losing the benefits of immersion in the data, the transcribed text and recordings were reviewed simultaneously in these cases and notes made on elements that I felt were significant (for example, tone and emotion).

Once transcription and initial analysis from the interview was completed, a second follow-up interview or discussion was arranged where practicable and where the initial analysis raised questions. Most of the participants were able to be very generous with their time and the initial interviews were comprehensive and thorough, with clarification of meaning mostly addressed at the time. Only three secondary interviews/discussions were undertaken and each lasted about ten to twenty minutes; they were undertaken by phone due to time and resource restrictions, and focused on discussing the data from the primary interview, clarifying meanings and the representativeness of the initial impressions. This provided some verification to improve the reliability of the study. The data-collection phase ended when categories were saturated and there was an emergence of regularities (Lincoln & Guba, 1984).

There were some challenges during this phase with recruitment slower than expected. Many different approaches were used to engage both the gatekeepers, with gentle reminder e-mails and clear expressions of gratitude for their help. There were some occasions where initial interest from potential participants then did not materialise into actual participation, mainly from health professionals, but this was respected and no coercion was employed at any point.

The secondary source of data was from documents. These were identified as being the clinical protocols/guidelines available at the time the births occurred and any other sources of information given to or used by the participants interviewed.

#### 4.2.6 Documents and documentary analysis

Much of social life in modern society is mediated by written texts of different kinds. In health care this includes clinical guidelines and policies, patient information leaflets, magazines, and books written to inform both the health professional and patient. These and other documents can provide rich and accessible research data that gives context to the study.

The type of materials collected for this study were considered secondary data sources as they contain material not specifically developed for the research but for other purposes (Stewart, 1984). The main advantage of using existing documents is that the data is readily available, takes little time to collect and provides a relatively-inexpensive form of data (Lincoln & Guba, 1984). In addition, a further strength of using documentary evidence is its 'non-reactivity', a claim to be unbiased within the research as its substantive purpose was for other things (Webb, et al., 1984).

Although this is true, all documents will be shaped by a considerable number of factors including the author's motive, beliefs and knowledge, political, social, cultural and economic pressures, and well as gendered lives - that of the author, and of those groups considered within the document. These elements were considered and, where possible and relevant, used to establish context in relation to the primary experience of the participant.

Documentary analysis can be approached in several ways, but as this is a subsidiary to the main research data gathered from interviews, the analysis approach was predominately thematic content analysis. Analysis followed a predetermined 6-phase approach, as described below, where themes are drawn considering presuppositions and meanings that '*constitute the cultural world of which the textual material is a specimen*' (Perakyla, 2008, p352. In (Denzlin & Lincoln, 2008). Additionally, the analysis of the documents incorporated some elements of critical discourse analysis to text analysis in order to consider the underlying constitution of subjects and objects. Critical discourse analysis is concerned with the way texts reproduce power and inequalities in society (Fairclough, 2003), which aligns strongly with the feminist research approach. The aim of critical discourse analysis is to map three elements: analysis of language texts, analysis of discourse practice (processes of text production, distribution and consumption) and analysis of discursive events as

instances of socio-cultural practice. An extract of the documentary analysis can be seen in [Appendix 11](#), but when documentary analysis provided some context to the primary data this will be presented in chapters 5 and 6.

By analysing the documents that were identified by the participants as being significant to their experiences, they provided situational and contextual data that intended to provide a fuller understanding of the meaning to the experiences shared.

Concerns about documentary analysis included the possibility of limited availability of the documents desired, due to it being missing or incomplete, or that it may be inaccessible to the researcher when access is only achieved through gatekeepers (for example, clinical guidelines which can only be shared where agreed by the NHS Trust involved). However, for this research the documents requested were sent and, as some were dated, it can be said that they were considered to be complete. Whilst not fully appreciated prior to the study, several participants stated that they accessed websites for information. It was more problematic to undertake full analysis of websites as it is difficult to establish the content at the time it was viewed by the participant, so a pragmatic approach was used to analyse the general tone, context, language and message presented at the time I accessed them.

Further, where documents were referred to, this was often in a generic way such as 'hospital policy'. This limited the ability for this research to use documentary analysis as a source of secondary data to the extent that was originally expected. This was reflected in the findings and discussion chapter.



## **4.3 Data analysis**

### **4.3.1 Introduction**

The primary source of data was collected through interviews and transcribed into written text within a four-week period. The data collected was analysed in a systematic, disciplined, transparent and described way (Punch, 2005) in order for readers to have confidence in the findings. This was undertaken in two phases; an initial analysis during the data-collection phase to identify general themes and generate general thoughts and concepts that helps to guide the data collection, and a more detailed analysis towards the end of the data-collection phase to identify where saturation point had been reached: where no new information was emerging.

### **4.3.2 Thematic content analysis**

Thematic content analysis was chosen as the method of data analysis for this research. Thematic content analysis is a method for identifying, analysing and reporting patterns or themes within data. It is a flexible tool and can provide a rich, detailed, and yet complex account of data (Boyatzis, 1998). The approach allowed the data to be analysed at a latent level beyond the semantic content, exploring the underlying ideas, assumptions and conceptualisations, ideologies that shape the data (Attride-Sterling, 2001). One of the main benefits to thematic content analysis is its theoretical flexibility, being compatible with the constructionist paradigm amongst others (Braun & Clark, 2006). This flexibility means the analysis can allow for the full and unconstrained exploration of the data collected, maximising the ability to provide a rich and detailed account of the experience or phenomena. Within the social constructionist paradigm this method of analysis will examine the ways in which events, realities, experiences and communications are the effects of a range of discourses operating within society (Braun & Clark, 2006). This enabled meanings and presuppositions to be considered, building new concepts on how the breech experience is constructed and given meaning through social relations and social, cultural and gendered context. In order to do this, the analysis needed to go beyond the semantic content of the data to identify underlying ideas, assumptions and

conceptualisations that inform the semantic content of the data (Punch, 2005). This latent thematic content analysis will enable identification of the features that give meaning to the breech birth experience, interpreting the data to form concepts beyond simple description (Burr, 1995). Within feminist research this method of analysis offers the opportunity for women's experiences to be explored, its free nature not subject to the restraining pre-determined rules of other methods so more likely to enable the diverse and complex nature of women's birth experiences to be presented from within the social world in which it exists.

The free and flexible nature of thematic content analysis has potentially been one of the criticisms of it as a method. Concerns are that there is poor agreement on process and approach; it can appear to lack definitive and explicit rules on what is done and how leading to mistrust of the findings and its dismissal as a robust method. To address this there is a requirement for this process to be methodologically sound by explicitly describing the processes undertaken assuring the trustworthiness of the research.

Discourse analysis was seriously considered as an alternative approach to analysing the data as it aligned closely with the social constructionist paradigm of my research. This type of analysis assumes that our experience and internal constructions of reality are constituted in and throughout written and spoken communication, which can be unravelled to identify the processes through which the participant's internal worlds are constructed. Elements of this will be considered during data analysis as careful consideration will be given to values coded to identify individual's cultural and social meanings from the interview dialogue. However, in its purest sense, discourse analysis was not considered the most appropriate method for this research. The aim of the research is to not only to conceptualise the breech birth experience within a gendered and social framework, which may have been achieved with discourse analysis, but also to contextualise this within a framework of women's contemporary lives. The case study approach enables this context through collecting data from secondary sources, through interviewing people significant to the birth experience and through collecting documentary evidence. In this way thematic content analysis will be more appropriate as it offers a more flexible and comprehensive approach required to suit the diverse nature of the data collected.

The way in which thematic content analysis may be used to identify, compare, contrast and make sense of themes within text is described in several texts such as Boyatzis, (1998), Attride-sterling, (2001) and Edwards, (1993), but the work of Braun (2006) was felt most applicable to this research.

A 6-phase approach to data analysis was employed: familiarisation with the data, generalising initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report. Analysis of the data involved the data collected being analysed and given codes in order to be put into developing themes, alongside and in consideration of the data already produced. Data was gathered, read and re-read, analytic memos and observations made, codes given and organised systematically as patterns and themes emerge. Data was coded by obvious factors such as who, what, when and where, and also by conceptual categories or theories that interpret the data. Developing the themes and sub-themes involved looking for significant elements in the data that reflected the purpose of the research.

### **4.3.3 Coding**

Coding was started alongside data collection, with preliminary codes jotted down during transcription of the interviews along with analytic memos to enable initial thoughts to be captured (Saldana, 2011). Significant passages of transcript were highlighted as 'codable moments' (Boyatzis, 1998) which were returned to during further data analysis and some were used as quotations to illustrate themes. The research question and secondary aims were kept to hand, along with the theoretical framework to ensure focus when making coding decisions. A code book was developed to document codes that emerged from preliminary and secondary data analysis (see [Appendix 2](#) for an example of this) as this provided an analytical opportunity to organise and re-organise the codes into categories and sub-categories. These codes were reviewed several times by using analytical memos, reflective accounts and researcher reflexivity and adjusted as required.

Analytic memos were documented during the coding process in order to reflect on the process and choices made, emerging categories, and themes and concepts.

They are considered '*sites of conversation with ourselves about the data*' (Clarke, 2005, p. 202) and enable reflexivity on the data and the process, to allow for critical thinking, and challenging any assumptions and preconceived ideas that we bring to the research. It facilitates creativity and free thinking and allows tracking of the evolution of the study (Saldana, 2011). See [Appendix 3](#) for examples of analytical memos.

All coding was undertaken manually. This provided opportunity to have ownership of this stage of the process and allowed abstract information to become concrete data (Graue & Walsh, 2011). It was decided, after careful reading and on reflection, to employ a coding method that was in harmony with my theoretical positioning and allowed the research question/s to be addressed. An amalgamation of three forms of coding were used: attribute coding, in vivo coding and values coding. Attribute coding can be described as setting or context codes; it is useful as I used multiple sources of data and it provided good data management and context for analysis and interpretation. It was particularly useful for identifying patterns of interrelationships, influences and affects, and cultural themes to reveal organisation or hierarchical themes from the data, which is one of the secondary aims of the research. In vivo coding was used as a way of extracting terms that are from the culture and perhaps subculture of those being interviewed. This means that data is framed in terms from participant's everyday lives rather than the academic or midwifery paradigm that I bring as the researcher. This is very much in alignment with the feminist research approach as it seeks to preserve participant's meanings of their views and actions (Charmez, 2006). Values coding reflects the participant's views, beliefs and attitudes, representing their worldwide views (Saldana, 2011). As this research sought to explore the cultural and social values and intra and interpersonal experiences and actions, values coding provides an opportunity to develop collective meanings, interactions and interplays of interconnected data (Saldana, 2011)

The second part of the data analysis process was where the primary coding was developed into categories, themes with concepts and new thoughts emerging. Initial codes were reorganised to develop smaller number of broader categories and then themes. Pattern coding was used in this process. This is described as like a meta-code, where codes are grouped into smaller sets of summary codes, and is

particularly useful for examining social networks, human relationships and formation of concepts and processes (Miles & Huberman, 1994). A lower number of general broad themes were developed and an overarching concept presented. In order to discuss and evaluate emerging themes and categories, regular meetings with my research supervisors at the University provided an opportunity to review transcribed data, codes and the emerging themes. This provided opportunity for further reflection, clarity of purpose and ongoing researcher reflexivity.

<b>Data</b>	<b>Code</b>	<b>Category</b>	<b>Theme</b>
<i>I was kind of a bit devastated at that point because I wasn't going to be able to have a water birth. That is what I had <u>always planned in my head</u> and that was what I was really upset about.</i>	<i>Assumptions &amp; expectations</i>	<i>Unmet expectations</i>	<i>Losing the way</i>
<i>Finding out that my midwife did not want to support a breech birth was shocking to me and my husband and <u>left us lost</u> we didn't know where to begin... <u>we were completely lost.</u></i>	<i>Lost and found</i>	<i>Loss of identity</i>	
<i>And actually that's what I think, up until then, all the other people, <u>it was all just based on "oh it is a breech" so therefore a caesarean.</u> There was no "How old are you, how many children have you had?" <u>There was nothing based on me as a person,</u> it was all just breech = caesarean</i>	<i>The norm / individuality</i>	<i>Loss of normality</i>	

**Table 4: examples of raw data to code, to category, to theme**

<b>Data</b>	<b>Code</b>	<b>Category</b>	<b>Theme</b>
<i>I couldn't lie to myself that the hospital is the safest place <u>because I had experienced that it wasn't</u></i>	<i>My experience</i>	<i>Guided by experiences</i>	<i>Deciding the right path to follow</i>
<i>We would normally made decisions by collecting lots of information and sifting through it but we couldn't do that in this situation. Not possible. <u>You have to go with intuition, I guess. There isn't always time to make a decision for some people.</u></i>	<i>Knowledge source</i>	<i>Desire to know / have knowledge</i>	
<i>I remember it being absolutely fine... <u>It felt completely right being at home and I was very comfortable and then at that point I think determination took over in terms of decision-making. I had got that far and it felt so right so I just thought there is absolutely no way I was going to go [into hospital] and seemed more determined to push. I didn't feel like it was a cognitive decision; it was more I was just going to carry on here</u></i>	<i>At one / engagement</i>	<i>Engagement / disengagement</i>	

**Table 5: examples of raw date to code, to category, to theme**

#### **4.3.4 Themes and development of findings chapter**

A theme captures something important in the data and represents a patterned response or meaning within the dataset (Punch, 2005). Researcher judgement was applied to determine key themes during analysis. These were not necessarily the most prevalent across the data collected - a numerical application, as required in quantitative data analysis, is not a requirement - but it is recognised that within the flexible framework there is an ability to demonstrate how themes were developed, if not from the number of times things were mentioned. The research questions provided a framework for determining developing themes. Themes emerged during the analysis approach which were considered to capture something important in

relation to the research questions (Braun & Clark, 2006) in the judgement of the researcher, and evidenced by the data itself through examples and quotations.

In order to show transparency of how the themes were developed from the data during the analysis phase and alongside the development of the code and categories, I developed tables to show how the themes were directly informed from the participant's stories. This tool was found to be very helpful during the analysis stage to demonstrate the thought processes and workings, but also showed how the spread of the different types and diversity of experiences informed each theme. The interpretive summary represented the bringing together of key important emerging issues from the narratives that, along with the development of code, category and themes, contextualise the findings when presented. This additional step in the analysis process was not only very helpful for me in building the themes coherently, but also increased the rigour in the process, providing additional transparency and direct connection to the voices of the participants.

Extracts from the tables developed for the 4 themes can be seen in the Appendix 1.

#### **4.3.5 Reflecting and reflexivity**

Analysis involved a constant movement back and forward between the entire data, the extracts of data being coded and analysed, and the analysis of the data already produced. Alongside this, a personal reflective diary enables enhanced researcher reflexivity that considered the process, journey, alternatives, emotions and meanings.

To enhance trustworthiness during the data analysis phase, verification was sought from participants where possible, with discussions between the participants and researcher (Ramazanoglu & Holland, 2005). Practically, due to time and resource limitations, this predominantly involved discussing with the participants, at the end of the initial interview, some thoughts and issues that I felt had come through strongly in their narratives. I also conducted three follow-up discussions by phone, clarifying meanings and discussing initial thoughts with participants. As the research is asking participants to recall events from some years ago, participants' perspectives and

recollections may alter over time (Sandelowski, 1993) so discussing initial thoughts on the emerging elements with the participants themselves provided an opportunity for clarity of recall of experiences. The aim of this method was to ensure the experience of the participants is reflected as they wish, to provide opportunities to connect ideas and experiences, to assess their and my understanding and interpretation, and to challenge ideas and themes as they develop (Holloway & Wheeler, 2002). This approach, common in feminist research, also acknowledges and attempts to address the issues of power within the researcher/researched relationship, discussing and agreeing themes emerging and giving an opportunity for participant input with the analysis phase and to be part of the creation of the research. Interwoven with this element, and throughout the research, was a process of continual reflexivity that considers how the researcher is situated within the research and how this has an effect on the research itself.

Reflexivity is seen as a vital part of the process of generating knowledge in qualitative research (Blaxter, et al., 2006) and is commonly seen as the process of a '*continual internal dialogue and critical self-evaluation of researcher's positionality*' (Berger, 2015). It also acknowledges how the researcher's position affects the research itself as a form of self-appraisal. This means:

*"turning of the researcher lens back onto oneself to recognize and take responsibility for one's own situatedness within the research and the effect that it may have on the setting and people being studied, questions being asked, data being collected and its interpretation. As such, the idea of reflexivity challenges the view of knowledge production as independent of the researcher producing it and of knowledge as objective"* (Berger, 2015, p. 220)

Feminist researchers consider reflexivity as a central, almost second-nature part of the research process, with self-reflexivity an essential component for '*unsettling hierarchies*' (Nencel, 2014, p. 76). By this, reflexivity provides an explicit way of positioning the self within the research, disclosing the researcher's own assumptions, identity and ideas and being open about how these influenced the relationship of the researcher and researched in the research process. In this way,



feminist research is being done differently to other research, since the aim is one of non-exploitation, consideration of power relations and support of a process of change at an individual or a social level, or both (Kobayashi, 2003). Whilst this can be done very explicitly and visibly within the research text, the approach taken for this research was to be continually aware through keeping a diary, writing reflective accounts during the research process. Additionally, I was open about myself as being both a researcher and a midwife throughout the research process, acknowledging that this may have had an effect on the relationship between the research subjects and myself, but wanting to be honest. This was, I felt, an advantage to some of the individual participants who, on some occasions, asked questions about their births to which I was able to provide some answers or advice. However, I was also aware of the centrality of the mother-midwife relationship, both positive and negative, that has considerable effects on birth experiences (Hunter, et al., 2008) which could inform preconceptions and shape the relationship and dialogue between the midwife researcher and woman. Further, there is knowledge both from literature (Tew, 1990) and from my own experiences about the relationships between different professionals can be collaborative or poor, which may also have an effect on this research. Being aware and considerate of this was an important consideration for this study, most particularly during data-collection and analysis stages. See [Appendix 5](#) as example extract of reflexive diary and Chapter 7.

#### ***4.4 Ethical considerations***

The research was carried out in accordance with the University's Code of Good Practice in Research (University of Brighton, 2010), guided by the principles of beneficence, non-maleficence, justice and respect for autonomy.

Risk, in reference to the potential of physical or psychological harm, discomfort or stress to participants, was considered and minimised where possible. These were considered prior to the recruitment phase of the research where, as much as is possible, the eventualities that may arise as a result of participation were considered, and plans made to mitigate, manage or assist were put in place. All participants were informed of the potential risks and benefits of participation, both verbally and in written form, via an information sheet (see [Appendix 13](#)) prior to giving consent or

refusal. Suggested potential benefits to participants included an opportunity to share their story, reflect on their experience and feel valued as a contributor to a research study. Potential risks were identified prior to the recruitment phase, and included potential distress of remembering an unpleasant or difficult time or event through the interview process, identification of participants or birth, the potential vulnerability of participants (due to age, social inequality, psychological or medical condition) and maintenance of confidentiality if information such as child protection issues or professional misconduct is disclosed.

To minimise these risks, all potential participants were fully informed of the aims, purpose, methods potential use and dissemination of findings. Verbal and written information outlining what exactly participation in the research involved, including the possible risk and benefits, was made available prior to recruitment and at every stage of data collection. Participation was entirely voluntary and participants were not coerced or induced to take part through use of a gatekeeper, and as reminders during the data-collection phase. It is acknowledged, however, that as the gatekeepers were also midwives, there was a potential for some power relations to have an effect, inadvertently making some women feel pressured to participate or decline depending on their individual experiences and perceptions of the midwife-woman relationship. Whilst this was hard to avoid, as the small numbers of breech births required a direct invitation to participate in order to achieve the study, this was mitigated as much as possible by preparing the gatekeepers for their role, discussing their approach and providing ongoing support and guidance. Participants were given time, approximately a week, to consider whether or not they want to take part prior to making a decision, and they were given the right to withdraw consent at any time during the research process through reminders at each point in the process (at initial discussions, prior to consent, prior to interview, after the interview). The language, both written and verbal, was appropriate for the population from which the potential participants were drawn, to ensure complete understanding when informed consent was gained (DoH, 2005) by asking two non-health professionals to review and provide feedback on the documents used.

I acknowledged the possibility that I may have had existing relationships with health professional participants, both independent midwives, and midwives and medical

staff who work in NHS maternity units, that may have an influence on their participation or the data they shared. Having worked in the NHS for 15 years and undertaken facilitated learning with Independent Midwives over the last five years, it was possible I would have known the participants or be known by them. To minimise this I excluded potential participants with whom I had worked or for whom I had provide care. However, even then, due to the close network of relationships within midwifery in particular, I was known to three of the midwifery participants, although I had not worked with them. By discussion with them at the pre-consent stage, it was established that what they knew of me was limited (only name and location of work for example) so it was considered to be reasonable to include them in the research study.

Since the number of women having vaginal breech births are quite low in the UK, there was a small potential for identification of the birth, mother and health professionals involved. All cases and participants were anonymised and false identities were assigned. To safeguard privacy and confidentiality I transcribed all interviews within 6 weeks, which are stored on an encrypted personal computer accessible only to me and my University supervisor (Parliment, 1998).

Following approval of the thesis panel, ethical approval was sought from the Faculty of Health and Social Sciences Research Ethics and Governance Committee at the University. Ethical and governance approval was also gained from the places/sites where potential participants were identified; the Research and Development departments of the NHS Trusts and from the Independent Midwives Association. Ethical approval was gained in September 2011 through the Integrated Research Application System (IRAS). I was granted ethical approval with 2 minor changes required: to include a sentence in the participants' information sheet and consent form - "*Direct quotes will be anonymised in the report, but there is a small chance that the participant may be identified*" - and to change the wording in the confidentiality section of the Participant information sheet to "*I will follow ethical and legal practice*". These changes were made as required (see [Appendix 12](#) for summary letter of approval)

I had considered during the ethical approval process the potential risk of harm for those participating in the research. The main potential source of harm would be

distress or upset that may arise from the participants recalling their birth, which may be traumatic for them. I had made provision for this in that I planned to be sensitive and reactive to any signs of distress, provide immediate and appropriate support to the participant, and offer to stop or pause the interview and offer verbal and written support which I brought with me for this purpose (see [appendix 15](#) for support sheet for participant). This was good preparation as during one interview a participant did become suddenly upset when re-calling the moment she was told her baby was breech. I responded by being caring, empathetic, and supportive, and offered, as planned, to pause or stop the interview. However, the woman was very keen to continue telling me that it was helpful for her to talk about her experience, as she had not had an opportunity to do so before. When the interview ended I offered further support, gave her the prepared written sheet with information and support groups, and advised that she sought support from her local maternity unit GP. As I reflected on this interview experience, it highlighted the impossibility of separating personas. I responded instinctively as the multitude of components that I am; a human, a woman, a midwife, an auntie etc. as well as a researcher. The response only altered in the sense that, as a researcher, I could not do more than offer advice and information for the woman to decide what action to take, if any. As a midwife I would have actively offered more, such as a debrief session, a referral to a specialist support group and a follow-up visit. I also reflected on what this opportunity offered the woman. She has been only one of two participants who have contacted me directly via the contact number on the initial information sheet (the others had been contacted initially by the gatekeepers to gain first permissions, then their names passed on to me). She was very keen to talk, and to share her birth experience, which I perceived she found helpful - even cathartic - to describe and explore, at least to some degree, the emotions she felt during her birth experience. This was an important learning point in changing my perspective of the role of the researcher, in that we bring ourselves into every situation and have to consider the potential implications of this before, during, and afterwards. This reflects the feminist research approach where, as well as bringing new knowledge, research is seen as a chance for change either for the individual and/or for social improvement.

#### ***4.5 Summary***

This chapter outlined the methods used for this research study including the sampling approach, recruitment strategy, data gathering methods, data analysis approach and ethical considerations. It outlined the rationale for the approaches and how they aligned with the overall theoretical framework and design of the study. These careful considerations enabled the findings, which will be presented next, to be gathered in an open, transparent and most appropriate way in order to answer the research questions in an ethical and trustworthy manner.

## **CHAPTER 5: FINDINGS**

This chapter will outline the findings from the analysis of the data and present the emerging themes. The data will be presented with an overview of the categories, themes, and constitutive pattern, and then the individual themes will be offered in turn. The themes, informed by the data, will then be presented in detail. Whilst presented as separate themes, there is a fluidity and overlap reflective of the complex interrelational landscape of birth and evolving birth space. Real quotations will be used as illustrative examples throughout the themes.

### **5.1 Introduction**

Unsuspected breech presentation presents a unique situation in late pregnancy or during labour, where the anticipated birth is interrupted and the birth landscape is significantly altered. Women and health professionals adapt to this uncommon and different 'from the normal' event through active processes of negotiation, communication, establishing, disengaging or strengthening relationships, and consideration of inward and external beliefs and perceptions. The current medical recommendations would advise all women to have a caesarean section. However, for those women who choose an alternative route of vaginal breech birth and the health professionals who provide care, the journey is deeply personal and informed by social, cultural and gendered constructs and beliefs.

Following detailed coding and analysis of the data, seventeen main categories emerged that informed the development of four themes which will be presented in this chapter. The four themes are: ***Losing the way; Fighting fear and seeking trust; Deciding the right path to follow, and Towards a place of safety***. Whilst these themes are presented as stages along the journey for the purpose of this research, birth is not a static, linear process. Rather it is complex, dynamic, and fluid, so drawing on the concept of space, the characteristics of these themes can be explained by 3 interwoven dimensions of ***Disrupted space, Uneasy space and Third space*** that will be presented in the subsequent discussion chapter.

Where the stories gained through interviews have been analysed, there is fluidity between the categories, with the different elements having importance at different times for the participants. The case study approach provides multi-layered information to build a comprehensive picture of the case: the vaginal breech birth experience. For the purposes of the research, this experience is presented here as a specific instance that makes up the case, but it is acknowledged that the interrelated nature of these experiences means that categories and themes are dynamic and can overlap each other. The analysis provided an opportunity to capture moments of the breech birth experience, providing clarity about the strongest elements of the case and make it understandable and meaningful. In attempting to conceptualise this very complex and individual experience, simplified commonalities were sought within the data. Several attempts were made to identify these critical moments and it became apparent there were many ways to interpret the data. However, with reflexivity and going back and forth to the initial raw data, the categories, themes, and a constitutive pattern emerged as being the most illustrative of the landscape of the vaginal breech birth experience, and these will be presented in this chapter.

These themes address the primary research question: What is the experience of vaginal breech birth within a social, cultural and gendered context? Also the secondary questions: How is the experience of breech birth constructed within a gendered and social context? In what ways do social, cultural and political constructs impact and influence the experience of vaginal breech birth for women? How do issues around gendered interrelationships between those involved in the birth shape the experience of vaginal breech birth for women? How do the places and contexts of care provision impact and influence experience of vaginal breech birth for women?.

Categories	Themes	Constitutive Pattern
<i>Unmet Expectations</i>	<b><i>Losing the way</i></b>	<b>Disrupted space</b>
<i>The loss of normality</i>		
<i>The loss of identity</i>		
<i>The loss of choice and control</i>		
<i>Conflicting Narratives</i>	<b><i>Fighting fear &amp; seeking trust</i></b>	<b>Uneasy space</b>
<i>Trust and mistrust</i>		
<i>The vulnerable self</i>		
<i>Emotions and tensions</i>		
<i>Guided by experiences</i>	<b><i>Deciding the right path to follow</i></b>	<b>Third space</b>
<i>Desire to know / have knowledge</i>		
<i>Engaging / disengaging</i>		
<i>Time pressure</i>		
<i>Making safe places</i>	<b><i>Towards a place of safety</i></b>	
<i>Protecting personal agency</i>		
<i>Taking Responsibility</i>		
<i>Making sense</i>		

**Figure 3: Categories, Themes and Constitutive Pattern**

Throughout this chapter, participants will be referred to by their pseudonym. Reference to other people and places have also be altered to protect anonymity.

In describing the participants, the women who have given birth will be identified by name only in the text, as these were at the core of the case. Health professionals will be identified by both name and profession. When quoted, directly or indirectly, the participants will be identified and the page number (p\_) given to the transcript interview data.

The use of 'women' in the chapter refers to the participants interviewed who had given birth.



## 5.2 Losing the Way

The theme of 'Losing the way' relates to the time following the discovery of breech presentation. This is the time during the birthing process and also to the time following the birth, when women attempt to define their place in society during early motherhood. 'Losing the way' refers to the disruption of the expected 'norm' of cephalic childbirth, as discovering the baby is breech fundamentally changes events, experiences and status. The theme establishes which elements of identity are lost through the breech experience such as the 'normative' pregnant woman, the 'with woman' midwife, and the autonomous health professional. The theme, formed from the categories arising from the data during analysis, shows how birth expectations, knowledge, experiences and emotions are shaped by social, political and cultural influences and narratives. The consequence is a sense of loss of the expected birth, of personal agency, of decision making, of a place within society and of skills and knowledge.

The categories which informed this theme are *Unmet Expectations*, *The Loss of Normality*, *The Loss of Identity*, and *The Loss of Choice and Control*.

Many participants expressed expectations and assumptions about themselves, the key relationships around them and, for pregnant women, their forthcoming birth experiences. These shaped the place they occupied in society, together with their identities as pregnant women, women and health professionals. They also contributed to the sense of loss on the discovery of a breech presentation, when there was a feeling that these expectations would not be met.

For some participants, their expectations were informed through previous birth experiences that advised their decision making when planning subsequent births. Amy felt uninformed prior to her first birth because she had nothing with which to compare it, and felt dependent on the hospital staff (Amy, p1). Her poor first birth experience, which she perceived to be related to the medical environment of hospital, shaped her decision to have her next birth naturally at home. This expectation was challenged when she was informed that her baby was breech

during the latter part of her pregnancy. This resulted in the shock of the immediate loss of her planned normal birth experience:

*“I was in absolute shock because when you hear the word breech you know you have to go into hospital and have a caesarean... there is no other way. The woman who took the scan straight away said you need to see the consultant right now so he can book you in for a caesarean... I went home and cried my eyes out because I thought that was the only option’ (Amy p1)*

The strength that Amy had from planning her homebirth was removed from her once she was told that her baby was breech. The implications for a caesarean section removed not only the choice of location and type of birth she had wanted, but challenged what she perceived of her own identity as a woman able to give birth (p4). In a similar way, Jessica also wanted to avoid a surgical birth with beliefs founded from those around her. Whilst pregnant with her first baby, Jessica reacted to other people’s birth experiences as a strong influence on her decision making about what type birth to avoid, in this example making connections between caesarean section and postnatal depression:

*“Right from the beginning I didn’t want a caesarean. I actually don’t know anyone who hasn’t had postnatal depression who has had a caesarean, all my friends, lots of people, who have had terrible trouble with it. And not being able to do anything... and we did so much straight away, those first weeks were so full, I think if I hadn’t been able to do any of that I would have missed out on so much’ ” (Jessica p3)*

Thus, for Jessica, being faced with the recommendation of a caesarean section when the baby’s breech presentation was discovered during early labour was a considerable issue, and had more of a substantial effect on disruption of her expectations. Jessica found this new situation ‘scary’, and more so as she had not had a baby before so she ‘*didn’t know what to expect*’ (Jessica p4), an echo of Amy’s feelings during her first birth. Jessica’s reaction of being ‘*really really upset as I thought that meant I had to have a caesarean*’ (p1) provides insight into how much these expectations mean to her and how synonymous the identity of breech has become with abnormality and surgical birth. Sam also shared the desire to avoid

caesarean section delivery with both her previous and the subsequent births. The thought of a caesarean was '*terrifying*' (p2) for her as she felt this would mean relinquishing control to the medical team, which was motivation for her avoiding it. This loss of normality for breech has deep effects on women's reactions and challenges their identities as a childbearing woman whose '*belief in women's bodies is very strong*' (Sam, p2).

Sam's experience is similar to Lara's who also had a breech baby unknown until midway through the labour. Lara was coping well, labouring relatively swiftly for a first baby, when the position of her baby was discovered. Her options of a caesarean or a vaginal breech birth with an epidural were both distressing for her:

*'...as soon as I was told the news I kind of lost my focus, I lost all of that because I didn't feel I was in control any more... I wasn't in my right place in my mind by then, I had no control, I was powerless'*

(Lara p5&6)

Lara had clear expectations about her birth and her central concern was to not have an epidural and to be in complete control of her body, so this news left her distressed and in shock. The deep sense of loss of control and power reflected in this statement illustrates the fundamental change in her own identify as being powerless over her own body and birth. However Lara did consider that she was able to maintain '*one bit of control*' (p5) by not having her baby in theatre, emphasising how much she valued control as a central part of her experience. Sarah's experience of how her midwife's reactions left her feeling lost also reflects the complexity of the assumptions, expectations and social relationships between the pregnant women and the health professionals providing care (elements of which will be explored in more detail in the next theme). To Sara, the lack of support and empathy from the midwife when the baby's breech position left her feeling distressed and lost:

*"Finding out that my midwife did not want to support a breech birth was shocking to me and my husband and left us lost, we didn't know where to begin... we were completely lost."* (Sara p1)

This emotive description demonstrates how unmet expectations can shape an experience, leaving women feeling adrift from that they assumed would happen. For Lucy having her first baby was a chance to fulfil her lifelong expectation about having a homebirth in the water as she says she:

*'... never ever wanted to go into hospital, all my life, like girls usually plan their weddings all their life, I had been planning my birth and I wasn't going into hospital' (Lucy p2).*

Lucy puts this desire down to discussions about childbirth that she had heard as she was growing up; these determined her views and beliefs and sense of identity as a childbearing woman. The knowledge that her baby was breech was devastating for Lucy, who felt this would stop her having her waterbirth which she *'had always planned in my head' (p1)* and which she *'had a definite picture in my mind' (p6)*. This demonstrates once again the way that discovery of having a breech baby alters the parameters of normality, limiting options and requiring women to alter their expectations for birth. In a similar way to Lucy, Hannah also expressed strong views about where to give birth and who had authority over it. This also appears to have been shaped by how she was 'brought up', and her previous experiences with medics and hospital institutions:

*"I assume they [medics] know best. I have always had good experiences with hospitals and doctors in the past and I guess I was brought up to respect medical professionals and do what they say"* (Hannah p2)

Based on this Hannah chose to give birth in a consultant maternity unit and, when faced with the situation of a breech presenting baby, Hannah gained some reassurance of being in hospital, although the experience was still *'not good' (p1)*. Hannah had experienced a rapid and straightforward labour up until the time when the breech position of the baby was discovered just prior to birth leading to a *'frantic' (p1)* situation. Hannah described feeling *'panicky' (p1)* with the rooms becoming filled with people, and she listened for instructions as the medical team took over and delivered her baby for her. Whilst this aligned with her expectations of medics knowing best and hospitals being the safest place to be, Hannah's feeling of being *'out of it' (p1)* during the experience does suggest a sense that this was not what she

expected her birth to be, and of a move from the normality of a woman labouring and giving birth towards abnormality, lack of control and a passive patient role.

Further to this is the feeling of loss of individuality experienced by some participants, of being treated as a homogenous group rather than as a single entity. Kerry experienced a loss of her individual identity and birth options when discovering her baby was breech, and explained what she desired in terms of care approach:

*“And actually that’s what I think, up until then, all the other people; it was all just based on “oh it is a breech” so therefore a caesarean. There was no “How old are you, how many children have you had?” There was nothing based on me as a person, it was all just breech equals caesarean... it made me feel horrible. It made me feel very out of control, very like they totally didn’t understand how important this was to me” (Kerry p1 / p3)*

Kerry’s experience was not unique, with several women describing how they were made to feel when choosing something different from the mainstream norm. Sara described the ‘*badgering*’ (p5) she experienced for wanting to consider birthing her breech baby vaginally, and Lara felt unheard by the health professionals around her during her labour, emphasised by them talking with Lara’s mother rather than with her about having an epidural:

*“All I think about is the choices I had and maybe they think it is the patient’s best interests but maybe they should have listened to me more. Maybe they should have reacted on how I reacted to the news. Instead they seemed to think “why doesn’t she want to do this?” They could have been more supportive maybe towards me. If they spoke to me instead of my mum, as well. I remember her asking my mum, not me. Maybe she should have spoken to me really” (Lara p4)*

Kay also expressed the difficulty of going against the expected pathway as the pressure of being perceived as a good mother when making decisions. She believed in the importance of maintaining her ability to make individual decisions right for her, but felt the pressure to adhere to the dominant viewpoint, making it a challenge to maintain her individual identity:

*“It is very difficult because as soon as you tell people they are breech their automatic answer is that it is going to be caesarean. And there is a perception if you don’t do that you are therefore not doing the best for your baby. You are taking choices that are for you, as a mother, not wanting to have a caesarean, you as the mother trying to work out the best for both of you” (Kay p2)*

However, Hannah felt that it’s easier if you aren’t given options as ‘*none of them are great*’ (p2), suggesting that a greater sense of normality is lost when faced with a breech. Health professionals, and in particular midwives, appear to share a feeling that loss of normality around breech birth was due to the medical dominance around breech and childbirth more generally. For example, Midwife Rose felt that women are ‘*more influenced by the doctor, the consultant*’ because ‘*he must know best, after all he is a consultant*’ (p2) and considered the gendered and medical language used around breech birth as being alienating to women from themselves and their experiences. The label of ‘high-risk’, and use of terminology such as ‘*failure to progress*’ and ‘*incompetent cervix*’, midwife Rose considers unhelpful, as women ‘*don’t go wrong, they may need help, and there is nothing wrong with needing help*’ (p1). This medical influence midwife Rose considers to be further compounded by the Term Breech Trial (Hannah, et al., 2000) which she considered to be responsible for changing the way breech delivery by caesarean sections are now considered a safe option (p1), altering the identity of surgical delivery into the realms of normality in childbearing. However, midwife Rose also felt that midwives have their part to play in managing expectations, saying that:

*“We midwives have sometimes been too keen to encourage women to go for a vaginal breech birth as a goal, it is not the goal, the goal is to see how it goes” (Rose, p2)*

Obstetricians interviewed also shared their views on the influence of doctors and how this alters the choices and puts limitations on the breech experience.

Obstetrician Betty described how, since the research study undertaken by Hannah et al (2000), vaginal breech is ‘*thrown in as an afterthought*’ in discussions with women, describing a conversation as: ‘*oh yeah if you want a vaginal breech that’s fine but you really should have a section*’ (p1). This is echoed by obstetrician Jan who described the limited and coercive manner of counselling women in their choices:

*'Most people are swayed, no not swayed, are usually advised to have an elective section which is for the best... But I guess deep down we are trying to get them to have an elective section. I mean I don't think I mention the pro's of having a vaginal breech, we mention the risks, the negatives of what can happen'* (Jan p1, p 3)

This is borne out by Kerry's experience who felt that lack of effective communication and individualised advice left her feeling isolated:

*"Up to that point I had had no two-way discussion; I just had these things thrown at me... And I saw a consultant after that who I did have a discussion with but it was still very kind of we can't force you to but we really advise you to have a caesarean. There wasn't a lot of room for "what would you like to do? "Nobody actually asked how I felt or what I would like to do about it"*  
(Kerry p1)

For these women, choices are lost to them and there is limited scope for attaining the expected normal birth experience they had wanted. By categorising breech as a 'high-risk delivery' (obstetrician Jan, p3) the options are limited considerably and the normal identity of that pregnancy altered. This also applies to those health professionals who support breech birth, with both obstetricians Betty and Jan noting the differing views of obstetric consultants who '*unless pro-breech, will advise a section even in advanced labour so we don't have much [shrug]...option'* (Jan p2). Obstetrician Betty believes herself different from her obstetric colleagues, noting that she has more vaginal breech deliveries than her colleagues, which she puts down to her colleagues being '*more risk-adverse'* (p3) than her and that she considers herself:

*'...the [obstetrician] who will take the greatest risks... because that is my speciality... maybe it's because I'm interested in intrapartum care, I look after a lot of women after they have had a caesarean section who are really disappointed'* (Betty p2)

Obstetrician Betty's self-identify as a risk-taker compounds the view of breech birth being not within the realms of normality, and is explained by Katie, an experienced

midwife, as having evolved with the increasing medicalisation of childbirth (p2). The lack of exposure has changed breech birth to be seen as an emergency, its rarity creating loss of confidence and an altered perception:

*“I think the sad part for me is that, as a very experienced midwife, I have no fear of breech at all... but I am surrounded by very junior powerful medical staff who have never even been in that situation and I find that sad because they have lost the skills and therefore if there are only a few of us with these skills you are never going to get the whole journey. [Breech] was never felt to be an obstetric emergency in quite the way it is now and I think what it has done is make people think ‘oh it is really abnormal, it is really frightening, and how do I deal with it I can’t remember I can’t remember, I have to go through that drill’ (Katie, p2)*

Kay too described feeling that there is a general loss of confidence both in breech and in the body’s ability to birth a baby:

*“It is what we are designed to do and there is something very strange about we have been given this body and it is designed to birth a baby, it is designed to feed a baby; these processes work. And if you let them do what they are meant to do they will probably work. We just don’t believe in it [breech birth]. We have lost the ability to believe in our body and believe in our baby” (Kay p3/5)*

Midwife Rhian felt that this dominant view of breech and the loss of birth options also leads to a limited choice in terms of location of birth, which is at odds with the current expectations around the way care should be provided for women:

*“...so for many women if they want a vaginal breech they have to look outside the service. Only some hospitals support women’s choice but it’s patchy. So for many they have to stay at home to get their vaginal breech because if they come in [to hospital] it’s an automatic [caesarean] section. That’s wrong, I mean we should be supporting choice here” (Rhian p3)*



For midwife Liz the consequence of this changing identity of breech, with its consequential high-risk medical approach, has had a deep effect on her identity as a midwife. Following a traumatic obstetric-led breech delivery, where Liz felt that she was unable to be an advocate for the woman she was supporting, she questioned whether she was able to continue as a midwife. Describing the experience as the '*most horrendous two hours of my life when I was going to give up midwifery*' (p3), Liz expressed the emotional toll on the woman and, as the situation was taken over by the medical staff, her feeling of loss of control. This breech experience demonstrates the expectations Liz has as a midwife to be able to support and advocate for women, but that this can be overridden by what is perceived to be an emergency situation and an '*obstetric-led birth*' as described by obstetrician Jan (p3).

The theme of 'Losing the way' draws together aspects of this birth journey where there was a deep sense of loss. The expectations about the birth to come are considerably disrupted, identities of and concepts of normality are altered with the knowledge of breech, and a sense of loss of control and choice manifest. Both childbearing women and health professionals sensed the loss around breech; the shifting from the previous pathways and expectations, the changing of assumed identities and roles and the loss of breech from the normal birth space. These experiences brought tensions and emotions within the breech journey both between people and between people and institutions. These tensions, borne of differing perceptions, experiences, beliefs and personal requirements, led to conflict, emotional distress and characteristics of trust and mistrust. This will be explored in the next theme of '*Fighting fear and seeking trust*'.

### 5.3 Fighting fear and seeking trust

This theme evolved through the data created from the categories of *Conflicting Narratives*, *Trust and Mistrust*, *Emotions and Tensions*, and *The Vulnerable Self*. These elements represent a stage in the experience of vaginal breech birth where there is a turning towards people or places to trust and of fighting fear that engenders mistrust. These are mainly externalised and expressed through relationships and communications with others, but are also seen through a woman's internal dialogue, perceptions of self, and sense of body and birthing. This is a time of unease, moving from a stage of feeling lost to seeking assurance and trust. The prevalence of fear within the narrative at this stage is pervasive and managed in different ways by individuals. This theme represents a challenging, unsettling and emotional time during the vaginal breech birth experience.

Conflict in the narratives spoken, heard and described by participants was a considerable factor in the reassurance, or lack of reassurance, that women felt about their experiences. Participants recounted how they felt communication was challenging in its delivery and content, how conflicting information was sometimes given by different health professional and how general opinion was at odds with their own experiences and beliefs. This was a significant part of the breech birth experience and shaped responses and consequences for many involved. Amy described how the midwife told her a '*completely different story to what the doctor told me*' (p1) and further told how:

*“After I talked to [the midwife] she reassured me that my child would not be half out with its head stuck in there. That was like the horror story the doctor told me”* (Amy p5)

The language used here is strong ('horror') and absolute ('completely') creating an image of the information being diametrically opposed. Use of 'story' also suggests an intimacy and imagination involving emotion and elements of personal interpretation. A story can be used to create a visual picture, as described in Amy's second quote above, and/or to persuade listeners to join the teller in agreeing with their

conclusions. This visual picture is mirrored by Kay, who described her dialogue with health professionals as:

*“..quite frustrating by the end of the conversation and I would come away thinking [shrug]... and I said to my partner why is it they can see things that are important to them but they can't see things that are important to me”*  
(Kay 5)

The tension rises as a result of the health professional's unwillingness to even acknowledge Kay's views, only placing value on their own opinions and demeaning her by calling her a 'stupid girl' (p3). This leaves Kay feeling discouraged and distant from the health professionals and their recommendations for her birth and baby. For Carla this made her journey feel like a 'battle' and 'more and more stressful' as she 'encountered so many people who didn't seem to get where I was coming from' (p2). This language of conflict also demonstrates the individual effects this has on the birth experience, with emotional and isolating results. Kerry too used descriptions of conflict in her account of how she perceived she was being coerced into a decision to have a caesarean section for her breech baby:

*“Up to that point I had had no two-way discussion; I just had these things thrown at me”* (Kerry p1)

*“I think that any information that I was given was more statistical and I don't think it is fair to give it because it was based on all breeches and not separating high-risk and low-risk and I think that is really key, and actually had I not been the kind of person who was adamant I wasn't going to be pushed about...”* (Kerry p3)

The visual analogy Kerry used of having these things 'thrown at me' and being 'pushed about' suggesting a dominant and aggressive dialogue, perhaps implying both parties are outside their comfort zones on this subject.

Sara also used combative language as she reflected on her experience of choosing and achieving a normal breech birth. She described how she would have liked the health professionals to:

*“...not to badger me as to how I feel, understanding the different attitudes that people have. If they are going to give me support then give me support and don't make me feel bad for just wanting to do something that was different”  
(Sara p5)*

*“While I am happy with how things went looking back I can say that it shouldn't have to be such a fight to get to that experience” (Sara, p3)*

*“when you have been speaking with the doctors it was like coming from 2 different worlds so they couldn't understand where I was coming from and I couldn't 'conform' or 'behave' for them. A lot of doctors looked down on me”  
(Sara p4)*

This suggests that the dialogue has personal consequences for women who perceive that they are made to feel wrong for being different and that they have to overcome opposition to achieve what they want. This feeling of exclusion for wanting to do something different from the usual moved Sara into a combative zone. This coloured her childbirth experience and her views of the health professionals providing her care at the time. This perceived pressure and dominant language is also described by midwife Liz, who shared her experiences of the persistent and pervasive attitudes she comes across from other health professionals when dealing with women who choose a different path to the one recommended:

*“Time and time again.... I've been there when they [doctors] say you want to kill your baby [to the pregnant woman for choosing a vaginal breech birth], I wash my hands of you... how dare they! And I have heard them say it. And I mean how are they allowed to get away with it?” (Liz p8)*

This emotive description of the conflict that arises when women choose not to take medical advice elicits responses midwife Liz perceived as a verbal attack, emotional blackmail, distancing and dismissive rather than supportive. Jessica also experienced elements of coercion as she describes how *'he [the doctor] explained this is how we do it... he didn't tell me I had to have it [an epidural] but he explained it in such a way that I kind of did'* (p2). Kerry too felt a lack of consideration of her views as the consultant obstetrician informs her that they *'can't force you but really*

*advise you to have a caesarean'* leaving Kerry to express that *'nobody actually asked how I felt or what I would like to do about it'* (Kerry p1). The authority of the health professionals in the descriptions is evident, but it is perceived as disempowering when it leads to the women's needs and opinions not being considered, and in some cases can lead to direct conflict.

Conflict was also seen within the different opinions of groups of people. Amy experienced different information and advice from her midwife and other health professionals:

*'[The midwife] was also of the opinion that there was no big deal about it, don't have one [a caesarean section], have it at home, you need to be relaxed, you don't have to go into hospital. This was completely contrary to all the other opinions I had'* (Amy p6)

This conflicting information is interpreted in different ways and has consequences for the women and their birth experiences. Carla described how using emotive language relating to the safety of her baby would have persuaded her to have a caesarean. However, she *'would have been really upset if that had been the case and then found out it wasn't necessary'* (Carla p2). Kerry used her own experience as her own truth or evidence, and expresses shock at the disparity between the information given to her and her actual birth outcome:

*"To think that I was advised by most of the medical profession to have a caesarean and actually as a birth it was fine and very quick. I find that quite shocking and how does that work"* (Kerry p5)

For Carla, there were an *'awful lot of people who thought I was mad'* for choosing her vaginal breech birth, but she *'had to go with what my gut was telling me despite virtually everyone telling me it was the wrong thing to do'* (p3). This, again, reinforces the suggestion of conflict between unequal sides and of resultant isolation for the women who choose differently. Carla's experience suggests that there is more widespread territorialism over childbirth, beyond just the health professionals and childbearing women and families, and this may be seen in the language and emotions shared by participants. However, Carla also shared an underlying issue of

mistrust with the obstetricians that caused her anxiety and may have contributed to her perception of conflict and tension:

*“I don’t trust when I go to the hospital doctors will understand what I want so I think again if the hospital had told me that I needed to have a C section [because the baby is breech] it would have been another battle in my head”*  
(Carla p2)

Orla also had perceptions as to the medical approach of the obstetricians, considering them ‘*very quick to step in and cut us open*’ (Orla 3). These perceptions form part of women’s experiences as they often choose to distance themselves from those who they perceive to be a threat to their needs or, at the least, a possible disruption. There was a distinct difference between the views women had about obstetricians and midwives. Whilst obstetricians were mostly considered as likely to be interventional and authoritative (Orla p3, Carla p2, Hannah p2) midwives were mostly expected to be more of a source of support and social relationship (Amy p5, Sara p5, Lucy p2). Kerry and Sara’s experiences when discussing her baby’s breech presentation with their midwives was the more upsetting discussion due to these pre-conceived notions about their midwives and their relationships with them:

*“...but I didn’t know that the implications were for the birth and she [the midwife] just said ‘Caesarean!’ That was the first thing she said so that really threw me because I had completely always planned a home birth and she knew that so actually I was a bit disappointed with her”*  
Kerry p1

*“We thought that midwives were all the same. That they knew of the importance of having a natural birth, so for someone [her midwife] to say that the baby was in danger for being in a breech position – that was shocking”*  
Sara p5

Sara’s misconceptions about her midwife demonstrate the importance of this relationship to her, the disruption leading to her own emotional distress and a sense that both Sara’s and Kerry’s underlying foundations of trust in this key relationship had been disturbed, emphasising the sense of difference that a breech presentation

brings. Finding who or where to trust was seen as a central component in adapting to the breech situation. For Lara it was her trust in the doctor and his assurance the baby would be small that enabled her to believe she could birth her breech baby (Lara p5), whereas for Amy it was her midwife who made sense to her as she talked about the birth without fear (Amy p6). At the point the breech presentation was discovered in labour, Hannah was able to put her trust in them and remained passive '*listening for instructions*' as she felt '*this was the best thing to do*' (p1). Jessica also placed her trust in the doctors and midwives in the maternity unit by agreeing to a required epidural in order to have a vaginal birth as '*you just think they know what they are doing*' (p2). Orla not only has trust in her own body but also described how she '*put her faith in [my midwife] 100%*' (p6). Like Orla, Kay felt the deepest trust was within herself; giving herself the space to '*listen properly to your body*' and '*trust in yourself*' which gave her a '*real sense of confidence*' (Kay 2).

Midwife Rhian explained the importance of reciprocal trust, with the midwife having to trust the woman as much as the woman having to trust the midwife (p2) in order to work completely safely together. Midwife Erin also emphasised the importance of the trust between midwife and woman where they both have to trust each other and '*work completely as a unit*' (p5). Midwife Rose felt her role is to establish a relationship with the women she cares for, with '*making sure they have an informed choice*' (p5) as central to the breech birth experience. Women also mentioned the relationship they had with their midwife as being a source of strength and reassurance. Lucy found the knowledge her midwife had gained through previous breech birth experiences was the key to empowering her own decision-making as a woman. The 'frank' and comprehensive discussions with this midwife also provided her with information about her options and possible outcomes, but ultimately her decision was anchored on trusting her midwife who would know if she needed to go to the hospital for help if required (p3):

*"I think knowing that the midwife that I had had lots of history of breech birth that I actually felt confident in her skills and that meant that I felt confident as a woman that I could make the right decisions..."* Lucy p2

Obstetrician Betty also agreed about the vital importance of trusting relationships between the mother and health care professionals. However, this is presented as a

non-reciprocal relationship, as women needed to trust themselves and those around them, but were not trusted in return:

*“they [the women in labour] suddenly find out they have a breech on board they will probably be quite frightened because they are not expecting it... they need to have a degree of trust, significant trust, in the midwifery looking after them and in the medics looking after them and the father and themselves to achieve a vaginal breech.”* (Betty p2)

This suggests an established social hierarchy of trust that needs to be navigated within the birth space. This sense of women putting their trust in those around them and themselves is not shared by obstetrician Jan, who described that in her experience the women who may want a vaginal breech birth have ‘*to go through lots of hoops*’ (p1) and suggests a difficult and obstructed journey, with a focus on the ‘*baby safety*’, ‘*complications*’ and ‘*risks*’ but ‘*they don’t tell them of the positives as well*’ (p2). This, and the sense of the linear relationship, is echoed by women themselves who described feeling like they have ‘*one avenue*’ with no other options (Kerry p1). All of these relationships are deeply influential on the breech birth experience and reflect the complex social relationships involved. The language used also was suggestive of the emotional importance of trust and trusting relationships during breech birth.

Whilst all childbirth experiences can be emotional, a common emotion shared by participants was one of fear; both perceived in others and within themselves. This fear was spoken and explicit, and also unspoken and sensed, and recognised for its absence as well as its presence. Fear, both of birth and of breech birth, was perceived to be a personal issue but also considered to be endemic throughout society, and the repercussions were similarly considered to be individualistic and also in the wider context. The powerful effects of fear appeared to contribute to a feeling of being in a place of uncertainty and discomfort.

Many of the participants reflected on the strong emotions that they perceived in others as they talked to them about breech birth. Amy described a strong sense of fear in the underlying message from the health professionals whom she saw when discussing the breech position of her baby and birth options:



*'It wasn't actually so much what he was saying, it was more the fear in his voice that you pick up, it was the fear. The problem was you want your child to be healthy, no matter what, but if you hear that fear, that unspoken fear that is in the room, that fear is everywhere'* (Amy p1)

*'The underlying information the doctor was giving me was pure fear, the whole hospital, it was just pure fear. Even with my own midwife I could sense the fear. And you think "wow, apparently they are scared to deal with a breech, why are they all fearful?" Why are they all afraid if it is not much of a big deal? They didn't say it but you could hear it in their voice, and certain comments they made...'* (Amy p5)

This sensing of fear was a powerful tool, the unspoken nature naming it more sinister, emphasising the fear of the unknown entity. Helen, a midwife, also felt this fear, but tries to understand this by considering and concluding that the reason that the doctor she had spoken to was so scared was because he had only seen complicated breech births. This rationalisation enabled Helen to '*understand where he was coming from*' (p 2), rationalising his fear and making it less powerful and influential in her decision-making. Whilst the lack of explanation about the cause of the fear made it appear more threatening, creating a more powerful impression, when information is provided about the reason for the fear this was also perceived as being underlined with fear. Carla described speaking with her GP, who happened to be pregnant too at the time, about the breech birth options, but she felt this discussion '*pressed some buttons for her because she reacted in quite a panicked way and she reeled out a load of risks really from her own concerns rather than addressing mine*' (p3). This example was echoed by others who also were offered information in a way that they perceived to be biased or weighted. Kerry was given unrequested information from a health professional who:

*"...came out with some random facts about something about if you have it vaginally it is much more harmful to the baby and she gave me some sweeping statistics without being asked for it which again I don't think was here place to say it. She wasn't the doctor or the midwife and I hadn't asked her for any information on it. And it was like a bit of a scare tactic"* (Kerry p1)

This perception of using scare tactics was echoed by midwife Erin who reflected that women '*instead of being frightened [with] terrible pictures*', should be provided with information '*without fear or bias*' (p2). Amy also felt the pressure of responsibility over her child's health with the doctor using emotive images which may be used to manipulate behaviours and decisions:

*"There was one thing the doctor said to me, he said 'yes, of course we can have breech birth and everything goes fine but what if your child was the one which goes wrong'. And of course, you know, that is the fear. And nobody can guarantee you that.* (Amy p4)

These approaches suggest a form of emotional persuasion or manipulation that is very powerful and difficult to resist for the responsible mother who is expected to keep her child from harm. However, for some women the perceived or sensed fear is challenged as is not supported by information or facts or because it simply does not align with their own views. Amy found her midwife's lack of fear of breech birth to be the strongest influence in her decision making. Amy felt this enabled the midwife to be '*matter of fact*' and thus the '*explanations she gave me, it all made sense*' to Amy (p 6).

Furthermore, women gave their own accounts of when they felt strong emotions and fear. For Sam, it was a fear of going into hospital that was an influential factor in her decision-making to continue with her vaginal breech birth at home (p3), whilst for Lara, it was epidural anaesthesia that was her overriding fear as she embarked on her birth (p1). Hannah's immediate reaction to being told her baby was breech was that it was '*really scary*' as she knew '*it wasn't good*' (p1). Similarly Amy's reaction to being told was that she '*cried her eyes out because [a caesarean] was the only option*' (p1) and Kerry described spending the evening '*feeling quite upset... because I have not been presented with any other option [than a caesarean]*' (p1). These strong reactions are suggestive of how breech birth is currently represented by health professionals and society as a whole. Amy reflected on how she felt the message of breech was represented in the '*information that you get sent from everywhere – internet forums, newspapers, women's magazines and stuff like that*' (p1). It was only later, with additional information, knowledge and development of key relationships that these initial reactions changed and develop into a more

considered response. The consequences of this traumatic time had lasting effects, as Lara acknowledged when reflecting on her birth experience during her interview:

*“I’m more emotional now, I feel like crying. I don’t talk about it I guess but when I do I get quite upset. It has probably upset me more than I realise... it took me quite a while to get over it” (Lara p6)*

The sense of fear linked with the sense of vulnerability was acknowledged by many participants to be part of childbirth but was exacerbated by the baby being breech and the situations that ensued. Both women giving birth and health professionals expressed the strong emotional influences and consequences around the breech experiences. For Amy, birth is a vulnerable time since concentrating on the activity of labour altered her ability to communicate:

*“Because I feel when you give birth you are very vulnerable. What you need is a calm environment...not somebody who is scared... and [the health professional] has to explain things to you [about breech] and you are not listening because you have to concentrate on what’s happening [the contractions during labour]” (Amy p2)*

The suggestion from Amy is that the extent of the feeling of vulnerability is influenced by the emotional responses of those around her to finding the baby to be breech. Women described the importance of looking inward during labour and birth, which is disrupted by external influences, such as being given information and needing to answer questions and make decisions. However, this situation was not limited to labour. Hannah described her immediate reaction to being told her baby was breech when she was 36 weeks pregnant as being ‘*really scary*’, as her view was that this ‘*was not a good situation*’ (p1). Midwife Rhian corroborated this from her experiences as a midwife, where she feels pregnant women are ‘*already vulnerable*’ and there is panic, fear and negativity surrounding breech that is a considerable impediment to a positive experience (p3). Obstetrician Betty also alluded to women feeling frightened when being told their baby is breech, something that she considered understandable when the risks are higher for their baby. Further, she considered women particularly vulnerable when breech presentation is discovered in labour with ‘*all the hormones*

*flying all over the place'* leading to them being more influenced by a clinician's opinions and how information is presented (p1).

This is also apparent when discussions took place about breech presentation during late pregnancy. Sara found the reaction from doctors during her antenatal discussion about the breech position of her baby to be very negative, making her feel poorly understood, isolated and threatened, and her reaction was to run away to protect herself and her baby:

*"These doctors, they didn't understand where I was coming from and to me they want to endanger my baby but they didn't see it that way and they saw me as endangering my baby and it was terrible to have someone... tell you how you are going to do it [give birth], and it causes you to run with your baby. Stay as far as you can away from that place"* Sara p4

This act of removing oneself from the place of danger suggests the woman feeling out of control, and a desire to regain control in alternative places. This basic human trait of moving away from danger is also seen with Kay, who alluded to protection from vulnerability by describing closing off '*other people's negative thoughts*' (p3) when dealing with the discussions about the baby's breech position. Kay also perceived this is unique to childbirth because:

*"... it is one of the only areas where effectively you lose so much control that things can happen that you are not even aware of... but it is OK to do things [to you] because you are having a baby, not for any other reason, not because you might need it or because yes, you have agreed to certain things at a time when you were probably not aware of always what you had agreed to"* (Kay p4)

Kay intimated that this is a negative and uncomfortable place for women to be in. Kerry suggested that the kind of person you are influences whether you follow your own journey or follow a different one. She '*put it down to me as a person anyway as I was before, regardless of whether it [the baby] was breech or not*' (Kerry p3). However, by not conforming to society's apparent assumptions that breech is abnormal and requires delivery by caesarean section, there is a sense of being

different within childbirth and society more generally. Kay herself epitomises this in her initial reaction to being told her baby was breech when she became very focused on '*how you are going to fix it and get it right*' (p5), with the notion that breech was a bad situation that needs to be resolved. These beliefs appear deeply embedded and affect perceptions of how groups of people will react to the knowledge of breech presentation.

Health professionals also feel elements of vulnerability for themselves and for the women they care for. Midwife Erin felt that there are limited choices related to location of birth, which she considered inadequate:

*"...but the only option in many areas is that they stay at home and have a vaginal birth or they go in and have a caesarean and that is not good enough, that is not a service. And it leaves her in a vulnerable position, me in a vulnerable position and the baby in a vulnerable position. And it's not good"*  
(Erin p3)

This implies that location and choice around breech birth are interlinked: that choice is only provided under specific circumstances, and is controlled to the extent that it alienates anything considered to be outside of the contemporary childbirth zone. Midwife Helen echoed this with her experiences as a midwife, sharing that she feels birth is a very private event for women, and that homebirths offer a sense of privacy and own space, whereas in hospital women can feel '*on show and being watched*' (p5). These uniquely vulnerable positions are dealt with differently by different people. For example, Jessica used humour to deflect from the lack of privacy and personal space around the moment of birth:

*"The only person who said anything were my husband and the midwife who delivered him but the room was full [of people], yeah canteen staff [laughing] no, not really, umm yeah... but I didn't care [shrug]"* (Jessica p1)

Lara, who was rushed to make a decision about the mode of birth for her unexpected breech baby, used reflective time after the birth to gain understanding of '*why they [the health professionals] did what they did*' (p2). Meanwhile, Kerry described wanting to '*scream*' with her frustration at her experience (p 4) and Sara wanted to

stay as far away as she could from where she felt vulnerable (p4). This alludes to 'fight or flight' response, a basic physiological reaction when feeling threatened, stressed or fearful, which may be heightened when feeling vulnerable during these unique experiences. Although feelings of vulnerability are not just unique to childbirth experiences, or indeed to health care experiences in general, the findings show there were specific issues around breech birth that appear to exemplify and condense these feelings, making them more intense.

This theme draws together some challenging elements of the vaginal breech birth experience, where conflict and fear are underscored by communication and relationships. The complex weave of the social roles played out within the breech birth paradigm shaped the experiences of both the women involved and the health professionals. The role of protector and enabler was evident for some of the midwives, but elements of more hierarchical relationships between women and health professionals were also evident. Key relationships between women and health professionals and between health professionals themselves underpinned this experience together with elements of trust, distrust, and strong emotions guiding their journey. For some women, relationships with their midwives based on perceptions of supportive roles and trust were not as expected, and they turned to others to fulfil these needs. Relationships with obstetricians were also central to this experience, but bring a strong sense of social hierarchy in terms of decision-making that can be both welcomed and a negative for women and midwives. The presence of breech brings to the fore the centrality of these key relationships that both heighten and challenge the position of breech and the roles of women, midwives, and obstetricians within the current childbirth paradigm. Within this theme, however, there is the action of deciding in whom, or in what, to place trust, which is the start of the process to filter information to make decisions. It is this which was the next distinct theme: where information was sought, and gathered, and drawn upon, to enable the right path to be followed.

## 5.4 Deciding the right path to follow

A central component to the breech birth experience was the action of deciding the next step, the right path to follow. This consisted of categories of *Guided by experiences*, *Desire to know / have knowledge*, *Engaging / disengaging*, and *Time pressure*. Experiences and knowledge featured within nearly all of the participant's stories and they drew from a number of sources to inform their decisions or to delegate decisions to others. The underlying desire was to do the right thing, find the right path to follow. However, when this path (a vaginal breech birth) was not the mainstream behaviour expected (a caesarean section) the process of making this decision was considered and deeply personal.

Peer and professional experiences were highly valued by both women and midwives, for informing decisions and providing guidance or confidence for both women and health professionals. Orla described that for her, '*other people's experience is what is going to convince you that it can be done, it is fine*' (p4). She also went to peer support groups to '*talk to people who have actually done those things [had different birth experiences]*' (p4) and chose her midwife carefully during pregnancy so she was assured that she could manage any situation that occurred. This implies that she values and aligns with experiential knowledge gained from others; the proof she requires is that it has been done by others. Carla and Kerry both add to this sentiment by the value placed on the experience of the health professional to give them the confidence to make a decision:

*"...just talking to someone who had been there and done it and knew what the risks were"* (Carla p4)

*"I put it down to... having a long talk with someone with experience, I think that's the thing"* (Kerry p3)

For those whose breech baby was discovered during pregnancy, several actively sought information and resources additional to what they were being told, in order to

maintain their own agency, but they perceived this may not be the same for all women:

*“I think a lot of people do more research into buying a car or television than they would for having a baby” (Orla p4)*

Orla alluded to the different approaches people have to childbirth. For many participants it was other people’s positive birth experiences that encouraged a decision to do similarly. Sara aligned to the notion that all bodies are the same, and what others can achieve provided the evidence that her body can do the same:

*“The only information I had was maybe two experiences... one a documentary I saw on breech birthing and one woman’s experience and then another one was a book recommendation I read about someone and they had given birth breech. Those two experiences I am looking and these women they were able to do it so why can’t I? My body is not any different” (Sara p5)*

Other participants used past experiences with health professionals to help inform and guide their decisions about who to put their trust in. For Hannah it was her ‘*good experiences with hospital and doctors in the past*’ (p2) that enabled her to make a decision about how and where to give birth. For Sam, however, it was a single comment from a midwife at her previous birth that she recalled to help align herself to a course of action during her spontaneous unknown breech labour:

*“and I remember at this point in this breech labour that the midwife [at her previous birth] said to me afterwards; I remember she had looked into my eyes like someone who knew and she said ‘you can have any baby any way; don’t let anyone tell you you can’t get a baby out’ and so somewhere inside me I had remembered this. I had forgotten about I as it was nearly 7 years before” (Sam p2)*

Sam had little time to gather an array of information and opinion, and therefore relied on her previous experiences. Kay, having her second baby, directly linked experience to knowledge through her perception of the loss of breech skills and



knowledge by health professionals that contributes to the generation of the contemporary social norm about breech being abnormal:

*“I think that is the general thought that breech births don’t come out naturally. But then if skills have been lost and the experience is lost and actually every person that you hear has had a breech birth has a caesarean that’s what you know”* (Kay p2)

Kay’s linking of skills to experiences and knowledge provided an insight into a perceived way of learning, and what is required to enable the space in modern society for breech birthing. Midwife Erin reiterated this in her views on breech skills being ‘*suppressed*’, and suggested that we should be learning from and working together with doctors who come from countries where vaginal breech birth occurs frequently, as they will have had the experiences and thus the skills required (Erin p7).

Health professionals valued what they gained from being part of experiences that influenced their learning and knowledge. Midwife Erin claims that although ‘*I know a bit about midwifery... it’s the women who have taught me*’ (Erin p7) and Midwife Rose believes that the doctors ‘*don’t have the privilege that we have had learning from women*’ (Rose p2) in relation to caring for women during normal breech birth experiences. Midwife Katy acknowledged that the effects of her previous experiences of caring for women with breech births whose babies were not well around the time of delivery could have made her think it was risky, but then shared her belief that we shouldn’t ‘*brand every women with the same journey*’ but as ‘*whole women*’ (Katie p2). These beliefs show how each experience is an opportunity for learning, that a fresh approach must be taken to each new woman’s birth journey, whereby the skills and knowledge of clinicians are enabled to grow. Midwives, by aligning with women and valuing the learning from their birth experiences, provide an enabling act of social action, while a secondary consequence of women choosing breech birthing in turn informs the knowledge of the midwife providing the care.

Knowledge was described by participants in a number of different contexts; as research and information from a website (Sara p3), as knowledge of a specialist field (Orla p3), as opinion (Sara p1), as wisdom (Sara, p4), as clinical protocols (Liz p3),

as a collection of information (Sam p3), as knowing from experience (midwife Erin p5), as historical collective knowledge (Sara p4) and as knowing from within oneself (Lucy p3). This suggests that knowledge is multifactorial and created from different sources that are valued differently by individuals. For Sam, it was not her knowledge that she used to inform her of what to do during her unexpected breech birth, but her religious faith. She shared how she didn't feel alone, as her faith helped and supported her during her birth decisions and experience. This deep sense of knowing was not related to research or medical knowledge, but a sense of completeness. Kay described this after her breech birth at home, in a way that she had not felt during a previous birth experience:

*“I had a homebirth, I had her with me, I let nobody touch her and do things with her when I wasn't there... that whole experience was different... To know exactly what happened to you. There are no bits of you that I don't know about [talking to the baby]” (Kay p5)*

For Kay, knowing everything about her birth and baby during her birth experience was paramount, the knowledge gained from her previous experience strongly influencing her decision to have a homebirth. Midwife Erin also shared how she draws on a variety of sources to inform her practice as a midwife, demonstrating how the breadth and depth of knowledge is transformed into deeper knowing when working clinically:

*“It's a deep deep knowing, you can call it instinct, but then what's instinct. It's something that you are gathering [pause]. All the information, sight, sound, all of that.... it's about gathering all of that information and being able to feel safe enough to follow that and that is what, in the system, has been destroyed.”*  
(Erin p4)

Midwife Erin's description highlights that views and opinions can be divided, not only about what knowledge is, but by how and what is valued, and by whom. Midwife Liz also picks up on this in her story about discovering an unknown breech presentation late in labour. Midwife Liz described how her midwifery colleague felt the obligation to inform the obstetricians as per hospital protocol, but for Liz this had considerable negative consequences:

*“...I said look you can do [the birth] here because I know how she delivers, she will be quick, but she [the other midwife] said ‘no I have to call the doctors’. So she called the doctors but [shrug] no answer so she did a crash call and from then on it was the most horrendous 2 hours of my life, I was going to give up midwifery at this point”* (Liz p3)

Midwife Liz’s description suggests the powerful influence of the hospital procedures and clinical protocols; they imply an expected standard of care, based on the evidence available, within which clinicians are required to practice. Midwife Liz’s professional knowledge of the woman and her clinical assessment of the situation appeared to be less valued by her colleague than the requirements of acting within the clinical protocol but, in Midwife Liz’s opinion, this action has direct negative consequences for the birth outcome (p3). This, perhaps, shows the gap between clinical research, protocols, and guidelines, and the value of experiential knowledge that was found within the participants’ stories. The relationship between midwife and woman as well as between midwife and midwife is tested at these times, where cultural expectations and hospital protocols dominate over these central relationships. Midwife Katie felt that there is an element of midwives conforming to hospital policies and guidelines for fear of getting in trouble if they step outside of the comfortable zone of the expected management of birth (p3). She put this down predominately to increasing litigation, which leads to clinicians *‘paying lip service to treating each woman as an individual and completely autonomously’* (p3). This reluctance to move out of the comfort zone of hospital policy or cultural expectations is echoed by obstetrician Jan, who shared that she has experienced a *‘lot of resistance’* (p2) from senior consultants when proposing a vaginal breech birth and felt that this is due to safety and litigation culture.

Midwife Helen negotiated the challenges of institutional expectations by networking, using the time to contact people she considered to be of influence to support her and her clients’ wishes, including support from a midwifery colleague experienced in vaginal breech birth and her Supervisor of Midwives. Her Supervisor of Midwives *‘...in a very nice way managed to help her [the midwifery manager] to change her view [about supporting the vaginal breech birth in her maternity unit]’* (p2) enabling the mother’s wish to be achieved. These important relationships are used by

midwives and women to realign their birth expectations, to gather support and to overcome barriers. Women were also aware of the influence of clinical guidelines, and their potential to leave women feeling alone in their decision-making. Sam discovered during her labour that her baby was breech and described how her husband counselled her about her decision. With the additional knowledge that her baby was breech, Sam was required to re-think her birth plans, but this was very solitary decision for her:

*“I remember my husband saying very clearly you have got to make the decision, you can’t ask the midwife to tell you what to do because it is not their decision to make and there are guidelines they have to follow so if you want to be at home I will support you but it is your decision” (Sam p2)*

For midwives, too, there was an acknowledgement of the reflective nature of supporting women in their birth choices. Midwife Erin described a period leading up to the support of a women who was to have a breech birth: how she became inward-thinking, drawing on her past experiences and considering what she knew, to gain assurance and trust in herself.

*‘[I] had to go really deep and go through everything I have learnt, how I had learnt it... it was from all the births I had seen, the ones which did proceed to good births, the ones that had been complicated... I was using all of that... before I could go [to a breech birth] with clarity within me” (Erin, p5)*

Midwife Erin went on to describe how she decided on the knowledge on which she based her experiences, showing the complexity and depth of her considerations as she draws from all of her clinical experiences to help inform her of the right path to follow. She engaged fully in this process to be assured she was doing the right thing. Alternatively, obstetrician Betty shared how she saw her role as ‘*an information giver*’ and a ‘*sounding board*’ (p3) when women come for an appointment to discuss their breech birth options, but also considered that it is necessary ‘*to correct them [the women] with the scientific evidence if they have come with the wrong impression of it*’ because of the requirements to use ‘*evidence-based medicine*’ (p3). This suggests an emphasis on her value of this type of knowledge over others.

From the data a clear thread of engagement and disengagement emerged, as participants negotiated through their breech journey. This negotiation led to complete withdrawal from institutions and people for some, but for others it led to complete engagement with people, systems, and themselves, as they decided the right path to follow. Participants commonly described a withdrawal from perceived negativity about their birth decisions and chosen pathway. Amy describes withholding information about her breech birth plans from some of her friends as a response to them telling her previously in her pregnancy that she was '*completely nuts*' (Amy p4) for wanting to have her baby at home. She shared how she disengaged from the '*ones that doubted*' (Amy p4) as a protective response to the perceived negativity. As her labour progressed Amy felt increasingly confident in her abilities and shared her feelings as her baby neared being born:

*I just knew I could do it. The moment she told me I was ten centimetres I knew I could do it... because it wasn't very long that I was in painful labour, if you know what I mean, it was only like maybe 40 minutes or something and that was it. And then "I can do this!"* (Amy p3)

Amy compared the confidence that this birth gave her to her previous one. She felt that this time it was she who gave birth, by having the baby in a fully-engaged way, rather than being delivered by clinicians in her first birth. Sara echoes this when she referenced feeling that her vaginal breech birth was something she '*was 100% for*' and that she '*had to...ignore the outside negativity*' (p5). Sara described how fully engaged she was with her birth which she felt was '*down to the work of me, my baby and the midwife*' (p2). Sara felt that her experience fundamentally changed her and gave her a new perspective on life, consequently instilling a '*wisdom*' in her that she wished to share with other women (p6).

Orla had a similar experience, but it was her body telling her what to do, something beyond her control but one she went along with (p3), emphasising the importance of birth being instinctive (p5). These examples show how engaged these women were with their births and how much internal dialogue they had with themselves around the time of birth. For Carla, the time when she found out that baby was breech, when in advanced labour at home, required an intuitive response. This was an internal engagement that not only aligned with her original reasons for planning a home birth,

but recognition that what '*felt right*' was in alignment with the biological process of birth:

*"I remember it being absolutely fine... It felt completely right being at home and I was very comfortable and then at that point I think determination took over in terms of decision making. I had got that far and it felt so right so I just thought there is absolutely no way I was going to go [into hospital] and seemed more determined to push. I didn't feel like it was a cognitive decision; it was more I was just going to carry on here"* (Carla p2)

Carla recalled the sense of focus that it had taken to get to the point of birthing her baby, and the confidence it gave her in her convictions (p3). Midwife Helen shared how woman's internal knowledge of her baby being breech is an innate thing, instinctive and unconscious rather than mindful and formed:

*"When I talked to the client later I said 'Did you know that the baby was breech then?' and she said 'I think I did'. But she hadn't articulated it but we find with quite a lot of women they know in terms of knowing in their inner beings without being able to verbalise it."* (Helen p1)

This internal knowing can shape the space for breech, influencing actions and decisions. For Sara, it was her actively holding back from making a phone call to book in for her caesarean section. Sara felt '*something was holding her back*', that she '*could not make the phone call*' (p1) as she continued to hold the space, seeking alternative answers to the surgical delivery she had been offered. Midwife Helen, too, felt she observed the power of intuitive knowledge, through a woman she was caring for deliberately holding back the birth until a breech-experienced midwife arrived. The woman's ability of '*not letting herself proceed with the birth*' (p9) was given credence as she birthed her breech baby within ten minutes of the arrival of the midwife who had some experience of supporting breech births. However, Lara's description of her experience of being told the baby was breech during labour was the opposite; the sense of control and internal focus was lost rather than strengthened by the news. The option of vaginal breech was offered with the caveat of requiring an epidural, the one thing Lara was adamant she had not wanted in her birth plan. Lara's language suggests a separation or disengagement of mind and

body as she struggles to take in the information and maintain the internal focus she had felt up to this point in her labour:

*“As soon as I was told the news I kind of lost my focus, I lost all of that because I didn’t feel I was in control anymore, so it was difficult, the anaesthetist when he kept trying to explain to me about the epidural ...it’s come and go come and go because they couldn’t get a response out of me because I wasn’t in my right place in my mind by then. I had lost control of things”* (Lara p3)

Midwife Liz also shared her perception of complete disengagement of a woman with her surroundings, following what she described as ‘*the worst birth I have ever been to*’ (p5). An unknown breech found in late stages of labour, Midwife Liz expressed how the subsequent actions and management of a breech delivery were ‘*horrendous*’ and ‘*total chaos*’ (Liz p4). The birthing woman’s response to her experience was to withdraw; she became mute, not communicating and apparently ‘*numb*’ (p3). The disengagement with those around could be seen as internalising emotions, feelings, expression, or alternatively be seen as a demonstration of a disengagement with the reality that she had gone through. For Midwife Liz, too, the experience led to feelings of disconnection as a reaction to what she had witnessed.

The temporal influence on deciding the right path became apparent when women described their experiences. For some women, having the time to think and consider was invaluable, but for some the time of trying to make a decision with a deadline of the end of pregnancy looming was a deeply stressful time. For others, not knowing until just before the baby was born - and therefore not having to make what they perceived as hard decisions - was helpful, whilst others found the lack of time and space limited their choices. Carla, whose baby was discovered to be breech just prior to birth, felt that the lack of required complex decision-making was a benefit to her:

*‘I am really glad I didn’t know beforehand. It was much better to have to go through it there and then. I didn’t want any decision-making in pregnancy’* (Carla p1)

Carla didn't feel the need to understand more about breech: the decision to stay at home and continue with her vaginal birth was more intuitive than cognitive (p2) and the inevitable process of birth took over and the baby was born with less effect on her personal journey than described by other participants. Lara, whose unknown breech was discovered when she arrived in labour at her local maternity unit, was given limited choices and only a short time to consider her options, making it difficult for her to take it all in. The choices offered to her - a caesarean section or a vaginal birth with an epidural - were both things she had wanted to avoid so *'the way I understood it I had no choices... that why I was so upset'* (p3). Lara was also given *'no time to think, it was a bit of a rush maybe. They wanted to get on and do it [give the epidural]'* (p5). This lack of time, of space to think and consider what she wanted to do left Lara feeling detached from her birth experience (p2). Kay felt that the lack of time helped her to achieve her vaginal breech birth as she arrived at the hospital just prior to when the baby was born, not allowing for the option of a caesarean section:

*"It was lucky that we got there at the point they couldn't do anything but, so I am sure that is what made the difference"* (Kay 1)

For Sam, however, there was a consideration of the lack of time which limited her opportunity to consider her options as she would normally do by *'collecting lots of information and sifting through'* (p3), but it was *'not possible'* when discovering her baby was breech during labour, so she drew on other means to help her. These examples suggest the interlinking of the temporal element with the place of birth, and stage of labour as influencing the overall experience and outcome. Meanwhile, for Sara, whose breech baby was discovered during late pregnancy, the period of time of trying to make a decision was fraught with stress:

*"A lot of time and energy just worrying and trying to decide, and constantly going back and forth was frustrating. At one moment I was deciding to investigate a C section and just quit worrying. I was trying to tell myself I know better... I was coming towards 38/39 weeks pregnant, so time was running out. I was under even more pressure to come to a decision... a lot of moments I would wake up in the night and panic, "Oh my gosh, I still don't have a plan!" Even though during the day I could concentrate on work, I*



*couldn't really understand what was going on in my mind. It really affected my work, my work relationship because I was so consumed in this trying to figure out what I was going to do" (Sara p1/5)*

Whilst temporal elements appear to have an influence on the birth experience for women, health professionals also shared some of their experiences where time was an important factor. Midwife Liz shared how she responded when discovering a breech late in labour when caring for a woman at home, acknowledging there was no time for explanations or questions, just direction and guidance (p1). When breech was discovered during labour in a hospital environment, there was a similar lack of time for discussion, but the decision by the doctors was to take the woman round for a caesarean section was challenged by Midwife Liz, who felt it was inappropriate as the baby was nearly born (p4). Midwife Erin, too, noted that ideally women need time to *'go away, think about it, settle with themselves and then know what is right for them and their baby'* (p3), but when this is not possible, it is the midwives role to step in and guide the woman. Obstetrician Betty agreed that there were challenges relating to the time and context of women trying to make a decision about her birth:

*"The way medics in the last however many years since the Term Breech Trial have approached it, they have thrown in vaginal breech as an afterthought 'oh yeah if you want a vaginal breech that's fine but you should really have a section' and I think that can influence hugely especially women who have come in with an undiagnosed breech, they are already in labour.... I think you need to give a balance approach, I'm not entirely sure women always get that"*  
*(Betty p1)*

Sam's experience bore out the challenge of taking in information when in labour, saying that *'it was all very hard to take in with the hormones and lack of sleep'* (p1). The health professional guiding role appears to vary under different time pressures, being more directional the later the breech position is discovered. These examples bring together how time, in the context of the inevitable birth of the baby, can play a part in shaping the experience, but how these pressures manifest in different ways dependent on the spaces, places and people involved at the time. This represents the complex and unique nature of the breech birth experience, where discovery to

decision-making or to the birth is always under the pressure of time, which can be a benefit and a disadvantage dependent on multiple factors.

This theme brings together the characteristics of deciding the right path, guided by experience, and the desire to know. There is both engagement and disengagement in this theme, elements exacerbated or aided by the pressures of time and space. These actions provide the basis of a route to follow, and one that appears to be towards a place of safety, which is the final theme.

### **5.5 Towards a place of safety**

This final theme describes elements of the breech birth experience relating to safety, protection and responsibility. These characteristics emphasise the importance of safe places and spaces for birth, but also bring to the fore the elements particular to the vaginal breech birth journey. Due to the infrequency and uncommon occurrence of vaginal breech birth, there is no established place or space for it to occur, so each time it is unique and individual. The categories that informed this theme were *Creating Safe Places, Protecting Personal Agency, Taking Responsibility and Making Sense*.

Both the participants who birthed at home and those who birthed in a maternity unit within a hospital shared their perceptions of the impact that location had on their birth experiences. Participants who were health professionals were also concerned about birth location, but this was more strongly expressed by those working mainly in the community and providing care at women's homes. Consideration of risk and responsibility were strong categories from the data, with safety being a paramount consideration for both the women giving birth and the health professionals. Frequently mentioned alongside this was the influence of the fear of litigation on the breech birth experience, a modern phenomenon that appears to be deeply embedded in medical health care and shapes care and decision-making in childbirth. All these elements were intertwined and formed an important element in the breech birth experience.

Sam's expectations of her birth were strongly linked to physical location. On hearing that her baby was breech she considered her options and '*fear of going into hospital*' (p3) was an influential part of her final decision to continue to birth at home. The elements that made up this fear were to Sam the possibility of having a caesarean section which was a '*terrifying thought*' (p2) to her and having to '*submit*' to decisions by a medical team whom she did not know (p2). This was echoed by Orla who also thought that going into hospital would mean an automatic caesarean section, substantiating her lack of faith in the medical profession and their default to surgical intervention (p3). Amy also held the view that medics would have '*panicked and*

*interfered'* (p1) had she gone into hospital, that she would not have been given the opportunity to birth her baby herself, leading to a negative experience. These concerns suggest an underlying set of assumptions about personal agency and location of birth which, in Kerry's case, were further compounded by her previous experiences, which left her feeling disempowered:

*"I suppose it was a first experience for me of having a child in a hospital unit and all that and that power struggle where you just want to scream to have my baby given to me and then you can't do anything because you are in their space and it was my first experience of that and I didn't really like it"* (Kerry p4)

Kerry's experiences left her feeling that she and her baby were not safe when her ultimate aim was to ensure *'that they were in good hands when giving birth'* (p1). This determined how she made choices for her second birth, finding a midwife with knowledge and experience to support her and birthing in her own way in a supportive hospital environment with a midwife whom she trusts. Midwife Helen also identified with this sense of difference between birth environments, as she described a woman she looked after who had a breech baby at home. She described how the woman, a *'really private person'* (p4) had expectations of how and where she wanted to give birth, *'in her own space'* at home rather than *'on show and being watched'* in hospital (p4, p5). However, this was not without consideration for the risks and benefits to her baby, which she carefully considered alongside her own requirements. This suggests that protective and private space is an important component for breech births, but that it is considered not to be achievable in all environments, so this becomes an important consideration for women in their decision-making about birth location. Carla also considered the privacy of homebirth an important factor as she was *'worried about going out onto the street and people seeing me'*, (p3) but felt that her decision to remain at home rather than transfer into the maternity unit when her breech baby was discovered to be not cognitive, but instinctual, as it *'felt so right'* (p4) to be at home, suggesting an element that decisions were ones that made sense.

In a similar way Kay felt that having her breech birth at home was *'pretty huge... very huge and personal'* (p5), and acknowledged how outside the expected norm this is in

contemporary maternity care. For Kay this shapes her beliefs in herself and in the decisions she made, as she was '*trusting in what I thought could happen*' (p5). Kay's previous negative experiences of being separated from her daughter after her previous birth in hospital strongly influenced her decision to have her next baby at home, reducing her perceived risk of separation from her baby. She voiced how completely she knows this baby and how connected she feels it makes their relationship (p6).

Jessica and Hannah, who both gave birth in hospital, also felt that this decision was right for them. Jessica shared how she felt reassured that she was in hospital when her baby's breech position was discovered, and imagined the potentially poor outcomes had she stayed at home (p5). Similarly, Hannah described how she had decided to give birth in hospital '*in case things went wrong*', and when the breech position was discovered, she was glad to be there and felt '*safer*' (p1). Lucy also considered that her environment was strongly linked to feeling safe, but for her this was at home. Lucy described how she felt she was able to '*create the safe*' at home and the consequences of feeling safe were that '*you know you are going to give yourself the best opportunity*' (p2). Her instinct to birth her breech baby at home was strengthened by trust in her midwife, and her expectations of a homebirth, which she had had since she was a girl (p2).

In these descriptions, the place of birth creates particular meaning for women about their experiences. It enabled participants to feel both the ownership and assurance of their own decisions on where to give birth, and also the impact environment had on their experiences. Whilst these women carefully considered a place of birth that felt safe for them, Midwives Rose and Erin emphasised the importance of birthing in peace, no matter where the birth takes place (Rose p4, Erin p4). This was reiterated by midwife Liz, who felt the place of birth should be one where risks were minimised and the individual's needs considered (p3).

Protecting personal agency was a feature of participants' stories when they described feeling or maintaining safety. Personal agency was seen to be difficult to maintain in the face of strong and opposing opinion. Kay's personal agency, the ability to make a choice through the consideration of outcomes, also outlined the value judgments she and others felt were important (p2). However, Kay shared her

belief that people place their value on the baby alone whereas she considered she placed value on both the mother and the baby in terms of wellbeing. Kay responded to this perceived difference of views by distancing herself from it as she moves towards her place of safety:

*“It is almost like a protective bubble. It is not about being horrible to a person; it not about not valuing their opinion, it’s about protecting you and keeping yourself in a positive frame. And in a positive place, in a belief that you can do it, and that the baby can do it. And if you expose yourself to lots and lots of negative comments it makes it much harder to keep that momentum, to hold on to that positiveness”* (Kay p6)

Kay’s language suggests elements of feeling the need to defend actions and feeling exposed, judged and attacked. This intuitive response of needing to protect herself and her baby from this perceived harm is very real to her as she seeks to keep her baby safe. Kay shared the importance to her of having ‘*trust in yourself*’ and ‘*listening properly to your body*’ (p3).

This value judgment was also keenly felt by Sara, who felt it aligned with the medically-provided and controlled surgical birth, but thought that the same courtesy did not extend to those who choose an alternative:

*“They [women having vaginal breech births] shouldn’t be judged for doing things different.... there was somebody who was arguing for having women who choose to have caesarean section shouldn’t be judged and that is the norm. Hospitals are all for that for the most part. If they are looking not to be judged, and the people who want to give birth naturally shouldn’t be judged either”* (Sara p5)

This sense of imbalance and lack of individual considerations was also felt during discussions with some health professionals. Kerry felt like she was treated as a ‘*figure or number*’ (Kerry p2) rather than being considered as an individual, and Jessica emphasised the ‘*very personal choice*’ (Jessica p4) she felt her birth decisions were to her. Amy, too, acknowledged the personal nature of the decision she had to make about how and where to have her breech baby. She described that

she *'didn't feel secure enough to make the choice'*, and yet added *'but I knew it was my choice'* (Amy p4). With personal agency came an awareness and evaluation of the possible outcomes, and women keenly felt the weight of the worst case scenario. Lucy shared this too, feeling that she was confident in herself *'as a woman that I could make the right decisions'* (p2), also suggesting individuality was a strong factor in decision-making. Midwife Erin also suggested how personal agency for women can be enhanced through the approach of the health professional. The emphasis was again on the individual nature of the decision and the circumstance:

*"if you support women and treat them as if they are somebody with a brain, but you know if you give them the full information most women will be able to take that information, go away, think about it settle with themselves and then know what is right for them and their baby"* (Erin p3)

Kay found that making the decision about her approach to the birth was pivotal to how she regained her personal agency following difficult and conflicted discussions:

*"I made the decision once I got to 36 weeks, I phoned for [the midwife] to come; the sense of relief was huge. To know that this was what I was doing. I wasn't going to have to go and consult somebody; I wasn't going to be told that I was a stupid girl"* (Kay p3)

Moving away from the perceived conflict and pressures and regaining control over herself and her decisions enabled Kay to realign herself to the next phase of her experience. Regaining this space for breech birth was described as a tangible act, both passive and active, relating to both the place of the birth and the space women had around their breech labours and births that they sense. Midwife Erin's descriptions emphasised how she perceived this as an essential component required to enable women to be able to birth. This suggests that permitting time and space to consider and reflect is an essential element for maintaining personal agency in this situation, and that it is passed on between the social relationships when identified as a valuable factor in protecting personal agency. For Midwife Erin, this was the key to how she works as a midwife:

*“And that’s what’s so beautiful about the way I work is that most times you can be there, you’re not doing anything, you’re holding the space really, space holder, whichever way the baby comes out and you’re letting the woman birth her own baby”* (Erin p5)

This description of proactive inactivity suggests that this is recognised and valued by some health professionals as both a physical and emotional part of birth support, and of trust in the birth process. In this sense Erin perceived her role as a midwife as one of protector and enabler, negotiating space for birth. This view was also apparent in the period after birth, as women sought to make sense of their place in society as women with breech birth experiences. The contribution to society of a successful birth story brings mixed feelings, with some participants finding it difficult to share their experiences with other childbearing women and society in general, in turn affecting their relationships with them. Lucy described feeling ‘*guilty*’ about her good breech birth experience when other women have had poor experiences and she didn’t ‘*want to be seen gloating*’ (p7). Negative comments from a health professional about her birth left her feeling hurt and careful about what she shared with others:

*“I try and put it in a diplomatic way if I’m talking about it. I try and be careful how I say things”* (Lucy p8)

This dilemma suggests the tensions women feel about how their breech births are perceived, and their place within health care and wider society; there is a feeling of having to navigate their role and social relationships. Kay felt ‘*not guilty [pause] but always feel I have to explain to people*’ that she had two natural breech births (p1). This awareness of feeling, or being, different, and the possible reactions to this, implies the way society disapproves, or views with suspicion, achievements against the perceived and expected ‘norm’. Lucy found it ‘*really difficult*’ to talk to other women about her breech birth experience ‘*even though I would quite like to because I would like them to know that it is possible*’ (p7), suggesting that the space for breech birth discourse within society is limited to outside the mainstream childbirth narrative. The breech birth, whilst an individual success for these women and babies, is therefore not shared with others within social groups and the knowledge and experiences remain muted and lost.



In a similar way, the impact of a dominant or pervasive view on breech was found for some participants to limit personal agency. This can be due to a number of reasons, and in different ways and to varying extents. Amy described her perception of the consultant obstetrician who 'allows' birth choices:

*'You might find he [the consultant] is really nice and someone who will let you have a fairly normal birth'* (Amy 5)

This consultant's individual autonomy appears to govern Amy's choices on how she can have her baby, a thought echoed by health professionals who were interviewed. Obstetrician Betty considered the distinct difference in the number of breech births when she was on duty to when her colleagues were, as *'my colleagues have their own views [on breech]'* (p3) and they routinely recommend a caesarean section for all breech presenting pregnancies. Obstetrician Jan also experienced *'a lot of resistance... from senior consultants, unless they are pro-breech they will advise a section even in advanced labour, so we don't do many [shrugs]'* (p2). Midwife Helen's perception was that this enabling or disabling can go beyond the individual and be more at an institutional level. Midwife Helen described how she perceived that the consultant felt obliged to comply with his more senior colleagues when discussing breech delivery planning with a woman and her midwife. Feeling that he *'almost apologised'* (p4) for his medical approach, Midwife Helen surmised that he lost an element of autonomy in the situation due to being required *'to comply with the other consultant views and the hospital'* (p4). This limiting of individual autonomy has a considerable effect on the personal agency of the women giving birth, and how they react to it. Furthermore, it is also interlinked to the category of taking responsibility.

Taking responsibility for the choices and risk assessments made was also an element throughout the vaginal breech birth experience. Kay shared how she met a midwife after her birth who was very judgmental about her home breech birth experience, and considered that Kay was simply lucky things went without complications. Kay was very upset, as she felt deciding on a breech birth at home was safer after she had considered all the options:

*“Actually I didn’t take any more risk to my baby than any other mum would have done and I researched it completely. And actually what is better, to go into the unit where they don’t know a breech is coming through the door and the panic sets in, I could get a midwife who has never even seen a breech birth, or doesn’t even know that that can happen. So I didn’t take any risk. In fact I took less risk” (Kay p8)*

Although these participants expressed opposite opinions about where they felt the safe location was in which to give birth, the desire for minimising risk and maximising safety was expressed by most participants, with Orla summing this up as:

*“We both said “What are the risks?” And at the end of the day that is what it comes down to, a safe mum and baby at the end of it”  
(Orla p7)*

There were descriptions of where risk perception differed. Carla’s GP, who was also pregnant at the time, reacted ‘*quite panicked*’ and ‘*reeled out a load of risks really from her own concerns rather than addressing mine*’ (p3) when Carla enquired about the possibility of a vaginal breech birth. This suggests that risk perception is determined by a number of factors pertinent to the individual, including job role. For clinicians, risk perception was strongly linked to litigation. Obstetrician Jan considered that ‘*even the more experienced consultants with lots of experiences of normal breech deliveries will advise a [caesarean] section*’, which she puts down to a ‘*concept of safety... and ultimately it comes down to litigation*’ (p2). Midwife Katy echoed this as she felt that litigation has changed the very culture of birth where clinicians are ‘*frightened of getting into trouble*’ (p3). Obstetrician Betty gave a clear indication of this, as she shared how she felt that ‘*I have to stand up in a court of law and defend myself for allowing a women to have a vaginal birth*’ (p3).

Amy, too, described feeling the pressure of responsibility when the obstetrician uses emotive language when discussing the impending birth of her baby:

*“There was one thing the doctor said to me, he said “yes, of course we can have breech birth and everything goes fine but what if your child was the one*

*which goes wrong". And of course, you know, that is the fear. And nobody can guarantee you that" (Amy p4)*

*"When you go to a consultant it was like one sentence he said "but what if it is your [emphasised by pointing] child [that dies]?" And you think, yes, what if I do make the wrong decision and then you think, but how can I make the right decision? Because you don't know. There is a certain uncertainty in life we just have to live with but what do you do if your experts say one thing and you don't kind of believe them." (Amy p6)*

The personalisation and inferential language was interesting. Although the doctor uses the 'we' for the joint decision, the use of '*your child*' implies it would be Amy's consequence. Using the emotional pull of the baby's wellbeing can be perceived as leverage to persuade Amy to acquiesce to the mainstream management of a caesarean section delivery for her breech presenting baby. However, Amy did consider the level of responsibility that is effectively handed to you when deciding to move out of the expected childbirth space, by stating that '*Actually I don't think a lot of women want to have the responsibility. They would rather believe the doctor and sue the doctor afterwards rather than having to take their own responsibility*' (p4). This implies not only that responsibility is something that can be taken, rejected, or given away but also that it has different meanings for people, often negative and difficult. For example, Hannah appears to describe how she felt relieved that the responsibility for the decision to have a caesarean section with one of her children was '*taken out of her hands*' due to the position of the baby (a floating breech). She stated:

*"It was their decision not mine which was fine. It is much more difficult had I had to make the decision" (Hannah, p2)*

Sam provided some insight into how much pressure this was for the individual, saying that taking the responsibility of the decision to have a vaginal breech birth knowing there was a possibility of the baby dying was the '*hardest bit of it*' but that she took on the responsibility of her choice (p3). Midwife Rhian also considered it the responsibility of the clinicians to give information in a way that is supportive. Sharing her experiences of hearing a doctor giving what she perceived as an '*unbalanced list*

*of risks'* to a woman being counselled about her breech birth options (p2), Rhian considered fear and lack of confidence to be the reasons for the poor information-giving and coercive measures used to ensure women chose a caesarean section. This counselling approach appears to be borne out by obstetrician Jan, who shared that:

*"Most people are swayed, no not swayed, are usually advised to have an elective section, which is for the best. I give them a choice but I put it in a way that I will [pause] I don't think I do but [pause] just the hassle, the things they have to go through if they want a vaginal breech. And ultimately they have to take responsibility for that risk and not many of them want to do that and that's fair enough"* (Jan, p1/2)

For obstetrician Jan, the risks of caesarean section were justifiable because the surgery is so common place; an injury to mother or baby during surgery can be justified more than during a vaginal birth, as the vaginal breech birth happens so infrequently (p2). Whilst this broad approach appears standard for Jan's practice, Midwife Katy believed that *'we pay a lot of lip service to treating each woman as an individual and completely autonomous, but I don't think we do in a lot of cases'* (p3), finding women who ended up with caesareans for their breech presenting babies as feeling *'compromised into doing that'* (p2) after talking with her medical colleagues.

The complex decisions about location and mode of breech birth were underlined by what individuals consider to be safe, and about avoidance of that which is considered less safe. There was acknowledgement that taking your own decisions means accepting a level of responsibility and, for some, a sense of ownership. For some women, this had a considerable effect on how they perceive their birth experiences.

The connecting of mind and body to come together and, in essence, make sense of the situation, was evident in the stories. For Kay, this belief in self and one's own body was something that grows over time, requiring communication and trust, with considerable benefits in terms of developing a *'real sense of confidence'* (Kay p2). This description is analogous to a relationship, suggesting different elements: the body and the mind, both of which need nurturing in order to establish harmony and

keep safe. Whilst Kay trusts in her body to tell her mind what is '*not right*' (Kay 2), for Sam it was her mind asserting a decision over her body that she recalls. In an apparently instinctive decision to get on with birthing her baby, Sam perceived her body coming into alignment:

*"..so hours later he arrives. A leg was out and then he turned all the way around which they reassured me was really helping. The contractions were slow... but he turned gently, all the time there were no concerns for him or me, everything was fine. Then it wasn't very long when I decided it has got to come out now and my body obviously went with it and it was when the actual real pushing bit came it was fine"* (Sam p2)

Acknowledgement of our ability to control mind and body is considered by Orla, who believes that birth is not a process to be consciously controlled. Like Kay, she considered the body as the decision-maker, communicating what is required. Orla alluded to the mystery of birth as '*one of those things we just don't know*' (Orla p3), with the body shaping the mind's perception of the experience in order to make sense of it. The body's dialogue and demands during breech birth are considered a vital part of knowledge by both women and the midwives. Midwife Erin had strong views about ensuring that this communication is not prevented or disrupted by medical interventions, such as epidurals:

*"I won't tolerate an epidural as I think the women should have a dialogue with them [selves] and their babies, so it's inward not outward information"* (Erin 8)

This notion of receiving information from the body, and the baby within the body, to help make decisions, acknowledges the importance of the knowledge women hold within themselves. Lara was required to have an epidural as part of the agreement the doctor made with her to continue with her breech birth when she was progressing and '*doing so well*' (Lara 3). However, she epitomises this loss of visceral experience, as she described her labour and birth as:

*'It was kind of exciting, interesting and emotional. Not much control.'* (Lara p2)

The language here suggests a distance between Lara and the experience of her birth: a seeming disembodiment between her and her body as it performs despite, not because of, her interaction with it. This detachment leads to a feeling of lack of control for Lara, not just for this part of her birth, but over all elements of the childbirth experience, where she concluded *'I don't talk about it but when I do I get quite upset. It has probably affected me more than I realise'* (p6). This experience intimates that for some, the detachment to the birth event disrupts the element of making sense, and subsequent ability to come to terms with what happened.

Midwife Liz shared a conversation she had with a woman for whom she was providing care, as she tried to come to terms with her birth. Midwife Liz described the woman and her partner as having relationship difficulties, and how she considered that the partner's overwhelming reaction to the birth of his child broke down the issues the couple had and brought them together. With the woman previously expressing her view that the baby was breech to be nearer to her mother's heart during a distressing pregnancy, Midwife Liz had a unique sense of the breech birth creating new meaning for the adult relationship; perhaps a new beginning for the whole family (p1). This dialogue of the emotional mind affecting the body and baby shows how interconnected they are, and how strongly people identify with them.

This was also seen in the legacy of the birth as women made sense of their experiences. For many women, there was a need and drive to make sense of their experiences as an individual but also to make sense of their place within society. For Amy her birth provided her with a sense of confidence. She expressed a feeling of ownership about her breech birth that she had not felt with her previous birth, suggesting that her self-efficacy had grown with the knowledge and lessons she took from her first birth:

*'I feel a lot more confident. I think the first time [first birth] [shaking head, looking down]... this time I felt I [emphasis] had the baby, I [emphasis] achieved it'* (Amy p4)

Both Amy and Carla also felt that the birth not only gave them confidence in themselves, but also created a feeling of being able to prove to others who treated their birth decisions with scepticism that they themselves knew better. Carla, despite

considerable pressure from others, still felt able to resist, as her belief in herself was stronger:

*“I think it has given me, if anything, confidence in my own convictions. I came across an awful lot of people who thought I was mad and I had to go with what my gut was telling me despite virtually everyone telling me it was the wrong thing to do... so it has given me confidence that I can stand up for myself, I suppose”* (Carla p3)

Sara described her decision and subsequent breech birth as ‘*everything down to the work of me, and my baby*’ (p 2); Sam said ‘*it was completely down to me, there was no one backing me up saying this was sensible and wise*’ (p3); and for Kay, it felt like ‘*a balance in trusting what I thought could happen*’ (p 5). These descriptions show the isolating effects of making decisions that do not follow the expected norm, and how women try and make sense of this as they reflect on themselves. Kay considered this to be specific to pregnancy and babies, when ‘*people always feel the need to tell you what they think is right*’ but she insists that ‘*it doesn’t necessarily make it right for you*’ (p6). This suggests that childbirth is seen as more owned by society with individuals expecting to conform to the greater good regardless of the individual need. This was echoed by Midwife Liz, and by Sara, who both expressed the pressure felt during pregnancy:

*“I think it’s peer pressure, an awful lot of peer pressure. And each time I went to see her [the woman she was caring for] she would tell me ‘oh someone else has said oh you’re stupid, why would you do it’ that sort of thing... whether it is cephalic or breech, more of a society’s pressure”*  
(Liz p6)

*“so when you have been speaking to doctors it was like coming from two different worlds so they couldn’t understand where I was coming from and I couldn’t “conform” or “behave” for them... I knew that it was something that I wanted, that I was 100% for, that I had to just trust in what I believe and ignore the outside negativity”* (Sara p4/5)

Although this language suggests a sense of being outside, alien, distant, different from others, it was the internal loci of control that made more sense to the women to continue with their convictions. For Orla, this was confidence in her own body, as she was *'quite fit'* (p3), and for Amy it was a conviction to not be treated *'like a piece of meat... this time I was in full control'* (p4). These examples of high self-efficacy, driven by previous experiences and self-perception, suggest that the women may have understood their breech births had to be mastered: they had to achieve, and when they succeeded, their beliefs were confirmed.

For midwives, too, making sense of the breech births was both personal and shared. Midwife Rose described how she felt she *'helped her [woman giving birth] to feel successful whichever way the baby has been born'* (p3), suggesting a shared moment or a gift to impart to the woman. Midwife Erin described a more personal response when describing how the breech birth she attended re-enforced her knowledge; it aligned with what she believed, and confirmed what she knew and shared with others:

*"...and having watched it and it all happen [the birth] the way it should have happened and the way I had seen it happen and the way I had then described...that re-enforced my knowledge and my confidence"* (Erin p5)

Midwife Erin reflected on her applied learning, and the evidence she requires in order to continue with her convictions, which she shares with others. Breech birth for her makes sense through her learnt knowledge, and renews the experiential learning derived from a breech birth. However, Sam recalled the consequences of this situation for some time after her birth, and was left trying to *'make sense'* of what happened and why.

*"I felt shaken for a long time. We are not in control of life and death at all and I felt I had been very close at that point... although there was no risk to him at any point that we noticed. I felt we somehow ambled into this situation unknowingly and I felt shaken for a while.... I needed to speak with the midwife who had been there, because I couldn't make sense of it"* (Sam p3/4)



The need to understand her experience is strong; Sam wished to explore the issues that had been brought up for her in order to make sense of the different birth to the one she was expecting. The unexpected nature of this different birth is more acute with breech presentations discovered in labour, with women taking the time after birth to consider, reflect and adapt to the situation. For those who find their baby to be breech in pregnancy, the process of adaptation occurs much sooner and can even be reconciled before birth, as seen by Kerry and Amy. Sara, who found she was carrying a breech baby late in her pregnancy, had time to consider her options and to make a decision that made sense. To her, this was a pivotal moment of enlightenment and provides her with a direction of travel:

*“From there on there was no more hesitation, no more this and that, no more going back and forth because in my mind I had an answer, I was excited, I could breathe, focus on relaxing, and getting ready to give birth” (Sara p2)*

This final theme draws together the characteristics that focus on safety, responsibility and personal agency, and the connectedness of these creating a situation that makes sense. Whilst these elements occur at different times and in different ways, they were readily apparent in the interview data, and spanned both the experiences of childbearing women and health professionals.

## 5.6 Summary

The experience of vaginal breech birth comes with a unique set of challenges, issues and considerations. For those who move away from the expected dominant destination of surgical delivery toward an alternative route, there are four interlinked and interconnected themes that describe the characteristics of the vaginal breech birth experience within a social, cultural and gendered context. Inevitably these fluctuate between individual's experiences and are dependent on a number of variables, but the exhaustive analysis of the data gathered in this study suggests recognisable junctures within these experiences.

To summarise, the findings present four identifiable constituents to the experience of vaginal breech birthing:

- The theme of **losing the way** indicates that at both an individual and a wider social level, the breech experience is one of change, away from a known, to an unknown situation. The elements of loss are drawn from the loss of the expected birth and the loss of normality, identity, choice, and control on discovery of the unanticipated situation of a breech presenting baby. This sense of loss, or being lost, conveys a disruption to the expected way of things, and the sense that breech is not part of a normal birth paradigm.
- Alongside and entwined with this sense of loss and the unknown is the element of **fighting fear and seeking trust**, as the situation of breech brings uncertainty, conflict and heightened sense of vulnerability. There is an uneasiness of needing to navigate the strong emotions and tensions that breech evokes in order to find elements, internally and externally, to trust.
- This unsettled element continues but starts to resolve though seeking knowledge and guidance to consider the route to take. There is both engagement and disengagement in order to be able to move towards **deciding the right path to follow**, with time pressures shaping how decisions are made and what routes to take.

- Moving **towards a place of safety** there are elements of resolve, as things make sense and fall into place. Protecting the self and taking responsibility are necessary to enable safe places to be created in unique ways that enable vaginal breech birth to be achieved.

Whilst these findings have been presented in a linear way, the characteristics and stages of this experience are interlinked, merging and flowing throughout the breech journey. The social, cultural and gendered context of this unique birth experience is complex so I will draw on the concept of space to enable the constituents of this experience to be explained in a more comprehensive way. The next chapter will present a series of interlinked spaces comprised from the themes above, which enables the experience of vaginal breech birth to be seen as dynamic in nature, changing and evolving through time and space. Borrowing from the field of social geography, the concept of layers of evolving spaces provides an opportunity to re-conceptualise the vaginal breech birth experience, illuminating this unique journey through the social, cultural and gendered context and bringing new knowledge.

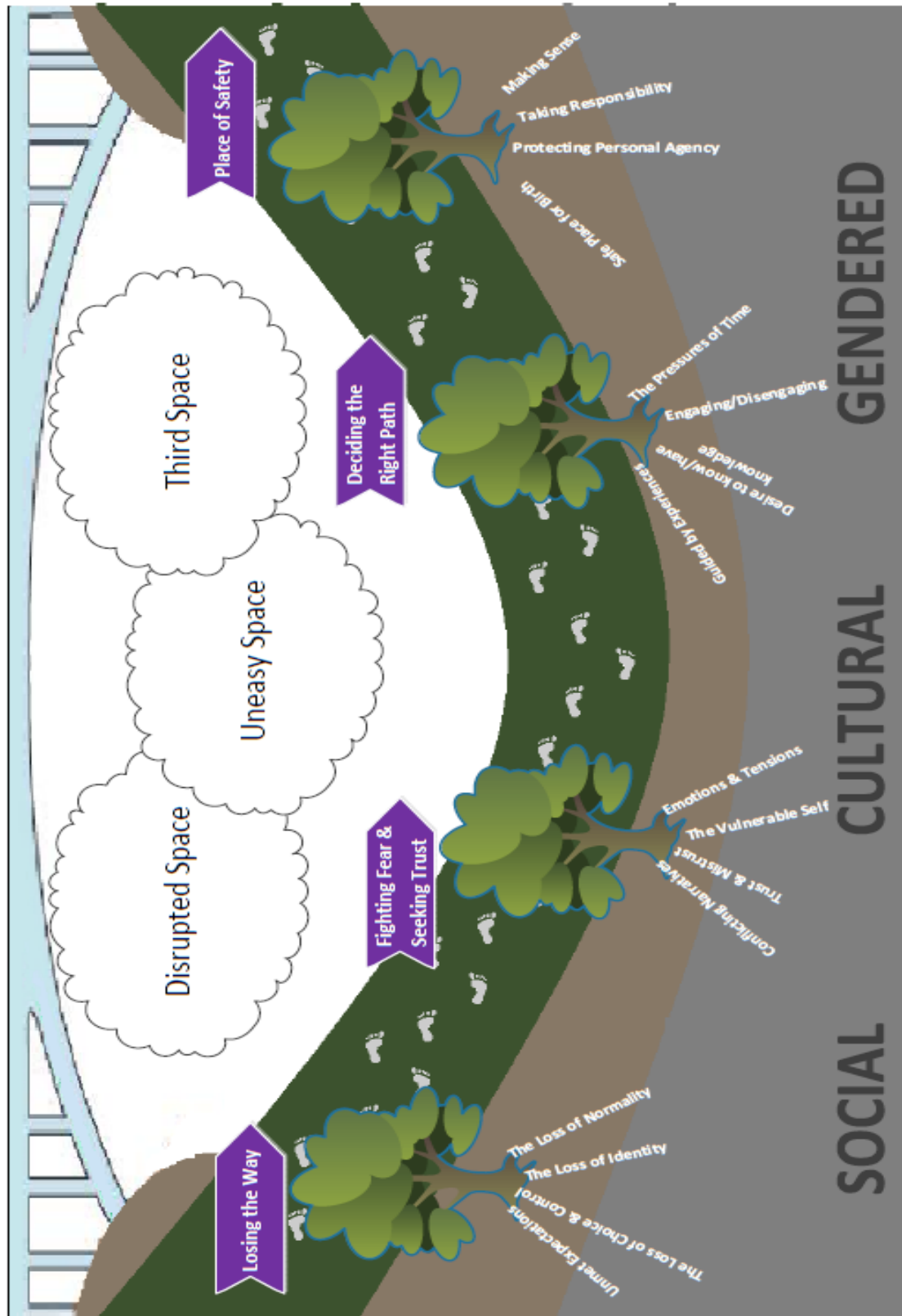


Figure 4: Summary Diagram of Findings

## **CHAPTER 6: DISCUSSION**

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### **6.1 Introduction**

The breech birth experience is unique in being largely unpredictable and discovered late in pregnancy or during labour. Most importantly, unlike other issues arising during this time in pregnancy, such as pre-eclampsia or obstetric cholestasis, breech presentation is not a medical condition but a different-than-usual event. Furthermore, despite inconclusive research based evidence, the concept of breech has changed in the last 20 years from being considered a variation of normal to being overwhelmingly medicalised, with nearly all breech presenting babies being born with surgical delivery (Borbolla Foster, et al., 2014). The breech landscape has been shaped by many factors, but with the main focus on medically-based research into breech. The elements of social and cultural relations, the geography of modern institutions and the position and representation of women and birth within society have been mostly overlooked. It is these elements that are the focus of the thesis and for discussion here.

The four themes presented in the previous chapter represent stages and characteristics of the vaginal breech birth experience. To make sense of these within a social, cultural and gendered context this chapter will draw on the social geographical concept of 'space'. The concept of space emerged directly from the data, with participants referring directly or indirectly to time and space as threads running through their journeys. Time was limited to a greater or lesser extent dependent on whether breech was discovered at the end of their pregnancy or in labour. However, the data also referred to broader emotional and psychological influences of space, such as midwives being space-holders, as well as reference to the physical location of home or hospital. Additionally, the concept of space illustrates the complexity and interconnectedness of the journey as social, cultural and gendered factors ebb and flow throughout, shaping the landscape and experience. Space provides a way of analysing and explaining gendered social relations in a particularly helpful way:

*“Spatial relations and the layout, the differences between places, the nature and form of the built environment, images and representations of this environment and of the ‘natural’ world, ways of writing about it, as well as our bodily place within it, are all part and parcel of the social constitution of gendered social relations and the structure and meaning of place. The spaces in which social practices occur affect the nature of those practices, who is ‘in place’, who is ‘out of place’ and even who is allowed to be there at all. But the spaces themselves in turn are constructed and given meaning through social practices that define men and women as different and unequal. Physical and social boundaries reinforce each other and spatial relations act to socialise people into the acceptance of gendered power relations – they reinforce power, privileges and oppression and literally keep women in their place” (McDowell, 1993, p. 3)*

In this context, consideration of gender is central, with the maternal body produced and affected by societal representations, shared understandings and cultural influences, as well as their physical attributes (Longhurst, 2008). This unique experience of vaginal breech birth is an exemplar of how birth is increasingly being seen as beyond a pure physical event, but rather as a more a complex social phenomenon shaped by relationships, beliefs and actions. The findings suggest three spaces are significant: **Disrupted Space**, **Uneasy Space**, and **Third Space**. These spaces enable the breech birth experience to be explained in a way that will draw out new knowledge and consider how this then situates with what we currently know. Gaining an understanding of how these spaces illustrate the journey of vaginal breech birth provides insight into how breech childbirth is represented in today’s society, and the extent to which social, cultural and gendered practices have defined breech, breech-birthing women, and breech facilitators.

**Disrupted space** draws from the themes of ‘Losing the Way’ and ‘Towards a Place of Safety’. This space refers to the time when breech is first discovered, where childbearing women’s hopes and expectations for their births are disrupted with the removal of options, choices and control. However, this space is also found where vaginal breech birth is achieved, as the spontaneous, physiological and straightforward

vaginal breech birth actively disrupts contemporary notions of normality and normal birth. This space reflects the effects of society's desire for certainty, the expectations of modern childbirth, and the wish to fit into the ascribed models of birth. These elements explain how developed notions of normality and normal birth have excluded breech, which leads to this sense of disruption and loss.

**Uneasy space** draws from the themes of 'Fighting Fear and Seeking Trust', 'Deciding the Right Path' and 'Towards a Place of Safety'. This space is found between initial knowledge of breech and the birth itself, and is a time of pause, consideration and interaction. The space reflects the tensions between expected social roles and behaviours, different knowledge bases, and the modern drive for consumer rights in healthcare. The nature of this space is one of conflict, tension, and emotion, with relationships and time pressures intensifying the sense of uneasiness.

**Third space** draws from the themes 'Deciding the Right Path' and 'Towards a Place of Safety'. This is a predominantly active space, with elements of ownership and responsibility, and of acceptance when decisions are made and birth is imminent. The physical nature of birth and location of birth are also grounding features of this space in an otherwise fluid, flexible and diverse process. This is a space that draws the maternal woman back to the centre of the birth experience, providing or enabling focus, and being connected to the embodied birth.

The aim of this chapter is to demonstrate the multiple ways in which vaginal breech birth experiences influence, and is influenced by, social, cultural and gendered processes and representations. The next section will examine these spaces in relation to what is already known, not only in order to find commonalities and differences, but also to demonstrate the study's specific contribution to knowledge. It will consider and answer the research questions, and suggest further avenues for investigation for future research. This chapter will also present anomalies and unusual findings arising from the data in the research, as these provide an opportunity to consider and reflect on the study design, and also to identify areas that may warrant more review. The following

section will be presented under the headings of the three spaces; Disrupted Space, Uneasy Space and Third Space.



## *6.2 Disrupted Space*

This space emerged as representing the overwhelming expectations and desires that women bring to their birth journeys, and how fragile and easily-disrupted these can be when something does not meet the ascribed criteria. Breech presentation does not fit into the normal constructs of pregnancy, and is viewed as something to be fixed, as lacking, or as something to be returned back to normal. At all levels, from personal views to national recommended practice, every endeavour is made to change it to the 'normal' cephalic presentation. With this sense of loss of normality comes a sense of loss of identity, with both women and health professionals re-evaluating their role and status when faced with a breech presenting baby. For midwives and women there is also recognition of other loss, of skills, knowledge, and confidence, for example, and also of choice and control. The emergence of the polarised views of the medical childbirth advocates and natural birth movements (Walsh, 2010) has contributed to the marginalisation of breech, and thus the ensuing sense of not fitting in and exclusion that this brings. Whilst both fail to consider the diversity of situations that fall between these concepts, these polarised views present attractive simplistic images of birth that reinforce the desire for certainty within childbirth, and expected compliant behaviours of childbearing women.

Vaginal breech birth, on the other hand, not only does not fit, but is not even provided with a place within the normal birth space due to the overwhelming expectation being that of a caesarean section delivery for breech, mirrored in national guidelines (Royal College of Obstetrics and Gynaecology, 2006). It is excluded both physically, as some women have no choice but to find their own place to birth, and emotionally, as choices and control are removed or limited. This element of not being part of, or not fitting in, contributes to the deep sense of loss for those involved. In a wider sense, this space reflects how childbearing women are positioned in a society with narrow constructs of normal, expected feminine behaviours. However, these narrow parameters of normality are also troubled by vaginal breech birth, as its very existence challenges the ascribed notions of normal. The presence of vaginal breech birth, whilst socially and medically labelled as high-risk and abnormal, often provides examples of the essence of the

normal birth narrative (such as spontaneous, non-interventional, midwifery led) which disrupts current notions of normality.

As discovery of breech is mostly unforeseen and occurs late in pregnancy or in labour, when expectations are mostly established, the immediate impact of the disrupted space is acutely felt. However, social relationships and emotions appear strong influencers on the extent of the disruption. Who is present when the breech is discovered, and how they react and respond, can heighten or reduce the extent of the sense of disturbance, sense of loss, and emotional response. Breech discovery also creates a highly-emotional time in an already highly emotionally-charged event, childbirth. Emotion is communicated through what is said, unsaid, and shown, emphasising the position of breech within society. For disrupted space there is the characteristic of emotional disruption: a time of mostly negative response, including fear, upset, disappointment and shock.

For childbearing women, this is predominately a passive space, where they receive information, are moved into a different pathway, and have elements of choice and control removed from them. However, it is also an active space, where vaginal breech birth challenges notions of normality and narrowly-defined notions of normal birth.

### **The premise of breech 'non-normality' and the desire to fit in**

The underlying premise of a normal birth and the 'non-normative' nature of breech was strongly represented by the research findings. On discovery of breech, many participants related expectations of requiring a caesarean section, and the devastation of the loss of their expected normal birth experiences. These responses to the discovery of breech are representative of how breech is now considered, with vaginal breech birth exiled from the 'normal' birth space. This sense of disruption is felt acutely at the time breech is discovered, but experienced more broadly during re-integration of the breech

birthing woman back into general society where there is a difficulty in being accepted, engendering a feeling of not fitting in.

The ideological normative view of birth has evolved over time. Human reproduction has been phenomenally successful but not comprehensively so, with some maternal and child deaths inevitable. In her writing on the history of childbirth, Marjorie Tew (1990), suggests that these losses are felt not only by individuals, but by communities and nations who require population to be successful at best and to survive at the least. She concludes that '*individuals and communities, therefore, share concern to find whatever assistance they believe will reduce the casualties of reproduction*' (Tew, 1990, p. 2). In this way, medicine in western society rose to prominence and prestige, claiming the credit for significant improvements in mortality and morbidity rates in the nineteenth century, despite epidemiology studies later showing that improvements in public health, nutrition and living standards had more effectiveness in reducing ill health than any intervention of medicine (Tew, 1990, p. 4).

The prominence, and ensuing dominance, of medical discourse has had a considerable impact on the maternity space today, shaping the politically- and socially-complex phenomenon with its intrinsic links with normative versions of birthing mothers (Longhurst, 2008, p. 80). Whilst there are arguments which claim that there are no universal birth definitions (World Health Organisation, 2014), a dominant version of normative birth needs to be considered to understand the roots of expectations. Based on white, male, heterosexual and western perspectives, with an assumed dominant male gendered view, Massey (1994, p. 240) claims childbirth has evolved to be seen as a problem to be tamed and controlled. This discourse is evidenced by the increasing 'normalisation' of the caesarean section, with claims of 'natural caesarean', and promotion of elements of traditional birthing such as music, skin to skin with parent and baby after birth, and delayed cord clamping being undertaken during surgery and in theatre (Mercer, et al., 2007). The space for normal birth appears increasingly medicalised, and provides an opportunity for increased certainty to be achieved through control over the body and nature. Certainly the findings of this study suggest that in this disrupted space, there is a dominant view of breech as abnormal and requiring a

caesarean section delivery, which immediately removes childbearing women from the normal birth sphere. This is further re-enforced by the clinical response of intervention: referral to an obstetrician, booking a scan and an offer to turn the baby (External Cephalic Version). These initial responses and actions unequivocally disrupt the birth journey and disconnect women from their birth expectations.

Additionally, there are social pressures to conform or fit into groups or behaviours: expectations communicated through social relationships. In social geography, the nature of belonging or fitting into a certain place is part of social transformation, as people and places fit changing versions of the past to the current, and shape the future. Feelings of fitting in or not fitting in are constantly evolving with changing cultural and social values, nationally (Ahmed, 2000) and more locally, within different groups and communities. Described as 'economies of feeling' Taylor (2012) explains how this desire to fit in is present at local as well as macro levels of social structures, and has emotional consequence:

*"Imagining ourselves to be in, or to have a place, often involves complex feelings of loss and gain, entrenching a sense of belonging or rupturing this through disconnecting claims entitlements and longings"*

(Taylor, 2012, p. 2)

Gender, as well as class, is reproduced by the expectations of 'fitting' into social structures with normative behaviours. However, many individuals cannot or do not want to 'fit in'. This research highlights the effects of this in a specific situation, with the disrupted space providing a way of understanding how these social pressures impact on the breech birth experience, which doesn't 'fit in' with the current medical and natural birth paradigms. This disconnect between the simplified binary of normal and abnormal, natural and medical, is as disrupted as the vaginal breech birth experience, as demonstrated by the fact that this research fits into neither descriptions.

This social desire for ideal norms and expectations of conformity is particularly seen in institutions such as the military, legal system, and hospitals. French philosopher

Foucault's (1979) writing in this area explored institutions where the universal criteria can be imposed on less-powerful people in the name of valuing normality, despite there being no universal standards by which to judge. Foucault's work on institutional power claims that organisations subscribed to models such as prisons and schools, which seek to homogenise people rather than acknowledge distinct and individual social identities (Foucault, 1994). His theory of 'docile bodies' reminds us of the power of the medical gaze, where breaking down the complex human into elemental parts ensures routine performance and conformity. Foucault also surmises that individuals are self-policing in their homogenisation (Foucault, 1994), which gives some explanation as to the tensions between the individuals who decide to swim against the flow and choose a vaginal breech birth, and who as a result may be left with feelings of judgement and exclusion from general society. This reinforces this overarching view of normality and abnormality, and the expected behaviours of the mothers to conform to the dominant view: that breech is risky, and delivery of the baby by caesarean section is safest. However, Foucault's work has been criticised by feminist writers, who see the portrayal of the body as genderless and essentially passive as problematic and limited. Feminist theorist Lois McNay summarises these concerns:

*"In terms of identity in general, the reduction of individuals to passive bodies permits no explanation of how individuals may act in an autonomous and creative fashion despite overarching social constraints"* (McNay, 2004, p. 12)

This research demonstrates just this point. The participants interviewed established their own normative views of how they wanted their births to be, with core elements held in great importance, shaped by their own and other's experiences and by interactions with those around them. The participants acted in their own and their baby's self-interest despite the overwhelming expectations that they would conform to the 'norm' of a surgical delivery. This shapes their identity as individual active decision-makers, which will be discussed in the coming sections on Uneasy space and Third space. All the women interviewed desired a vaginal birth (or desired an avoidance of a caesarean section) but their other expectations varied considerably from a more 'natural' approach (for example homebirth, non-medicated) to a more medically-framed experience (for

example, in hospital, with accepted interventions). The diversity of meanings given by participants as to their own 'normal' birth expectations is replicated in debates over the definition of 'normal' birth (World Health Organisation, 1996). Whilst many groups have attempted to define 'normal birth' there are no fixed accepted parameters, with different professions, cultures, and societies conceptualizing birth in different ways (Young, 2009). For example, the Canadian definition of normal birth includes the use of epidural analgesia, whilst the UK definition includes both continuous fetal monitoring and medical interventions with an impact on the physiological birth process (SOGC 2009) (Maternity Working Party, 2007). These conflicting interpretations demonstrate how normality is shaped within society and the accepted views of those within it. Both countries have a dominant medical culture which tends to lean to a universal solution, but also have strong consumer groups and midwifery provision which demand a culturally-specific model of normative birth.

Whilst there is diversity in definitions, ideas, beliefs, and the core elements that individuals decide are important to them, there was also an underlying desire for certainty which was intrinsically entwined with birth expectations.

### **Uncertain birth**

While certainty of birth outcome relating to a live mother and baby is a primary focus of obstetrics, for other participants in this study there was a desire for certainty in other elements of birth. What was apparent from the data is that this knowledge of breech altered their certainty. For many women, the discovery of breech meant that they were not going to be able to have the birth they intended, and for others it led to a period of uncertainty, and loss of control. These changes are challenging to experience, often leading to negative reactions such as shock and distress. Similarly, Lundgren and Berg's (2007) research on the relationship between a woman and her midwife suggests that loneliness was associated with the unknown and the uncertainty of pregnancy and birth, which is exaggerated when there are complications arising (p. 224). This uncertainty is mirrored in other research, particularly in studies relating to women's experiences of Vaginal Birth After Caesarean (VBAC). Whilst the research on VBAC is

more consistent as to the relative benefits of vaginal birth, compared to vaginal breech research, there are similarities in terms of both VBAC and breech being considered 'high-risk' and medically-led. In a number of VBAC studies, women reported feeling uncertain in terms of their choices, labour, and birth, leading to anxiety, going back and forwards about what to do ( (Meddings, et al., 2006) (Goodhall, et al., 2009)). My findings echo these, and raise questions on how and why certainty and uncertainty evolve.

This desire for certainty can be seen as the evolving concept of the 'evidence-based' approach as the dominant model in healthcare. However, Soo Downe (2004) challenges this concept, stating that it has been '*subverted by a wider professional demand for certainty*' (p. 6). Downe continues that the intent of the 'best practice' approach was an amalgamation of good-quality data and practitioner skills and experiences, and attention to the individual service user's beliefs, knowledge and values; however, the requirement for increasing medical certainty led to creation of clinical protocol and guidelines often adhered to as if the evidence was comprehensive, without limitations and equally-applicable to all individuals in the population. This certainly reflects the situation with breech, where controversial and contested research specifically based on a single randomised controlled trial methodology, the Term Breech Trial (Hannah, et al., 2000), was the only research mentioned by participants in this study. This research was noted to be a source of frustration by some in the study, who recognised its limitations but also saw it being used as a way of coercing women into having a surgical delivery. This was further corroborated in the documentary analysis that showed medical documents, such as clinical protocols, focussing nearly exclusively on quantitative research, weighting randomised controlled trial research and Royal College of Obstetricians and Gynaecologist guidelines over other sources of information.

Whilst surgical and interventional childbirth is increasingly normalised, breech birth has continued to be labelled as high-risk despite emerging research that selective vaginal breech birth, an individual assessment to determine suitability of a vaginal birth, is a reasonable clinical approach (Goffinet, et al., 2006). In a drive for evidence-based

practice, medicine has stratified research approaches and established the authority of the 'gold standard' randomised controlled trial methodology as a way of establishing generalised principles that can be applied in clinical practice. The randomised controlled trial (RCT) methodological approach has been promoted as '*the most rigorous way of determining whether a cause-effect relation exists between treatment and outcome*' (Sibbard & Roland, 1998) and RCT research findings have been adopted by clinicians with alacrity in the field of breech birth (Steen & Kingdon, 2008). Whilst more recently there has been an acknowledgement that the use of RCTs in complex and multifactorial areas of health care has limited value, and that bias cannot be eliminated from any research, the RCT continues to maintain its dominance in shaping clinical practice, and in recent years has been presented more as a certain fact than as a guide (Jadad & Enkin, 2007). The aim of the RCT is to homogenise a population with the intent to identify the best way to treat/manage an issue or problem, increasing certainty. Individual variants are dismissed in an effort to ensure the results are not contaminated with confounding variables. By attempting to apply this simplistic construct to a social, cultural and bio-physiological complex event such as childbirth, with such a vast number of variables, is not only difficult, but inappropriate (Glezerman, 2006). The reductionist approach is inconsiderate of the individual nature of one of the most corporeal of human experiences. Indeed, this research showed the consequences of generalising an approach to breech childbirth, and a desire for a more individualised care. Jelinek suggests a broader approach to evidence-based care would better meet the individual's needs:

*"...has to be balanced with other evidence of a biomedical, psychological and sociological nature and with previous experience derived from both a core of relevant literature and of a personal or institutional base. It has to be applied to the individual patient and perceived by both patient and doctor"*

Jelinek p86 *IN* (Downe, 2004)

The desire for a linear way of thinking is also a reflection of the medical authoritative knowledge that is seen in obstetric institutions of hospital-based birth (Davis & Walker, 2010). Progress in labour has been distilled down to how much a cervix dilates, applied



to a timeframe (Friedman's curve), and deviations from this lead to interventions and finally failures ('failure to progress') if the cervix does not behave as prescribed (National Institute Clinical Excellence, 2007). This is in contrast to the midwifery descriptions of births outside of the medical control and dictates; cervical process is inconsistent, erratic, and influenced by complex factors such as personal knowledge and experiences, emotions, and environmental, spiritual and social factors (Downe, 2004, p. 9). These factors are commonly disregarded in medical research. Instead, the focus is on the surveillance and testing of objective measures of the dysfunctional maternal body, set by obstetric criterion. These values and assumptions shape the lens through which childbirth is viewed, creating a particular construction of what birth and a birthing mother should be (Davis & Walker, 2010).

### **The 'lacking' breech**

The position of the maternal woman within society is a central element that shapes vaginal breech birth spaces. What it is to be a woman varies in space and time due to different cultural understandings, with the maternal woman relational to a fixed narrow social construction of the idea of essential femininity: compliant, complicit and certain (McDowell, 1993). This is in strong contrast to the feminist notions of woman as fluid, multiple and uncertain (Fraser, 1991). It is these tensions, with their destabilising effects, that can be seen within the experience and expectations during vaginal breech birth. Pregnancy and birth are times of particular focus, with notions of the pregnant woman and mother created from a "*repeated citational and bodily acts that produce the appearance of the natural and the 'true'*" (Longhurst, 2008, p. 9). As behaviours are repeated, these become the expected standards on which judgements are made and expectations about woman and maternal woman are created. Statistical conceptions of normality can make abnormal phenomenon appear normal; for example, the most common way to give birth to a breech baby in the UK is by caesarean section (Gov.UK, 2010). The expected behaviour is affirmed by the majority of women, who agree to a caesarean section delivery following the medical advice that this is safest for the baby. This leads to the reconstruction of the normative breech as one of surgical delivery. Whilst this cycle of reinforcing actions and behaviours becomes the accepted norm, it

nevertheless leads to substantial disruption for many women to their anticipated birth and core elements (such as not wanting an epidural, or wanting to birth at home) that they hold dear.

In a broader sense, the vaginal breech birth experience is also an example of the gendered notions of women and mothers as lacking; breech is perceived as something failing, requiring correction. This lacking is gendered and linked to feminist theory of conceptualizing sexual difference, through females lacking what males have (the penis) and the social construction of some mothers as more lacking than others (Whitford, 1991). Single mothers, sex-working mothers and lesbian mothers can be construed as lacking family, money, morals and men to make them complete (Longhurst & Johnston, 2011). The mother who has a vaginal breech birth is viewed against the expected standards of society and seen as lacking: the lack of carrying a cephalic baby, the belief that the maternal body lacks the ability to birth a breech baby safely, and the lack of ability to follow the recommendations of the medical experts. Whilst the other groups of women bring the elements they 'lack' within them into pregnancy, such as a scarred uterus from a previous surgical birth or a medical condition, the breech experience is unique in that the transition occurs late in pregnancy, sometimes even in labour. For most women, there is no other problem; the issue is only that the baby is not in the expected position and the (debatable) potential risk seen around the time of birth. Despite this, the findings show that women's experiences alter drastically from their expected path at the discovery of breech presentation.

Whilst this sense of lacking was experienced very differently and to varying extents in the individual narratives, this lacking or loss was a thread that ran through the findings. Where it was most powerfully-felt was in dialogues related to emotions around the time breech was discovered, or during dialogue with others around breech and its meaning and impact on individuals. The perceived fear of breech birth seen in the research findings, and its continuing label of non-normal, appears to stem from the inability to achieve the levels of certainty desired in science and reflected within society. Nietzsche believed that fear is driven by a desire to be rid of unpleasant uncertainty in any way we can, particularly being reliant on habitual explanations regardless of their worth or value

(Nietzsche , 1889). He continues that the need to extract something familiar from something unknown or uncertain is not only comforting, but also gives a feeling of power, which again pulls in the issue of gendered relations and communications within this breech birth experience. The research findings reflected how endemic is the view of breech as a problem to be solved and to provide the desired certainty. This mirrors in the masculinist presuppositions that underpin medical discourse of childbirth, which see the maternal body as a machine that, when faulty, can be fixed (Davis & Walker, 2010). Research and practice tends to proceed on the premise that the machine is *'fundamentally faulty and these faults can be best contained by setting 'quality control' rules beyond which the machine must be fixed'* (Downe, 2004, p. 5). The dominant risk narrative has created the problematisation of childbirth that has been adopted more widely within society. Whilst the vaginal breech birth is constructed as a problem and as something uncertain, the woman who is having the vaginal breech birth is similarly seen as a potential source of disorder, needing to be *'tamed and controlled'* (Massey, 1994, p. 258).

The findings from this study revealed not only an underpinning discourse on the loss of normality, but also expectations of complicit behaviour in following medical recommendations for a controlled and certain outcome, deepening the sense of loss for those involved. The passive patient role is a common theme where there is a power differential; the health professional has the expertise and power, and the patient is the passive recipient (Warne & McAndrew, 2007).

These assumptions were explicitly expressed by some of the women interviewed. Although not all the women expressed this dominance overtly, their reactions and the reactions of those around them appeared deeply informed by this discourse, and it shaped their views, beliefs and behaviours about breech being non-normative. However, for the obstetricians, there was less perception of loss. Indeed, there was more certainty about the pathway towards a caesarean section and an element of gaining ownership of the role of ultimate decision-maker over a problem that is within their high-risk remit. This proves an anomaly for this space, where for medicine, abnormalising breech and adopting a singular clinical approach of caesarean delivery

strengthens the position of obstetricians as the provider of the solution and re-establishment of certainty. The social construction of power relationships leads us to examine these practices that establish both compliance and subversion (McDowell, 1993). However, to maintain control requires compliance through social interactions with both women and other health professionals.

This also highlights a time where relationships dislocate, as expectations about roles and behaviours are acutely challenged. Discovery of breech alters social relationships, with the current pathway referring women to see an obstetrician, mostly for the first time in their pregnancy. This moves women away from midwifery and 'normal' care into the sphere of obstetricians, who are experts in complex pregnancies (Royal College of Obstetrics and Gynaecology, 2006) heightening the sense of disruption. For many midwives, too, the shift away from being the main care-givers is disruptive, especially when experienced midwives feel they still have the necessary skills, but are required to acquiesce to junior but 'powerful' obstetric staff who may not. The dislocation of these relationships, and the disruption of previously-held roles, emphasises the negative emotions at this time, and how separated breech has come from normal birth pathways.

The behaviours of the childbearing woman provide information about how they occupy space alone and with others (Ainley, 1998). My findings suggest that the initial responses of women to the discovery of breech and the subsequent re-entering of society as a breech-birthed mother is strongly influenced by the marginalised position of breech. Rather than acknowledging the diversity and multiplicity of birth, the meaning and behaviours of birth have been increasingly narrowed, as if accepting difference is a '*challenge to the notion of the subject 'woman' that had hitherto been taken for granted*' (McDowell, 1993, p. 6). This gendered and political space is expanded on by Robyn Longhurst, who claims that:

*"the messiness of bodies is often conceptualised as feminized and as such is 'othered'. Bracketing out questions about boundaries of body/space relationships functions as an attempt to position geographical knowledge as that which can be separated out from corporeality, the corporeality of its subjects and its producers.*

*Ignoring the messy body is not a harmless omission, rather a political imperative that helps keep masculinism intact” (Longhurst, 2001, p. 23)*

The bounded and static nature of the medical model means the understanding of normal has been shaped by birth in the obstetric institutional environment, where assumptions of medicine dominate (Davis & Walker, 2010), leading to disruption at individual, professional, and societal level. Whilst practical skills and knowledge about breech birth are perceived to have been lost, the identity of the childbearing feminine woman has become more narrowly defined into simplistic brackets of normal and abnormal, and the role of birth professionals has been redefined as more births become seen through a medical lens. Breech birth experience provides an example of how the consequential response of difference, of not fitting in, and of not meeting expectations can be profoundly disruptive. This is a time where cultural and gendered constructs impose upon individual experience, leading to deep emotional response and feeling cast out and alone. This sense of being outside (of the normal or expected) brings a feeling of not fitting in, a time of uncertainty and dislocation from others, from expectations, identities and control. This predominately inactive or passive space for childbearing women is where external influences exert themselves, and move the breech experience onto a different route with different and limited options. However, this moment of being separate allows *‘for new elements to appear’* (Ainley, 1998, p. 19) as space is created for more active response when a new direction is sought. This is *‘Uneasy Space’*, which will be discussed next.

### **6.3 Uneasy Space**

Uneasy space relates to the time between the initial knowledge of breech and the birth itself. This is a transitional space where perceptions of self and others are considered and challenged. Similar to Disrupted Space, this space reflects the tensions between expected social roles and behaviours, but is also a time where there is navigation between ideas, knowledge, and a re-engagement with the concept of consumer rights and choice. The space provides opportunity to pause and reflect, enabling a chance to look elsewhere, away from the expected behaviours, and to hear different voices to inform and guide the journey forwards. Mostly, the experience is one of wanting to be informed, but for most this was to be informed beyond the provided medical narrative, and drew on multiple and diverse ways of knowing and knowledge. The nature of the space was of navigating and evaluating knowledge, challenging the assumed authority of medical knowledge, and considering its value in context.

Underlying this space are the social relationships and cultural expectations that require navigating. Within health-care culture there are informal but relatively fixed rules and expected behaviours that prescribe identities to those within it. These gendered roles have developed through social relations and power networks dominated by paternalistic institutions that seek to maintain hierarchy and exercise control (McDowell & Sharp, 1997). By following these rules, people can fit into the spaces they are in, whilst breaking the rules leads to embarrassment, which serves as a measure for control over them and their behaviours (Warren, et al., 2000). This research provides an opportunity to show how not following the expected pathway or behaviours leads to unease, not only for the individual involved, the birthing mother, midwife or obstetrician, but also for others around them who struggle with difference and non-conformity. This is an uneasy time, but also a place where strength was gathered internally and found through others; key relationships and trust featured highly in the findings. Whilst a time of interaction, this space is limited due to practical reasons, such as managing to find the knowledge, a person or place in which to place trust for the baby's imminent birth.

## Navigation and judgements

The concept of this uneasy space was informed from the original data. The participants shared their feelings of unease during their experiences, both from within themselves and as result of key relationships around them. Walsh (2010) expands on these tensions within a backdrop of increasing technologies, the challenges of medicalisation in childbirth, and professional territorialism between obstetrics and midwifery (p487). In his paper on childbirth embodiment, he highlights how these contrasting approaches to the maternal body have had a '*largely negative impact on childbearing women, professionals and maternity services*' (p. 486). Walsh further expands that:

*"... a number of discourses now compete for the status of the safest, most fulfilling birth experience. Supporters of biomedical and 'natural' approaches make their respective claims..., with obstetricians broadly aligning their professional interests with the former and midwives with the latter. There is mounting evidence that childbearing women's experiences of birth are often shaped in the uneasy space between the two"* (Walsh, 2010, p. 486)

Whilst breech is perceived to be within the medical and surgical space of mainstream childbirth, vaginal breech birth sits in an uneasy space outside from the mainstream. The findings describe the option of vaginal birth whether not given or thrown in as an afterthought. It also has the dichotomy of being labelled high-risk but with a non-interventional approach being the most appropriate and safe (for example, keeping hands off the breech and not intervening is a key principle to supporting successful vaginal breech birth (Cronk, 1998)). This creates a tension between the obstetrics, the 'high-risk' childbirth remit, and midwifery, with its 'low risk' childbirth expertise. The navigation of these messages is central to the uneasy space, which is a time of pause, consideration and interaction, internally and with others.

The findings showed that key relationships and judgments of others on individual choices were very powerful in influencing this uneasy space. These generalised concepts that have emerged in this study show how women experience and then

navigate these dominant views of the 'high-risk' breech (Delotte, et al., 2007). Many feminist scholars have concluded that the biomedical paradigm is maintained by the constructed authority of scientific knowledge and the medical professional's privileged positions of gender and social status in society (Oakley, 1980); (Davis-floyd, 2003). However, more modern feminist writing considers it more complex than that, with women being active consumers of medical interventions as a form of control and personal autonomy (Benoit, et al., 2010). This is reflected in the findings of this study, where participants implement different approaches to their breech births (for example, withdrawal from NHS care, or finding another healthcare professional who supports their choices) to achieve different elements (such as avoiding a hospital birth) that are of importance to them. Whilst this is seen as exerting their consumer choices, it also demonstrates the postmodern concept of women not being an homogenous group with only a single view or approach.

Coxon et al found in their longitudinal study of pregnant women that for many women, hospital birth with access to health care remained the default option, as they conceptualised birth as '*medically risky*' and interventions '*an essential form of rescue from the uncertainties of birth*' (Coxon, et al., 2014, p. 1). They conclude that despite 50 years of criticism of the technocratic birth model, society's general construction of birth is risky or uncertain, brought about by dominant discourses of risk, blame, and responsibility (p1). This study included women with both 'low-risk' and 'high-risk' pregnancies, and found, as with other studies (such as Lee & Kirkham, 2008), that women's perspectives of what is safe could differ significantly from the clinical risk assessment of health professionals. A small minority of women with risk factors felt that they were safer at home than in hospital despite having some clinical risks identified. Further, a significantly higher number of 'low risk' women felt safest in a hospital setting (Coxton et al, 2013). This provides some perspective on the findings of this study, where women who chose to have vaginal breech births, whilst perceiving this to be a safe option for them, came across the view expressed by a significant number of people around them, that vaginal breech birth was a risky and uncertain route to take.



The value judgment perceived by the participants was both explicit and implicit, and led to women seeking alternative routes and finding enabling relationships to assist or allow breech birth to occur. The risky breech concept was substantiated emotionally by a dominance of fear throughout the conversations described by participants. The messages to the participants from 'others' were that they were risk-taking, putting themselves before the baby, and being 'bad mothers'. These notions of the 'good' and 'bad' mother are found in other literature dealing with the interlinking of childbirth and meanings of mothering. Chadwick and Foster's (2012) work researching women's homebirths and elective caesarean choices in South Africa suggested one important element that regulated decisions was on the 'good mother' imperative. They concluded that 'good' mothering for the social and cultural group they interviewed was '*closely intertwined with gendered ideals of feminine selflessness*' (p331). Both home-birthing women and women choosing elective caesarean sections claimed this was in the best interest of the baby (p331-332).

In a similar way my study participants repeatedly claimed their desire was for the best thing for their baby, but also emphasised the importance of what was right for them and the family in a social context. This is perhaps a shift towards challenging this notion of good and selfless mothering, and engaging in a more equal status with the unborn child, with a wider consideration on mothering after birth. This suggests a movement away from the Foucauldian notions of technologies of power and patriarchal social discourses which shape contemporary maternity care and views of mothering. As these women challenge this identity, they shape their own view of mother as an equal player in the parent and child relationship, and contextualise this within the lives they are leading. Beckett (2005) also touches on the element of the separateness of mother and fetus as constructed through patriarchal ideology and emphasised by the rapid growth of reproductive technologies (p266). In this sense, conceiving the fetus as the 'second patient' has given rise to seeing pregnancy as a:

*'...conflict of rights between a woman and her fetus and the sense that the primary threat to foetal health comes from pregnant women'* (Beckett, 2005, p266).

Beckett continues that the pervasive view that 'good mothers' are willing to take on the risks of surgical delivery for the medical assurance of safety of their baby is asserted by medics and reflected in society. My findings emphasise how the fetus has become the bargaining tool, with the focus on the live baby as the most important outcome, and caesarean section offering a solution. Diana Parry's (2006) research on women's lived experiences with pregnancy and midwifery corresponds with this, as she describes women having to negotiate their experiences in a '*medicalized and fetocentric ideological context*' (p. 459). Whilst her research was not specifically about breech, Parry recognises the role of pregnant woman has evolved into being the '*bearer of fetus*', with pregnant women needing to remind others that the pregnancy is also about them (p. 466). In her study it is the women who didn't get an epidural that are seen as a '*select group*', with their birth choices questioned or decisions dismissed as being silly (p. 469). This reductionist view is unhelpful when considering the complex diversity of women and of birth in a social and cultural context.

Whilst this extends to motherhood where 'good mothers' make sacrifices for their children, this doesn't consider the short- and longer-term effects of a surgical birth on mothering, with the additional risks and complications to mothers which may negatively affect parenting - for example, exhaustion and mood swings (Veselovski, et al., 2012). The vast majority of the biomedical research on breech birth is focused on the short-term outcomes, predominately for the baby (Hannah et al, 2000) (Borbolla Foster, et al., 2014), with this knowledge forming the basis of judgment of what is the recommended 'good' way for breech babies to be born. A more contextual view was reflected in the findings of this research, where social conceptions of birthing are part of the participant's knowledge base for decision-making (such as wanting to be socially engaged with groups and activities after the birth). Therefore, within social geography narrative the vaginal breech birth experience concept of '*good mother*' is deconstructed and re-framed as the mother and fetus unit, with participants equally considering their and their baby's health, not just in the medical sense but in a social sense, beyond just the birth itself. It is social and contextual, individual but also relational, as it is dependent

on more than the single act of mother birthing baby, but also social concepts of parenting and family.

Despite this, the findings showed there is still perceived moral judgment of women who choose the vaginal breech birth from those around them. Robyn Longhurst (2001) suggests that these moral geographies are constructed on the view that 'bad mothers' are lacking in some way and '*provoke moral outrage*' with their unstable behaviours (p129). It can be perceived as a challenge to the dominant view and may be perceived as deviant behaviour by the society within which it has been constructed (Horwitz, 2008). Foucault's writings on 'technologies of gender' are reflected here, where concepts of feminine in childbirth are strongly shaped by the dominant patriarchal gaze, which regulates and disciplines the behaviours of women. Within this model, the technologies '*restrict women's behaviours, rendered them compliant, made them feel bad when they could not subscribe to the proper modes of being feminine*' (Martin, 2003, p. 60). Carter's study on American women echoed this, with women giving birth outside of the expected hospital institutions described as deviant and bad without remorse, voicing their own recognition of knowing the expected behaviours and knowing the differentness in what they did (Carter, 2009).

The construction of morals and principles has also seen as gendered, with feminist writers considering male gender relying more on universal abstract judgments and women considering context and individual situations on which to judge. Unlike men, women:

*"... argue for an understanding of the context for moral choice, claiming the needs of the individual cannot always be deduced from general rules and principles and moral choice must also be determined inductively from the particular experiences each participant brings to the situation. They believe that dialogue and the exchange of views allows each individual to be understood in his or her own terms. It is the rejection of blind impartiality in the application of universal abstract rules and principles that has, in the eyes of many, marked women as deficient in moral reasoning"* (Belenky, 1996, p. 8)

As the contemporary lens of childbirth is dominated by the medical risk model, breech is caught in the general 'rule' of surgical birth. Women challenging this, as seen in the findings of his research, experience considerable challenges from within health care and from society in general. Linking in with the theory of lacking described previously, the experience of vaginal breech birth is one of uneasiness; choosing a different route to the expected is a turning point that brought both unease but eventually an element of making sense. Whilst this may be seen as rebellious or being bad by the dominant group, it can also be a way of breaking out of the boundaries set by others, and hearing and producing the authentic voices of women (Belenky, 1996, p. 209).

The findings showed the diversity to the extent women experienced these uneasy spaces, with time being an important factor. The unease appeared heightened when breech was discovered in pregnancy, with time and opportunity for discussion and social interactions with others. This aligns with the post-structural feminist theory that acknowledges the diversity of individual situation and context. Nevertheless, commonalities did emerge from the findings which suggest that the vaginal breech birth experience included the influence of key relationships and the establishment of trust.

### **Trust and relationships**

Key relationships were an important element of the uneasy space, heightening or relieving the sense of unease. As a result, most participants described employing a strategy to seek out those meaningful relationships with those who aligned with their individual needs and support their decisions. For some, this was a conscious action of looking for and finding an ally health professional, but for others it was opportunistic connections. These key relationships enabled the participants either to maintain trust in themselves and their own bodies to birth, and/or to give the trust to their health professionals, to do their job of delivering the baby safely. Midwives also felt that the reciprocal trust between mother and midwife allowed them to work safely together to achieve a positive outcome. These key relationships appear to create a safe space for vaginal breech birth to enable women to move with confidence towards their birth.

Other key relationships created more negative emotions for participants, and heightened feelings of unease. In a similar vein, Lundgren and Berg's (2007) research described the centrality of the women-midwife relationship in influencing the elements of loneliness and confirmation. As described previously, the loneliness was connected to the unknown of pregnancy and birth, but additionally related to feelings of abandonment when the midwife is physically or mentally absent from them. This suggests that midwives are perceived as '*enduringly present*' and as an '*anchored companion*' (p224) during the birth journey, and disruption to this expectation enhances the feelings of being alone. Importantly, all the women reflected the relationships with the various health professionals they met in their experience as being powerful and influential. This is not unexpected, as Belenky's seminal work on women's ways of knowing describes:

*"Although women find the power in their voices and mind most readily in relationships with friends... they think of authorities, rather than friends, as sources of truth"* (Belenky 1997; 39)

Women's propensity towards health professionals as their source of birth authority was reflected in the findings of this study. Most of the women who had had a vaginal breech birth described midwives as their significant positive relationship, with two participants describing a relationship of trust with an obstetrician. This, perhaps, reflects the way women perceive their births. Despite being breech, they still desire the normality or natural approach that midwifery offers. Parry's study on Canadians use of midwifery (Parry, 2008) also demonstrated how women actively sought out and chose midwifery care in an effort of resistance against medicalised birth. In her study, Parry found that midwifery care gave them many perceived benefits, including natural approach to birth, women-centred care, informed choice, emotional care, professional ability and personal control amongst others (p796). These mirror the findings of this study, as the relationships between the participants and their chosen health professional enabled both trust and, for those with midwifery care, elements of personal agency and control. For the participants who gave birth in hospital under obstetric care, trust was still perceived as being present. However, personal agency and control were significantly lessened, with more compromises required to achieve their aims of a vaginal birth.

Again, this is similar to the Parry's results, where there were varying degrees of intentional resistance to medicalisation, since some women whilst '*resisting the dominant ideologies – although a deliberate and conscious choice – may not be absolute resistance*' (Parry, 2008, p802).

Midwives also felt their relationships with childbearing women shaped their experiences and informed them with new knowledge about breech birth, assisting them with addressing their sense of uneasiness. Midwives described the childbearing women as being at the centre of their vaginal breech birth experiences. However, obstetricians tended to look to other medical colleagues for guidance and to assuage their concerns. This suggests a fundamental difference in the social roles each profession has in the breech experiences: the maintenance of more permanent relationships within the institutions (obstetrics) and the establishment of transient but meaningful relationships with childbearing women (midwives). This reflects the gendered nature of maternity care provision; the desire to connect with other women as a source of knowledge is considered an essential part of the social experience of giving birth (Savage, 2003) and an acknowledged part of the midwife's role (Barclay, 2008).

This connected knowledge gains authority with time and space and, as shown in this study, the meaningful relationships evolve collaboratively. These relationships were shaped by and shaped the social identities of those involved. Where equal relationships were established, such as between a midwife and woman, both gain considerably from the experience. This indicates that meaningful relationships are an important element of the social geography of vaginal breech birth, both as enablers and as barriers. Moreover, these relationships can have wider repercussions as ways of sharing experiential knowledge more widely in society and amongst other childbearing women. Alternatively, these relationships can silence women, muting knowledge gained from experiences and maintaining the authority of medical knowledge.

## Desire to know

Desiring to know and have knowledge were recurrent features in the findings of this research, informing the theme of *deciding the right path to follow*. Drawing on Mary Belenky et al's seminal work on women's ways of knowing (1997), the vaginal breech birth experience can be described as one of hearing different voices that provide a pathway to vaginal breech birth. This occurs against a background of authoritative medical knowledge and its establishment as the expected or '*common sense*' views of the world (Campo, 2010, p. 2). The findings of this study provide insight into what knowledge, and whose truths, are drawn on to inform and guide decision-making, and how women and health professionals benefit and suffer in these navigations.

Feminist literature has strongly contested that medical dominance over childbirth is gendered, formed from a position of privilege. It argues that the patriarchal medical profession has conceptualised childbirth as one of risk, blame, and pathology, and any other knowledge to this (such as experiential knowledge) dismissed or devalued (Davis-Floyd, 1987; Oakley, 1980). This study's findings reflect elements of this view, with some participants feeling their own opinions are set aside in discussions with health professionals, with the main focus on the risky element of vaginal breech birth and comparative safety of the surgical delivery. This type of discourse leaves women often feeling unheard and unheeded; '*the womanly voice is dismissed as soft or misguided*', and further silenced in interactions with the male gendered institutions (Belenky 1997, p147) of which health care is one. The construction of medical knowledge as being the authority over other types is so well established that it is seen as the natural order of things, and substantially difficult to challenge, as reflected in the findings. This essentially is a reflection of the gendered power relations that shape and maintain roles and behaviours of the institution of maternity services, overwhelming any other lens or narrative:

*"To legitimize one way of knowing as authoritative devalues, often totally dismisses, all other ways of knowing. Those who espouse alternative knowledge systems tend to be seen as backward, ignorant or naïve troublemakers... the*

*constitution of authoritative knowledge is an ongoing social process that both builds and reflects power relationships within a community of practice. It does so in such a way that all participants come to see the current social order as a natural order i.e. as the way things (obviously) are” (p53) Jordan IN (Downe, 2004, 4)*

In this case the space for alternative knowledge is marginalised or excluded by those wishing to maintain the established power structures. These power relations are implicit in the transmission of knowledge (Massey, 1994, p242) and are certainly represented in the findings of this study. Information from medical professionals was limited to broad statistics and risk-focused, with obstetricians seeing themselves as informing women of the biomedical view of established breech knowledge. This concept of knowledge accepted by medics and adopted by society as truth has been shaped by the male domination of culture over history. Belenky asserts that in this way, men have *‘constructed the prevailing theories, written history, and set values that have become the guiding principles for men and women alike’* (Belenky, 1997, p5). The findings of this study are of interest as, whilst experiencing elements of these power paradigms described, the vaginal breech birth is one of challenging these established truths through both the decision-making, which confronts the knowledge authority, and in the physicality of the vaginal breech birth, which defies the espoused ‘truth’ of the superiority of the surgical breech birth. This challenge troubles the ‘truths’ and established ideas held leading to uneasiness and emotional responses, particularly of fear.

The emotion of fear features significantly in this uneasy space. Fear was felt by women in regard to birth preferences important to that individual (for example, avoiding an epidural). There was also a fear response from friends, family and other health professionals on the discovery of breech, and in particular around vaginal breech birth itself. For women, this fear was increased with lack of options, lack of consideration for individual needs, or heavily-weighted information, commonly about the wellbeing of the baby. However, fear was reduced through explanations: descriptions that connected to an individual and communicated to others without fear. Research suggests that there is



increasing evidence that fear in childbirth affects large numbers of women and men and that this fear leads to more compliance with medical intervention (Dahlen & Caplice, 2014). This was not found to be true in this research, where there was a move away from medical intervention, suggesting different elements here in overcoming or managing negative emotions. This study suggests that having and protecting the core elements of central importance to women, and the desire to know and have knowledge, were active characteristics that helped to overcome some of the negative emotions felt and encountered. Additionally, and in a similar way to other research (Dahlen, et al., 2008), this research found that establishing trust in terms of relationships and birth environments enables women to feel safe, which reduced fear. These active elements appeared to be central to the vaginal breech birth experience in overcoming the prevailing negative emotions and risk focus.

Whilst the desire to know and have knowledge was a key element in this space, it was the nature of what participants drew from this that subsequently formed their knowledge that was of particular significance. Findings suggest that women in particular drew from a wide range of knowledge to inform their decision-making, including personal experiences of birth and health care, other people's experiences and knowledge, stories on social media, intuition, wisdom and spiritual guidance. This is similar to other studies on women's experiences of childbirth, where previous births feature as a considerable factor in decision making (Montgomery, et al., 2007) (Fenwick, et al., 2003). Relatively little attention has been given to the more intuitive and diverse way that women learn and know, but what is suggested is that these ways are seen as more primitive and less valuable than the objective masculine biases that underlie scientific presented facts (Belenky, 1997, p6). Women in this study felt this conflict between their own knowledge and that which was presented to them, particularly by the obstetric body but also by some midwives and wider society. These conflicts were described as combative, aggressive and very stressful for the participants. The findings also suggest that where these alternative knowledges are respected and appreciated are amongst some midwives who provided different information to that of their obstetric colleagues.

The breech knowledge of the midwifery participants was developed in a broadly similar way to that of the childbearing women participants. Constructed from a diverse number of sources and considerations, both women and midwives interviewed particularly valued experiential knowledge. This enabled alliances to form between midwives and women, as they shared and valued experiences. However, this also added to the sense of unease for some women as they sought to establish the right pathway for them whilst being offered conflicting opinions and experiences. Lundgren et al's (2012) meta-analysis of women's experiences of Vaginal Birth After Caesarean (VBAC) similarly found the experience was like '*groping through the fog*', when decision-making and information from health care professionals during pregnancy and birth is '*unclear and contrasting*'. They also found that vaginal birth was seen as '*a risky project and positive aspects of vaginal birth are mainly described by women not the health care system*' (p9). The desire of women to see the whole picture was echoed in this study's findings, with women having to deal with the serious risks presented as fact from some health professionals, and a lack of information about alternatives. Lundgren et al (2012) conclude that this approach and deficit is due to the provision of maternity care within a risk focus, with more accurate statistics being quoted about the risks of vaginal birth, and limited or inaccurate information about the benefits of vaginal birth (p10). Whilst both studies demonstrate the gap between the imparted knowledge and the desired knowledge, Lundgren et al's study does not explore why and how some women will ultimately choose the vaginal birth route over the surgical option. The findings from this study provide some insight into the elements and influences that enable women to choose different routes to the recommended surgical one.

Many participants expressed an interest in the scientific evidence but also wanted the relevance to them as individuals, and a consideration of the wider ranges of knowledge available. Whilst there was diversity of the actions of the participants, most drew on alternative knowledge to scientific evidence that provided them with a personal assurance and confidence to birth their breech baby. This element I have described as '*hearing different voices*', taken from Belenky's description of women talking about personal moral crisis and decision-making, where they draw on an alternative point of

view (1997, p18). With this comes the development of a sense of self, as the decision about the commitment to a mode of birth is made. This research suggests the different voices are both internal and external, drawing on the self-knowledge and valued knowledge of others. From this position, women can define their own personal truths, enabling a sense of agency and control. In a similar way, Jouhki (2012) found in her study with Finish women that intuitive knowledge was one of the central reasons women gave for deciding on a birth at home, with one participant describing an '*inner voice... I did not want to go against it*' (p59). These internal voices are valuable, especially when there are external conflicting narratives that require navigating. Belenky describes this interior voice as the hallmark of women's emergent sense of self and sense of agency and control (Belenky, 1997; 68).

In contrast are the other external voices, with many participants in my study describing the emotional and combative nature of interactions with some health professionals. These negative associations are also reflected the findings of Jouhki's study, where there is an underlying distrust of medical science and a struggle with uncertainty and confidence as part of the decision-making process for women choosing homebirth. Instead, women turn to social and personal factors as positive influences in supporting the choice to birth at home (Jouhki, 2012, p. 60). Whilst not all of the women chose to give birth at home, in my study there is resonance in the experiences of choosing birth outside the system (homebirth or vaginal breech birth) where there is a period of unease and a pause for consideration of, or seeking out of, the knowledge to inform decisions on where and/or how to birth.

My findings closely align with others in that first-hand experience is seen as a valuable source of knowledge for women (Lindgren & Erlandsson, 2010) (Lindgren, et al., 2006) They begin to feel that they can rely on their experience and '*what feels right*' to them as an important asset in making decisions for themselves (Belenky, 1997, p61). Belenky describes some women as 'transitional' knowers who turn for answers to people closer to their own experience, and in the case of this research they turn to other childbearing women, breech-birthing women, and midwives, as truth for them is particularly grounded in real experiences. She describes how women:

*“...often rely on a maternal / female authority ‘maternal’ social agency...  
Whomever a woman finds to turn to – the significant educational action is the  
reassurance and confirmation that ‘maternal authority’ provides her that she too  
can think and know and be a woman” (Belenky, 1997, p60/62)*

This context of ‘hearing different voices’ is an important element in the vaginal breech birth experience, as women use the social relationships they value to develop their knowledge, consider their own personal values and seek those who they trust to enable their choices. By hearing and acting on these voices, women are able to gain personal agency and control over their birth choices to varying degrees, with the creation of an alternative space for vaginal breech birth.

Another way women are able to access different voices is through social media. For some, this source of information has replaced the knowledge once shared woman to woman, mother to daughter (Belenky et al, 1997). Technology is a modern space for unrestricted information that can be sought, shared, and accessed, and has a powerful influence over women’s knowledge beliefs and expectations about pregnancy and birth (Theroux, 2011). The findings from this study suggest that the internet was a limited point of additional information for women, with the reliance more on health professionals and their own internal knowledge and beliefs. This suggests that whilst the internet may be a source of information, it may lack the interactive relationship that women desire at this crucial point. Predominately, the findings of this study suggest this social element was provided through the relationship between women and midwives, although this was interlinked with being informed through experiences and a deep internal intuitive knowledge. This suggests the relationship with health professionals is still central to these women, and that the internet does not replace it. Acknowledging the social element to the vaginal breech birth experience is vital. Unlike narrow, institutional ways of learning, women learn in relationships and in dealing with families and communities, using experiences as a valuable source of knowledge (Belenky, 1997, p61). Their own experiences are seen as informing growth and building confidence in what feels right through the decisions they make: hearing their own [different] voices is an essential element.

It is also worth noting here that during the research it became apparent that documents were less influential than originally expected. Whilst documents such as clinical policy, books, websites and research featured occasionally in the shared narratives of women and health professionals, this was less than expected and often a more generic than specific reference. This suggested that what the documents represented was of more influence than the content within them. Consequently the importance of the documentary analysis element was less than expected.

This section has drawn together the elements and characteristics of uneasy space, a transitional time where perceptions of self and others are considered and challenged. This is an interactive space, shaped by emotions, distancing and establishing relationships and trust. It is a time of seeking and having knowledge that is more than just the provided scientific evidence. These elements move around a desire to protect a strong core element of importance to the individual, and to seek places of safety. This space challenges established knowledge and ideas of the good mother, troubling their rigidity and narrowness. This brings us into the final section, Third space.

## **6.4 Third space**

This is a space that re-establishes the maternal woman back to the centre of the birth experience. This space is characterised by a sense of ownership and responsibility for the creation of a safe place for birth. This is an active time of establishing and protecting the safe space, and physically giving birth with an inward focus. It is also a time of acceptance of the situation and of the decisions made. The physical inevitability of the birth event compresses time and space to become essentially connected, and the corporeality of the birth moves the experience from uneasy space to a place that 'makes sense'.

The findings from the research suggested a noticeable change after final decisions were made, such as where and how to have the baby, and towards the time of giving birth. This time brought a distinct change of activity, where there was less interaction between women and health professionals, friends and society in general. Women now turned back to the physical task of birthing, and health professionals to their designated roles in providing maternity care.

This space, developed from existing educational theory (Whitchurch, 2008), disputes the simplified dualities of normal and abnormal, and the polarities of medical birth and natural birth. It instead offers a different option that acknowledges the spectrum of individual experience. Like educational Third space, this birth space is created by those experiencing the journey rather than it being an established place provided by institutions. Third space represents the uniqueness of this final stage of the breech birth journey, established separately each time around the needs of the individual. This space shows that vaginal breech birth continues to be marginalised, by being only temporary and needing to be re-discovered and re-navigated each time breech occurs.

## Overcoming

Whilst breech has been simplified to a high-risk issue requiring surgical delivery, vaginal breech birth has been re-categorised as an obstetric emergency, and obstetric-led (Royal College of Obstetrics and Gynaecology, 2006). The findings of this research challenge this simplified view, and rather see vaginal breech birth as complex, somewhere between the poles of medical childbirth and natural childbirth, comprising of elements of both and more. With limited consideration for vaginal breech as a birth option in current maternity care, childbearing women become a central component in enabling the birth to occur. In this way, they, and those that facilitate them, shape their own experiences in a profound way. Women (and health professionals) also emerge from these experiences considerably influenced and changed by them. It would suggest that navigating and overcoming the challenges in the birth journey enables a sense of ownership and responsibility for the birth that has longer-term consequences both on an individual but also on a societal level. The findings suggest that these elements are strongly influenced by the place of birth and the approach of those providing care.

The concept of Third space illustrates where individuals create what they require for themselves, rather than fitting within the established institutions or expectations; new ideas and a new sense of self emerge. Third space is described by Bhabha as '*a place that eludes the politics of polarity*' and claims that 'this space enables us to *emerge as others of ourselves*' (1994, p. 39). This is a fluid, plural and inclusive space where there are less bounded forms of birthing that incorporate consideration for broader social context. Karlsdottir et al (2014) similarly suggest that the narrow focus of research has shaped how pain in childbirth has been approached and managed, proposing a third paradigm to enhance understanding on how women prepare for childbirth pain. They submit that '*the childbearing women's paradigm may be called the third paradigm in labour pain preparation and management; the first and second being the midwifery paradigm and the medical paradigm, respectively*' (2014, p. 315). The researchers argue that the focus of midwifery and medical paradigms are mainly about what the health professional can do to and for women, but not on what women can do for themselves, and thus are missing an essential element of knowledge. Further, they

acknowledge that these paradigms are built on opposing beliefs and values, including the meaning and purpose of pain and influence of fear (p. 316). Adopting the concept of Third space as an alternative to the midwifery and medical spaces assumes a similar re-focus on breech-birthing women's requirements, and necessitates placing them at the centre of the space. This can already be seen with the emergence of birth centres, which provide spaces that push the boundaries of modern childbirth and increasingly destabilise fixed concepts of childbirth. These intermediary spaces provide women with, in Virginia Woolf's words, a '*room of one's own*', and an environment where their own rhythms and beliefs are respected and guidance and growth are provided (Belenky, 1997, p209). Margot McNelis's study (2013) of women's experiences of midwifery-led care in Ireland found that a homely atmosphere and control were central to women's positive birth experiences, indicating the elements that contribute to an empowered birth experience are far more than just safety. For many women, 'home' carries a meaning of being a space of their own, a place of safety and control, and birth centres provide an alternative 'between space' of being like home but with the perceived safety advantages of being within an institutional setting.

However, for most women with breech presenting babies the 'between space' of midwifery-led or birth centre is not an option, as they do not fit the required criteria of being 'low-risk' (Downe, 2004). Whilst most women with breech have limited or no choice around the mode of delivery, for those seeking a vaginal birth the options have restrictions. Vaginal breech birth in hospital is most commonly obstetric-led, with negotiation between the institutions requirements and the woman's wishes (such as Jessica being required to have an epidural if she was to be supported in having a vaginal birth). Alternatively, women who birth at home may have more of their personal needs met, but with compromised access to medical care should it be required. Therefore, to some degree, compromises are part of the vaginal breech birth experience for all women, who evaluate which are acceptable to them to achieve a safe birth (see *Uneasy space*). However, in this Third space, these decisions have been reached, and there is a sense of acceptance and a re-focus of connecting to the physical act of birthing.



The Third space is grounded by the physical element of the vaginal breech birth. Women giving birth described internal engagement between mind and body around the time of birth or disengagement. The place and space of birth, and the analgesia used, appeared to be factors in shaping these feelings; those who gave birth at home used emotional and connected descriptors about the internal instinctive knowledge about their bodies and births. Shannon Carter's (2009) research on American women's childbearing narratives suggests that childbearing women themselves conceptualise their bodies both in and out of control. Further, she found that for women birthing within a midwifery model of care, their perception of their bodies was one of autonomy, accommodation, and collaboration (p. 993). This was in alignment with the findings of this study, where control was more complex than simply having it or not, with both women in hospital or at home, with midwives and with obstetricians, describing loss of control. However, the loss of control was described as both an internal and external process. The internal loss of control was seen as an accepted part of the birth process with the body taking over, whereas where control was perceived as being lost to other people or as a result of drugs, a more negative reaction was described. This suggests the type of control lost has a consequential effect on whether women make sense of their birth experiences, and at what point they are able to do this after the birth.

The consequences of birth were explored in Lupton and Schmied's (2013) study on childbirth experiences, who similarly described the differences between a vaginal birth and a caesarean delivery. Those women who had their baby by caesarean section were found to have more disembodied, disconnected and unreal experiences, as they miss the intense physicality of vaginal birth. In surgical births, women see their birth through the eyes of others and take longer to conceptualise their own bodies, and that of their infant's, after birth (Lupton and Schmied's, 2013, p838). Whilst this was a small-scale study, it provides insight into how the mode of birth has a consequential effect on women and their relationships with themselves and their bodies. The data from my study supports this, with most women growing in confidence from their own experiences. The exclusive nature of the breech birth experience emphasises the separateness of these women from the mainstream birth space, but from this comes

total commitment, the consequences profound for some of the women in the study, who described how they had changed and grown as a result of their behaviours, decisions and births. Rosa Ainley (1998) suggests that whilst this growth is of benefit for some, the key is to acknowledge the multiplicity and complexity of this development, with '*a recognised interdependence and need for others both physically and mentally*' (p11). This study supports this, in recognition of the multiplicity of the needs and experience of births shared by participants, with the previous Uneasy space a time when there is recognition of the importance of interaction and establishment of key relationships.

It is the diversity of vaginal breech birth experiences shared in this study that challenges limited institutional boundaries, and demonstrates how moving away from these can create new opportunities for birth. Celia Whitchurch's work in UK higher education introduced the concept of Third space, as she describes the '*emergence of territory between academic and professional domains colonised by less bounded forms of professional*' (Whitchurch, 2008, p. 337). Her study on professional managers from USA, Australia and the UK showed an emerging landscape of activity and changing identities in traditional academic institutions. Similar to health care, academic institutions are gendered spaces, shaped by patriarchal dominance and fixed with established dualisms, such as academic and non-academic roles. Whitchurch presents a diversification of these institutions to meet the needs of contemporary society, with increased blurring of boundaries between function, activity, and practice, and the development of mixed identities within the workforce. The consequence of this is both one of risk and of safety for the individual and institution; changes bring opportunities and growth, but also uncertainty and ambiguity. This, to some extent, can be seen in the challenges and opportunities of the vaginal breech birth experience, where the Third space blurs the boundaries of established childbirth paradigm, and provides both safety and risks for those who are a part of it. It is suggested that to thrive in the higher-education Third space, professionals must embrace and achieve a balance between the tensions, paradoxes and dilemmas of the traditional space and the less bounded Third space (Graham, 2013).

This is less achievable within the current childbirth provision for vaginal breech birth, where there is poor flexibility in the system and more bounded gendered constructions of childbirth and mothering that are deeply embedded, socially and culturally, in western society. This experience becomes one of being required to '*trouble*' the medical framework; to '*do mothering*' in a range of '*differently*' embodied ways, and change regulatory practices (Butler, 1990, p33). Longhurst argues that maternity is not '*coherent or consistent*' (2008, p149) with the continued subversion and re-articulation of dominant discourses by women. In this respect, those who experience vaginal breech birth could be seen, particularly by the dominant group, as subversive, and those who support it could be seen as destabilising the expected views of what breech is and how it should be managed. However, the findings of this research suggest it is less explicitly political than this, and based more on an individual's context and beliefs.

Other research suggests that women's negotiation of the system is socially complex. Mander and Melender's (2009) study on women's decision-making within maternity care showed women were able to feel safe and secure in their decision-making through '*trusting the system*'. However, this was despite feeling they lacked the '*courage and strength*' to implement decisions that could engender unfavourable reactions (p647). Whilst the study was undertaken with women from New Zealand and Finland, which could explain the variance in cultural expectations, the second findings of subversive activity as a form of resistance suggest more of a regard for the dominant power and a general feeling of not being able to directly challenge this authority. In comparison, Jackson et al's (2012) research with Australian women who freebirth<sup>13</sup> and women who are deemed high-risk having homebirths, found that risk perception and consideration was a key element for women choosing to birth '*outside the system*'. They perceive risk of birthing in hospital differently to most women and predominately make decisions based on their previous experiences, where some felt they were put at unnecessary risk by care providers whom they had trusted to keep them safe (p561). These two studies suggest that trust and risk are crucial factors for women during their birth experiences, and are central components informing decision-making. Broken trust is perceived as

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<sup>13</sup> Freebirthing is choosing to give birth without health professionals present.

risky and some women will seek to protect themselves from this by moving away from the mainstream to birthing in their own home environment, where they feel safe. Others, who feel unable to face the negative consequences of making decisions different from the expected 'norms', remain within it. The findings from this study reflects these elements, where women who had vaginal breech births were, to varying degrees, aware that they were deciding on something different to the actions of the majority of childbearing women, and not what was condoned by the moral majority.

Therefore, the women who chose vaginal breech birth were not subversive, but made conscious risk-based decisions themselves, or were facilitated to do so by others. The vaginal breech birth is more an experience of hearing different voices (of self and trusted others), and taking responsibility for listening and acting on them to create a Third space where the birth can occur. In this sense, the vaginal breech birth experience was one of consideration and remaining true to their core elements that were important to them. Whilst the vaginal breech birth experience varies, the Third space provides opportunity to push the boundaries of authoritative routes and destabilise the poles of natural and medical views of childbirth. This challenges the notion of a successful or significant birth, and the dualisms and binaries explored above that characterise the politics of childbirth (Longhurst, 2008, p95). This is an uncommon and temporary space formed by women, and supported by those who are consciously able, or are enabled, to do birth differently.

## **Safe places**

This interrelationship between safety, risk and places of birth has been explored by several authors, who have shown that hospital birth is associated with safety for many women (for example, (Houghton, et al., 2008) (Jouhki, 2012)). However, whilst some feminist researchers have purported that home is essentially 'good' for birth and hospital 'bad', Longhurst, 2008, argues that it is more complex than this, as '*women perform their gendered identities differently in different space*' and places are '*imbued with*

*culture and history which is not fixed or unitary*' (p. 99). Coxtton et al's (2014) qualitative study on UK women's views and beliefs about place of birth over the duration of pregnancy suggested women's choices were influenced by numerous discourses, rather than the notion of a fixed polarised view of medical birth and natural birth (p63). Similar to this study's findings, women highly rated safety regardless of where they gave birth, with the associations of safe originating in cultural, familial and personal histories and experiences. Also similar were accounts from women who chose to birth in hospital, seeing medical intervention as an essential rescue from the hazards and uncertainties of birth rather than a problem or risk. The participants in this research had differing views on where they feel safe to birth. In either place, the space for the breech birth to occur was enabled either by the woman herself, or by key people around her. Nevertheless, there was more awareness and acknowledgement of personal responsibility for those women who chose to birth at home. The strong association for some women on the security of having their own space was more evident in the data from the vaginal breech birth experiences at home, where they took responsibility for creating the safe space, whereas the security for women choosing to birth in hospital came from perceived safety provided by others. However, unlike Coxtton et al's study, where women planning birth outside of obstetric maternity units continued to see these institutions as a 'safety net' (2014, p. 63), this study's findings were different.

Women who chose to birth at home appeared to be committed to the place of birth being a vital factor, or core element, in achieving safety for them and their baby, and avoiding the perceived risks of the obstetric unit. This perhaps is a reflection on how firmly breech is constructed as an objective risk and, for these women, the only safety from inevitable medical intervention (of a surgical birth) was to choose to remain at home to birth. This can also be seen in literature around women who choose homebirth who are labelled, regardless of risk factors, as uninformed, gullible risk-takers (Devine, 2009) - but this and other research suggests the opposite is true. Jackson et al's (2012) research with Australian women who freebirth and women who are deemed high-risk having homebirths found that the women were of higher education than the general population, and that these women considered risk very seriously. Additionally, Jackson

et al found core themes of *'interference is a risk'* and *'the hospital is not the safest place to have a baby'* and concluded that women who choose to birth outside of the system are *'making a choice that protects them and their babies from the risk associated with birthing in hospital'* (Jackson, et al., 2012, p. 561).

Whilst risk and safety are interlinked, the focus on increasing safety rather than reducing risk reflects an important shift of re-ownership of an experience. It can be argued that the experience of vaginal breech birth for participants in the study, particularly the women who gave birth, represents neo-liberal notions of individual autonomy, free market enterprise, and ownership, as they consciously reproduce risk into their own notions of being safe. In this study, this was characterised by individual decisions about place of birth, who would provide care, and actions that were perceived to improve safety. This can be framed in a positive way as a safety capitaliser rather than a risk-taker approach. However, this is seen to be at odds with the medical categorisation of breech as 'high-risk', and expectations of conforming to the authoritative medical narrative by limiting options and having low tolerance for individual autonomy. This can be the cause of tension between those holding the dominant view, and those implementing neo-liberal actions of consumer choice.

Further, there is the recognition that this puts both women and the health professionals who support them in a vulnerable position. This separateness from others can leave women feeling unconnected, as the common desire of women is to seek networks and assurance through relationships and community ( (Belenky, 1996, p. 65). The findings describe this as unique vulnerability, as the lack of choices for breech limits women to fit into one or the other of the polarised paradigms: surgical birth in hospital, or natural birth at home. Participants recognised the different considerations for a breech birth, and made decisions based on what they felt was safest, but for women choosing to birth at home there was an acknowledgement of the feeling of added individual responsibility and ownership. Childbirth can be seen as a 'fateful moment' where there is a common recourse to the perceived stability of institutions based on well-established rules and expected behaviours (Scammell, et al., 2012). However, the findings of this study suggest this does not always occur. Women choosing to breech birth at home use their

intuitive belief in themselves, their bodies, their babies and their midwives, whilst those who birth in hospital place their belief more in the health professionals around them.

Davis and Walker's (2010) study on interrelations in maternity hospitals similarly found that women in obstetric settings are strongly influenced by the surveillance of others through the environment, equipment, and behaviours of care givers, re-enforcing the concepts of potential danger and risk and reliance on other to rescue. Chadwick et al (2012) also found that childbearing women saw their birth from the external eye of others when birthing in institutions with gendered relations reinforcing belief and values of the dominant and obstetric view. Certainly, those women who birthed in hospital in this study shared some of these elements, describing the lack of privacy and being watched, listening for instructions, being rushed and describing it as the hospital staff's space. This sense of distance was not reflected in the stories from women who birthed at home, who described the engagement with the birth as well as connectedness between their mind and body, with their baby and with their midwives. This suggests that whilst safety is desired, other elements are also central to the birth experience and appear shaped by the place and space of birth.

Third space represents a time new opportunities are created and shaped by individuals despite the lack of institutional provision. The limitation of options by current maternity care provision means women are required to compromise to some degree, regardless of where they choose to birth. However, this consequentially becomes a time of ownership, protection and responsibility, with individuals considering their own notions of risk, becoming safety capitalisers as they locate or create safe places for birth. Third space is grounded in the physical location of birth as well as the act of birthing, with the focus on practical rather than mindful elements. However, this is also a time for making sense of the experience to settle the previous disruption and unease. This is a unique but temporary space, for it is not established within contemporary maternity care provision. This can be of benefit in meeting the individual needs of women, but can also leave women and those providing care in a vulnerable position, separate and away from the mainstream services. Third space provides an alternative to the midwifery and

medical spaces, re-focussing on women's requirements and needs, and placing them at the centre of the birth experience.



## **6.5 Summary**

This research has provided new knowledge about the vaginal breech birth experience by using a feminist social geographical framework to explore the experience through spatial concepts. The three spaces presented draw from the four themes that emerged from the findings to make sense of how the vaginal breech birth experience can be more broadly explained and understood. It shows how the essential and physical nature of birth cannot be set aside, but combines with the social, cultural, and gendered contexts to create and shape the spaces where birth occurs. This research contributes to the literature and knowledge about breech birth by providing a deeper understanding on the experience of vaginal breech birth.

The findings and discussion chapters have also enabled the research questions to be answered.

*How is the experience of breech birth constructed within a gendered and social context?*

The vaginal breech birth experience fundamentally challenges limited concepts of normality and the expected behaviours of maternal women. Choosing the different route of vaginal birth to protect a core element that is of individual importance (such as avoiding an epidural or bring incapacitated in the postnatal period) leads to social moral judgement and further marginalisation. However, this experience also provides a sense of reconnecting with self and personal identity. The diversity of vaginal breech birth experiences challenge institutional boundaries, with birthing women and health professionals fostering new identities through their experiences.

*In what ways do social, cultural and political constructs impact and influence the experience of vaginal breech birth for women?*

Whilst healthcare is dominated by a medical risk focus which limits choices through established hierarchies and networks of power, neoliberal notions are enabling women to choose different paths. The polarised cultural views of medical and natural childbirth

and the practical consequences of them are unhelpful and simplistic, which leads to a sense of vulnerability when wanting to do birth differently.

*How do issues around gendered interrelationships between those involved in the birth shape the experience of vaginal breech birth for women?*

Social relationships based on expected social roles and responsibilities developed from institutional notions of the feminine woman lead to expected behaviours that have to be negotiated and navigated. Marginalising vaginal breech birth keeps the behaviours contained and mutes the experiences. The vaginal breech birth is one that troubles the normal and narrowly-defined meaning of birth, destabilising the dominant paradigms, and re-establishes the identity of women as central to their birth experiences.

*How do the places and contexts of care provision impact and influence experience of vaginal breech birth for women?*

Vaginal breech birth has no established place in institutional care, so safe birth places are recreated each time, creating exclusive but temporary pathways. The limitation of options by current maternity care provision means women are required to compromise to some degree, regardless of where they chose to birth. However, this consequentially becomes a time of ownership, protection and responsibility, with individuals considering their own notions of risk and safety.

Consideration for the contribution of this new knowledge, reflections on, and limitations of, this research will be presented in the next chapter.

## **CHAPTER 7: CONTRIBUTION, REFLECTIONS AND LIMITATIONS**

### ***7.1 Introduction***

This final chapter will explore the contribution to knowledge that has been made by undertaking this research, and how it has developed new knowledge around the experience of birthing a baby in the breech position. The implications for practice and future research will be then be suggested, and finally the limitations of the study and reflections of undertaking the research presented. This chapter will also discuss the challenges with which the study was faced, and the efforts that I made to mitigate them.

The thesis concludes by bringing together the overview and summary of the research and its contributions.

### ***7.2 Contribution to knowledge***

The knowledge gaps identified in the review of the existing literature provided a basis for this research and an opportunity to discover the experience of vaginal breech birth in the wider social, cultural and gendered context. The aim was to generate new knowledge on this unique experience to provide an alternative perspective to the existing bio-physical breech research that focuses almost exclusively on morbidity and mortality. The hope is that these findings can contribute at both a macro and a local level: from maternity service provision to individual interactions between childbearing women and health care professionals. By undertaking a case study feminist research approach, the research has provided rich data that illuminates this experience beyond previous knowledge and should benefit both other women in their birth journeys, and health professionals that provide care.

This thesis has uncovered valuable insights into the vaginal breech birth experience that can be helpful for childbearing women, health professionals and healthcare providers. The findings show that the vaginal breech birth experience is deeply shaped by the medical risk narrative which leads to disruption, uneasiness, and subsequent navigation

towards a Third space, a place of safety. The research design helped to show that these descriptors apply to those providing care as well as to those receiving it, an important factor when looking to the future development of breech services and care provision. The findings underline how breech birth space has been excluded from the mainstream, and how the contemporary breech birth experience is one of loss, negotiation, consideration, and action under considerable time pressures. The dominant medical conceptualisation of femininity, childbearing women, childbirth and of breech birth is a considerable influence on how these spaces are formed and shaped, so an understanding of these elements will provide an opportunity for broader consideration when making breech related decisions. The three spaces illustrate how there are inactive, interactive and active periods during this journey which can help to show how those involved with breech may respond and what they may need at different stages.

The new understandings developed through this research adds to the existing knowledge about breech birth in the following ways:

**It indicates that the prevailing risk paradigm has marginalised breech, enforcing limitations and alienating breech childbearing women from normal birth spaces. However, the experience also highlights how this provides an opportunity for the creation of new spaces, albeit temporarily and with some compromises.** The dominant discourse on breech as a high-risk birth has significant consequences for the breech experience. The medical-risk-focussed narrative creates a sense of loss and of lacking, emotional distress, of not fitting in and of changed identity for those giving birth and those providing care. This is countered in the experience by an alternative narrative of safety, as an element of re-ownership enables the space for vaginal breech birth to occur. This then eliminates the delineation of risk manager or risk-takers, and creates a more empowering concept of safety capitalisers. This contribution to knowledge has the potential for health professionals to consider how breech is presented to childbearing women and society, and the language that is used. This research suggests that women desire a more contextual 'real life' experiential lens on which to consider their options. Additionally, this new knowledge provides an opportunity for care providers to consider added support for women around the time they find out that their baby is breech. This

would potentially minimise the emotional distress and feelings of loss, lacking and not fitting in. This thesis contributes to existing knowledge by suggesting that the current care provision needs to be able to provide a more permanent, but flexible, emotional and physical space for vaginal breech birth, and needs to consider how established places can be more inclusive of individual requirements and needs around the time of birth. This notion challenges the idea that home/birth centre equals 'good' birth and that hospital equals 'bad' birth as being too simplistic.

**It illuminates how gendered knowledge, used to inform childbearing women's and midwives' decisions around mode of birth for the breech baby, is drawn from sources in addition to, or alternative from, that of the medical narrative.** Current information provided to women by health professionals tends to focus on statistics and homogenous recommendations based on existing medical research. This research has provided valuable insights into the further sources of knowledge women may need on which to base their decisions such as other people's experiences and the wider social consequences of the choice on them as individuals. This contribution to existing knowledge suggests that care providers need to consider what information women may find helpful when making decisions about their birth choices. It may also assist women in reflecting on what they may need to consider in order to make decisions that are right for them as individuals. This is a move away from a biomedical approach with a fixed end point to a more flexible individualised and holistic partnership approach.

**It provides insight into how social, cultural and gendered relationships and places temper or heighten perceptions of risk and safety around breech.** Although a risk-based approach to childbirth is a well-recognised concept in medicalised childbirth, this thesis adds further insights into how social, cultural, and gendered relationships influence perceptions of risk and safety. It also highlights the influence of institutional figures on a mother's engagement or disengagement during the birth journey, and the central importance of establishing a key relationship based on trust. This contribution to knowledge could inform future configurations of care provision for breech presenting babies and their mothers, with respect to establishing equitable partnerships of individualised women-centred care.

This research contributes to knowledge in contemporary childbirth by adding to the substantive theories on the medicalisation of childbirth. This thesis adds to the existing knowledge about the social, cultural, and gendered nature of birth and how this should be given more weight in decisions about care provision. It provides more evidence to call for the integration of the two polarised views of natural and medical approaches to birth, instead acknowledging the plurality and complexity of women and of birth. This research shows that this birth journey is strongly gendered in how women consider knowledge on which to base decisions, and are influenced by social interactions and relationships.

The thesis findings submit that breech birth is not linear or simple but complex, social, and gendered. It suggests that demassifying the binaries of normality and abnormality can allow for less restricted practice and a greater diversity of experiences for all childbearing women.

### ***7.3 Limitations of the research***

This research was an in-depth exploration of the vaginal breech birth experience, drawing on data from women who had experienced breech birth, health professionals, and relevant documents. This was an area that had not previously been studied in detail, and there was an established gap in the knowledge that we have about breech birth. This provided a rationale for focussing on the vaginal breech birth experience, rather than wider breech experiences such as elective caesarean section and emergency caesarean section. However, this focus on the vaginal breech birth provided an invaluable opportunity to explore in depth this particular experience.

A further consideration related to the inclusion criteria: in order to ensure that enough participants could be recruited, it was decided that the study would include women who had birthed at home or in a maternity unit, who had primary birth care by obstetricians

or midwives, who had care from NHS staff or independent midwives, and had known planned breech births or unknown unplanned births. These factors are recognised to be different, with place of birth, type of health professional and model of maternity care all contributing to the birth experience. This diversity of elements could be considered to be a limiting factor when attempting to explore social, cultural, and gendered factors as each on their own may have considerable influence. Nevertheless, as the aim was to explore the experience of vaginal breech birth, all the variations of this experience were considered important to include, to ensure the diversity of this particular experience was captured.

There were several practical limitations relating to recruitment and the interview process that had an impact during the data-collection phase that was presented within the methods in Chapter 4. These included the challenges of slow recruitment, the large geographical area of participants, and consideration of the practicalities of interviewing women with small children and/or babies. Whilst these created frustration and required a pragmatic approach, most issues were mitigated.

A further limitation could be due to the physical geography of the study. Recruitment was from a single NHS Trust, so it is possible that that this limited the diversity of the cultural and social backgrounds of the participants, and therefore may be considered a limitation of this study. However, the aim of this study was not to achieve a representative sample, but to explore in detail the experiences offered. Personal experience shows that whilst most NHS Trusts base their clinical guidelines on that of the Royal College of Obstetricians and Gynaecologist guidelines, there will be local variation, and recruiting from a single centre did not allow for this to be part of the consideration of this study, being a possible limitation.

Acknowledging the issues and being reflexive during the study enabled me to maintain focus. The above concerns were brought to supervisory sessions, and advice and guidance sought from experienced researchers.

#### *7.4 Personal reflections on the research*

This research has afforded me the opportunity to more comprehensively grasp the meaning of being a researcher. Having a better understanding about the process of research has enabled me to see the role and responsibility of the researcher through a different lens. The reflexivity required a shift from being a midwife with an interest in a subject, to a researcher who has carried out a systematic investigation. With this lens I was able to hear other perspectives and views, while at the same time gaining insight into how my own had been formed. Had I been unable to move to this position, I may have missed the subtleties in the data from the complex and plural experiences shared. My reflective accounts have enabled me to pause and see a change in my own perspectives, from a position of simplistic desire for women-centred care to one of complexity, as my awareness of the power of social, cultural, and gendered constructs became more apparent.

As a midwife this research has enhanced my ability to provide with-women care, but has also provided me with a broader understanding of the complexities of childbirth provision and paradigms. Throughout my twenty years working as a midwife it has predominantly been the experience of working with birthing women which has taught me a significant amount of what I need to know, and this is paralleled in this research journey where I have learnt a considerable amount from the participants. I have come to better understand different views, how they develop and are shaped and influenced. This has been useful at both personal and professional levels, particularly as my career has progressed over the period of the research.

I also continue to practice as a midwife and to counsel women about their birth options, and I feel that I am able to guide women in a more informed and insightful way as a result of my research experience. I recently talked to a woman who was trying to decide on how to birth her breech baby, having learned of this only a few days before. As she talked I was able to recognise elements that I had encountered in my research. This not only resonated with my research findings, but it also enabled me to share the stories and knowledge that I had gained from the study to help the woman on her own journey.



Whilst essentially an academic project, the research experience has inspired me to take practical steps which will provide assistance to and support birthing women and healthcare professionals. I have already purchased a website domain and will be developing an online website aimed at providing women and health care professionals with information, signposting and training aids. It will be developed utilising the new insights that this research has provided, and in collaboration with women and health professionals.

Despite the limitations outlined here, this research provides a fuller understanding of the vaginal breech birth experience. It is hoped the findings will add to the existing knowledge and provide guidance for future developments in maternity care.

### ***7.5 Implications for practice and further research areas***

The core elements from this study provide insights into the meaning of the experience of vaginal breech birth that can help to shape future developments in maternity services, support health professionals when providing care, and help women and their families when undergoing this experience in the future. This study will contribute to existing knowledge by providing additional understanding of elements of the vaginal breech birth experience not previously considered. In this way, the research could have implications for maternity care provision, for maternity-based health care professionals and for childbearing women. The limitations of the study also suggest some areas for further research, as well as other suggestions where future research could contribute to our understanding and knowledge of this unique event.

### **7.5.1 Implications for childbearing women**

This study brings new insights for childbearing women around the vaginal breech birth experience that have not been previously considered.

The key elements for women that may be helpful for women are:

- Recognition of the core elements of importance to them;
- Finding the information that will help them to make a decision;
- Identifying key relationships of trust; and
- Considering their own concepts of risk and safety, and taking or delegating responsibility when creating the safe place for birth.

The study has found the significance of core elements that are of great importance to some women (such as avoiding an epidural, or wanting to birth in hospital). These elements vary between individuals but are central to their expectations. Recognising these and negotiating the protection of them during the birth journey can be a helpful place for women to open discussions with health professionals. These may also feature highly in birth plans/preferences, enabling individualised care pathways to be developed. This research has also highlighted how women may seek knowledge from a variety of different sources in addition to the medical research-based information with which they may be provided by health professionals. Women can seek out the information they find helpful, such as other people's experiences, and use these to help them make decisions. Social media and the internet provide a powerful platform for information sharing, and women may use this accessible medium to find the knowledge they need.

The findings provided a clear indication of the importance of key relationships to develop trust. Whilst there was a diversity in who this relationship was with, the level of trust enabled women to move forward in their birth journey. Women can consider in whom they wish to place their trust and where they may seek alternative key relationships if they have not established one before this point. Where time is of the essence there can be other ways of drawing strength that may be less dependent on

external reliance, such as drawing on previous positive experiences or spiritual guidance if individually relevant.

Finally, women can consider their own assessment of risk and how to keep safe and create safety. The findings show how women can capitalise on safety through their decisions on where to give birth and who to have with them. This journey requires taking ownership of the birth journey, and taking or sharing responsibility with others. Within this, a woman has to evaluate what is safest, not only for the baby but also for herself, her family and her current situation. This may also include considering the core elements, making sure they are protected in the choice made, or that the compromise of them is acceptable.

This research places women central to this experience; it is not a passive journey, but one that requires engagement, consideration, interaction, and the physical act of birth. For women, this research also provides some insight into the spaces and phases of time they may experience during this journey. This may be helpful in navigating this challenging journey and planning ahead. It may also be useful when reflecting on the birth afterwards, to try to make sense of what happened.

### **7.5.2 Implications for health professionals**

The key elements from this study that I suggest are useful for health professionals are:

- Recognising and supporting women through the spaces and phases of their birth journey;
- Providing or signposting women to alternative sources of knowledge;
- Creating a trusting relationship with women;
- Respecting core elements of importance to individuals accommodating them where possible;
- Respecting women's decisions when they are made and protecting the space for birth; and

- In addition, health professionals can recognise their own sense of loss within the vaginal breech birth experience, and work together to resituate the position of breech in contemporary maternity care.

In recognising the spaces and phases that this journey entails, health professionals will be more able to sensitively support and guide women and families. Health professionals are well-placed to minimise the disruptive and uneasy nature of this journey through assurance and explanation. Spending time shortly after discovery of the breech to establish the individual core elements and consider how they can be accommodated will minimise the disruption and shock. There should be time given for contemplation and consideration of the information, and where possible women should not be pushed to make decisions without being able to gather the knowledge they deem important. Further, the research suggests that once a decision is reached, there must be time and space for women to inwardly focus to allow the birth to occur. This research provides an insight into the considerable influence of health professionals, and how interactions can create opportunities for the development of a trusting relationship, or, alternatively, a negative emotional response.

Health professionals should be encouraged to consider their own opinions, knowledge base and responses around breech birth as part of their required reflective practice. This research suggests the current care provision does not meet the needs of all women, and that a more flexible and inclusive approach should be considered to meet the broader needs of individuals. There is a compelling case for a team approach to breech and the vaginal breech birth journey. This will be a fundamental shift in perspectives about the nature and meaning of breech, and will allow for the range of needs to be met, from women choosing surgical delivery to those requesting breech birth at home. The role of the team will minimise the feelings of loss and uncertainty as a relationship of reciprocal trust can be established. This study has produced clear evidence that breech is more than merely a biological or mechanical issue, and has specific challenges. A consistent team approach appears best placed to help navigate these considerations *with women* as they decide on their birth options.

There was a distinct feeling of loss around health professional's knowledge of, and skills to support, breech birth, from the research. This is an area that can be addressed through a comprehensive training programme. The use of simulation training in maternity care is well-established, and studies have suggested that there is an improvement in clinical skills using models to learn breech manoeuvres. However, this research indicates that there is a need for education and training around breech, to include balanced information provision during communication with childbearing women and their families.

### **7.5.3 Implications for Maternity care provision**

This research provides several areas of consideration for maternity care provision. Providers should consider how services can improve women-centred care and meet the needs of individuals choosing a vaginal breech birth. There are several possibilities to consider. One would be to set up a breech clinic, run by midwives and obstetricians with the knowledge and skills to counsel and support women. The breech clinic or specialist service is modelled in a few places in the UK, and has predecessors in the VBAC (vaginal birth after caesarean) pathways and specialist clinics. The possible advantage of these clinics is that information could be provided in a knowledgeable and consistent way by experienced and specialist staff, thus increasing the likelihood of consistent advice and care, and a reduction of professional tensions. A possible drawback of this approach is that knowledge and skills become pooled within a small group of people working in the specific clinics, limiting dissemination of knowledge and wider confidence in this subject. Unlike VBAC, where the issue is known even before pregnancy occurs, breech has the added temporal element where it is only discovered in late pregnancy, with labouring women not being able to access this specialist knowledge and counselling. The breech clinic model may also come across similar issues to those experienced by the VBAC clinics, where holistic care is devolved to a few clinicians with specialist skills and knowledge, who run the clinic. However, this could lead to a

situation where breech is seen as an elite event needing additional expert skills and reemphasising its 'different' nature.

A wider cultural change in how breech is perceived may address the broader elements from this study, but this presents substantial challenges. Any changes need to be discussed, agreed, and implemented in a collaborative way with women, obstetricians and midwives all involved in the change process. The development of more flexible pathways for breech, supported by evidence-based clinical guidelines, will be helpful for both women and health professionals. Professional guidelines, developed collaboratively with the Royal College of Obstetrics and Gynaecology and the Royal College of Midwives, would be helpful in providing a platform for sharing knowledge and working together. Further to this, the development of National Institute for Health and Care Excellence national guidelines around breech would be powerful in establishing new standards of care for women with breech presenting babies. Training and education at all levels should include balanced information with which to counsel women. Information provided to women should be considerate of their desire for knowledge beyond the medical research and care; a multidisciplinary team approach will be more able to meet the social, cultural and gendered needs of women.

Finally, the research findings suggest that there is a need for a different language around childbirth. The use of language is an influential element in how the social world is understood. The current language around breech birth is constructed around binaries of normality and abnormality, good and bad, midwifery and obstetric, low-risk and high-risk, natural and surgical. Whilst this may help the maternity system to function and maintain a status quo, this does not reflect the social, cultural, emotional, and physiological complexities and pluralities of the birth experience found in this study. The findings suggest that approaching childbirth in a more individualistic manner, removing institutional binaries and accommodating needs based on a dialogue of safety, context and shared knowledge of those involved, will minimise feelings of loss and uncertainty. In practical terms, this links to consideration of a more inclusive approach to birthing classes, the language of birth during conversations with service users, and written or online information that is balanced and honest.

#### **7.5.4 Implications for further research**

This research explored the experience of a specific birth event. All the women had single, term, live babies with no or limited birth complications. There were few stories shared by health professionals, which included complicated breech births needing interventions, or breech births where the baby was born in poor condition. Future research may consider the breech experience more broadly. This might include exploring the diversity of experiences from homebirth vaginal breech to elective and emergency caesarean section, or straightforward and complicated births and breech in a different context, such as twins and premature births. In addition, this research did not seek to be representative of all women, and so there may be a case for carrying out the work in different areas of the UK, and including women from a wider variety of social, cultural and political contexts. This would add to the weight of knowledge in this area, building a more comprehensive voice to these different experiences.

Future research may also focus on exploring the experiences of different health care providers. This research did not delineate between independent midwives and the NHS-based midwives who contributed to the study. It would be of interest to explore this further to establish what each care model and ethos provides, and how this shapes modern breech experiences. Some independent midwives, NHS midwives and obstetricians describe themselves as 'breech experts', and there is ongoing debate as to what this means and how this would influence breech care provision in the future. This could be an area for further research to contribute to knowledge on developing services in the future.

Further research might also be considered into different models of collaborative ways of working for childbirth services, and breech care provision in particular. This study suggests the centrality of key relationships as an influencing element. Research into collaborative working would provide additional insights into professional tensions and changing identities, and how they might be addressed.

The need for further education and training around breech to address the problem of the loss of confidence, skills, and knowledge is one identified in this research. While there is a substantial body of evidence to show the positive effects of simulation training, there are only a few studies (identified in 7.3.4) that have focussed on breech delivery training. Findings from this study suggest that further exploration of a human factors approach to breech simulation training could help give insight into some of the professional tensions, and shape spaces for breech in more positive ways. Identifying improved ways of learning and sharing breech skills through research could be a practical way of shaping breech birth spaces in the future.

One feature which emerged from the study was the use of social media as a source of information for women. Increasingly, websites, blogs, twitter accounts, Facebook groups and informal meet-up sites have been set up and run by women for women about a wide variety of experiences, including breech childbirth. As modern technology influences and changes the way social spaces are shaped, and evolve understanding, this new emerging knowledge would be helpful in establishing alternative ways of knowing and sharing. This could improve and enhance the childbirth experience for both women and health professionals through more collaborative development of knowledge.

## ***7.6 Concluding remarks***

Breech and vaginal breech births are subjects that produce strong and conflicting responses - for individuals, within the maternity care profession/establishment, and more widely within society. This thesis has presented an understanding of why and how these reactions have been developed, and how they impact on the experience of vaginal breech birth. It sheds light on the social, cultural, and gendered context of this birth experience by drawing on multiple sources of information. What has emerged is that the pervasive risk-centred approach within childbirth has been greatly accentuated in the case of breech. This has marginalised vaginal breech birth creating a challenging journey for those involved.



The findings provide insights into a disrupted and uneasy experience, but also one that has the potential to actively create new and unique spaces. This work has shown how notions of normal and normality lead to feelings of loss and lacking when faced with breech. The study has also shown how knowledge is drawn from multiple sources to inform decisions, and how women are safety capitalisers in how they locate their safe spaces to birth. It concludes that this journey is one of compromise, responsibility, and ownership, as women are placed back in the centre of the breech birth experience when they reconnect to the physical act of birthing. In working to address these challenges, maternity care provision should consider broadening the options available to all women, working together as a team to create safe space for the multiple ways of birthing that women require.

As a midwife it is the women from whom I learn the most. They present challenge, they inspire, and they enhance knowledge. It has been a privilege to work with this particular group in this research. In recognition of this I shall end with a quote from one of the women from the research:

*“It has changed me completely. It has given me a whole new perspective on my life... it has made me more knowledgeable. It instils a wisdom in me that I wish I could pass on that people would appreciate. Regardless, if I could be that one voice that could motivate someone then I would like to be that voice... things need to be done differently definitely. I think the rights shouldn't be taken away from women to birth how they want to... breech birthing isn't common and that is why not a lot of women have journeyed, so [a story] like mine needs to be shared with women so they have the information.”*

*(Sara, p6)*

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## **APPENDICES**

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## Appendix 1: Extract from tables

*These tables were a working part of the development of the themes, and how data started to be clustered together. The below are extracts from the tables to show how the themes were directly informed from the participant's stories.*

### Losing the way – extract

<i>Pseudonym</i>	<i>Contextual information</i>	<i>Interpreted Summary</i>
<b>Lucy</b>	Known breech at home, first baby	Always planned a waterbirth and felt devastated this choice was taken away when found the baby was breech.
<b>Sara</b>	Known breech in hospital, first baby	Feels lost after not being given choices or options about her breech birth by her midwife.
<b>Lara</b>	Unknown breech in hospital, first baby	Felt the loss of control as she was told her baby was breech,
<b>Amy</b>	Known breech at home, second baby	Strongly wanted a homebirth due to her previous experience. Felt shocked that breech took this option way from her
<b>Kerry</b>	Known breech in hospital, second baby	Elements of loss of the relationship between her and her midwife. Felt loss of identity as an individual as not treated like one
<b>Rose</b>	Midwife	Feel women are seen as 'going wrong' with loss of identify as women undergoing a natural experience.
<b>Katie</b>	Midwife	Feels loss of skills and knowledge has changed the identity of breech as now seen an emergency
<b>Betty</b>	Obstetrician	Shares the effect of research & litigation on the loss of choices for women to have breech birth
<b>Jan</b>	Obstetrician	Expresses the loss of support from colleagues & loss of choices for breech birth

### Fighting Fear and Seeking Trust - extract

<i>Pseudonym</i>	<i>Contextual information</i>	<i>Interpreted Summary</i>
<b>Jessica</b>	Unknown breech in hospital, first baby	Experienced a coercive approach to manipulating a required response
<b>Kay</b>	Known breech in hospital first baby Known breech at home second baby	Not being heard. Sense of confidence in this pregnancy – trust in her body. Trust in her midwife
<b>Carla</b>	Unknown breech at home first baby	Tension as not being heard. Feels grateful for having her midwife there who knew her, deeply trusting relationship
<b>Orla</b>	Unknown breech at home first baby	Maintained her own agency by doing her own research in order to make decisions Complete trust in midwife and own body
<b>Kerry</b>	Known breech in hospital second baby	Felt like it was the medics space in hospital and power struggle. Scare tactics used
<b>Liz</b>	Midwife	Lots of peer pressure & judgement on women who go outside expected norms. Coercive language
<b>Erin</b>	Midwife	Feels fear is used to coerce women. Feel women have to trust themselves/ their bodies. Midwife has to trust the woman, woman has to trust the midwife.
<b>Katie</b>	Midwife	. Feel midwives are frightened about getting into trouble by going outside the guidelines
<b>Betty</b>	Obstetrician	Feels women will be frightened by the increased risks of breech birth, not sure women always get a balanced approach.

**Deciding the right path to follow – extract**

<i>Pseudonym</i>	Contextual information	Interpreted Summary
<b>Jessica</b>	Unknown breech in hospital first baby	Ensured her absolute requirements were met for her birth
<b>Orla</b>	Unknown breech at home first baby	Values other people's experiences as adding to her knowledge
<b>Carla</b>	Unknown breech at home first baby	Conflict between people's opinions and her instincts. Concerned about being told non-factual information relating to mode of birth.
<b>Sam</b>	Unknown breech home second baby	Felt this is a unique situation where you are not able to sift through information so rely on intuition for knowledge
<b>Kerry</b>	Known breech in hospital second baby	Found out her own information with which to make a decision.
<b>Helen</b>	Midwife	Feels pressure of groups of senior doctors over others which removes individual autonomy
<b>Erin</b>	Midwife	Period of deep reflection to consider knowledge and skills. Learning from women
<b>Betty</b>	Obstetrician	Feels her role is to correct women's knowledge if required

**Towards a place of safety – extract**

<i>Pseudonym</i>	Contextual information	Interpreted Summary
<b>Sam</b>	Unknown breech home second baby	Expresses a fear of hospitals that influenced her decision on where to give birth. Felt her birth was ultimately u to her and her responsibility
<b>Kay</b>	Known breech in hospital first baby Known breech at home second baby	Felt conflict with others about risk perceptions relating to choosing a homebirth and her parenting
<b>Hannah</b>	Unknown breech in hospital first baby	Felt it easier when the decision was taken out of her hands, had gone into hospital just in case things went wrong so assured her she had made the right decision
<b>Kerry</b>	Known breech in hospital second baby	Feels hospital is 'their' space and home is her space. Wanted to know her baby was in safe hands.
<b>Rose</b>	Midwife	Feels women should be able to give birth in peace wherever they are but this is difficult in obstetric led units
<b>Rhian</b>	Midwife	Describes how she perceives risks are given to women in an unbalanced way by some clinicians and feels this is a cover for their own fears and lack of confidence
<b>Jan</b>	Obstetrician	Feels decisions by medics are ultimately made around safety and litigation. Feels not many women want to take the responsibility for the risk of going against medical advice

## Appendix 2: Examples from code book

The following are in vivo codes for a single transcript

Code	Type	Content description	Data example	Reference
<i>Unspoken fear</i>	IV	Amy alludes to pervasive influence of fear on decision making. The unspoken nature of the fear makes it more powerful to the extent it may override previous decisions on what you think is best for your child	'The problem was you want your child to be healthy, no matter what, but if you hear that fear, that unspoken fear that is in the room, that fear is everywhere'	Amy 1
<i>She would be allowed</i>	IV	Amy suggests elements of domination and control are held by the hospital, the power to grant permission	'she said that the midwife I had she would be allowed to be my midwife in hospital, she would give her special permission so she can be with me'	Amy 2
<i>That is the fear... own responsibility</i>	IV	Amy refers to the issues of who has / should have the ultimate responsibility for a birth and the consequence of giving responsibility to someone else and the blame / litigation culture	There was one thing the doctor said to me, he said "yes, of course we can have breech birth and everything goes fine but what if your child was the one which goes wrong". And of course, you know, that is the fear. And nobody can guarantee you that. Actually I don't think a lot of women want to have the responsibility. They would rather believe the doctor and sue the doctor afterwards rather than having to take their own responsibility	Amy 4
<i>Give the women self confidence</i>	IV	Amy refers to the concept of breech normality which requires self-confidence. This self-confidence needs to be given to the women by others	'I think in normal circumstances you don't even need an experienced midwife, all you need is to leave the child alone and let it come out, but you need to give the woman the self confidence that she can do it'	Amy 5
<i>Pure fear</i>	IV	Amy describes the pervading fear about breech, unspoken and powerful. The fear makes Amy question her own beliefs that its normal	'The underlying information the doctor was giving me was pure fear, the whole hospital, it was just pure fear. Even my own midwife I could sense the fear. And you think "wow, apparently they are scared to deal with a breech, why are they all fearful?" Why are they all afraid if it is not much of a big deal. They didn't say it but you could hear it in their voice, and certain comments they made...'	Amy 5
<i>Uncertainty in life</i>	IV	Amy describes the conflict in trying to make the right decision in an area of life where there is no certainty	'When you go to a consultant it was like one sentence he said "but what if it is your child [that dies]?" And you think, yes, what if I do make the wrong decision and then you think, but how can I make the right decision? Because you don't know. There is a certain uncertainty in life we just have to live with but what do you do if your experts say one thing and you don't kind of believe them.'	Amy 6

### Appendix 3: Examples of analytical memo

Analytic memo 8S

7/1/13

Code description: **Resonant knowing**

Code	Type	Content description	Data example	Reference
<i>Resonant knowing</i>	A values coding	Sara describes her response to 'finding' the knowledge she was seeking and the resonance it had for her in her journey.	'I knew that she was going to be able to help me because the way she talked about breech birthing it was so different from what hospitals were explaining to me. There was something that she knew that hospitals didn't know. She was knowledgeable; she specialised in it and was supportive of it. She knew the wisdom in it and that is what stuck in my mind'	Sara 1/2

Sara describes the immediacy of recognising the knowledge (brought by the midwife) that she has been looking for, what had been lacking elsewhere. This interaction appears to resonate with her –the methods/ways of this communication is a vital part of how she reacts to it. Note the language used there; the hospital *explained to* Sara implying two roles, a dominate one and a passive one in the communication. Whereas the midwife *talked about* birth to Sara, a more mutual communication. This perhaps implies information is heard and evaluated differently dependent on how it is communicated

The implication is that the knowledge found here was at least partially already known by Sara, so when made explicit by the midwife it makes immediate sense. This means knowing (even in a scenario like this where no previous knowledge of the subject matter exists) is something already at least partially constructed by an individual, fundamental beliefs and values providing a knowing that can be transferred and applied to this new situation

This resounding point of knowing is a significant part of the breech experience; this occurs through communication and interaction here, but may be internal as found in other interviews.

This links to themes of feeling lost, seeking and finding during a journey; there are points of clarity when something being sought is found.

## Analytical Memo 7

7/1/13

Code Definition: **CONFLICTING STORIES**

<i>Conflicting stories</i>	A	Amy perceived different stories from different people; complete and incomplete information.	'[the midwife] was telling me a completely different story to what the doctor told me.	Amy 1
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Amy is referring to the differing narratives she hears from different people. The code reflects the opposing nature of the information that was given and the strong emphasis making it more tensional (conflicting would imply confrontational, opposite and antagonistic).

The code also picks up on the use of the word story. It is interesting that Amy uses this word here; by dictionary definition this can be a factual or fictional account of an event but implies a wider narrative rather than a brief factual explanation. Does this mean that there is a difference in delivery as well as content; the way the information is communicated is significant perhaps. The nature of the delivery of communication of information, like the presentation of a meal, has a considerable impact on how it is received. Is this significant to how Amy receives and considers what she is informed; does the evaluation of the information received include bias towards a style and delivery that she aligns or identifies with?

Is this a gendered issue; how information is communicated differs between genders, cultures, race, and social groups. Communication and language is constructed within different societies; perhaps medical language and communication has developed with different objectives (the perception of what information should be given) and within different ontological and epistemological viewpoints (what is knowledge and what is known) to that which Amy and the midwife align. Perhaps the story told by the doctor was intended to be different, the emphasis, content and delivery considered appropriate within the medical paradigm and the midwife told her story within her midwifery paradigm (or even considered the paradigm of the pregnant woman, or individual in front of her) and adjusted the story accordingly.

The code will be applied where there are **conflicting stories**.

## Appendix 4: Myself and this research

Feminist research should be grounded in the personal and be accountable to readers (Letherby, 2003). I have a personal involvement in this research, as a woman, a midwife, a student researcher and as a human being immersed in the social and cultural aspects of my own life. I cannot separate myself from the world around me and will bring my own principle, beliefs and values that will influence and impact on the research approach, analysis and interpretation of the findings. My purpose here is to be explicit about these, to consider where and how I will affect the research and provide a contextual location of myself within the research journey. Sharing my background, thoughts and influences enables me to introduce myself and to start the process of reflection and openness that will continue throughout the research and beyond.

I am a white, 30 plus woman and was raised in the UK by an Irish mother and English father. My father was a school master at the local grammar school and my mother gave up employed work to bring up my brother and me whilst continuing to run a small bed and breakfast business. Brought up in a middle class, stable and supportive framework, I was given opportunities both in sports and academia. Both my brother and I found areas of life we enjoyed and were good at and I always felt a fairness and equality to how we were treated. From an early age I was interested in women's rights and women's movements, perhaps due to my voracious reading on all and most subjects but also perhaps due to my constantly questioning, my family would say challenging, nature about why things were a certain way.

Within this was a leaning towards healthcare and during my late teenage years I considered a number of options but ended up falling into midwifery profession by default after not reaching the grades to get onto a different course. From the beginning of my training I loved being a midwife: it just felt right and aligned to my beliefs, what I enjoyed and what I held to be important; it was centred on women's health and wellbeing, it enabled the potential of autonomy for myself and had the aim to empower the women by working in partnership with them. It was community-, family- and social-focussed, it allowed me to meet a huge number of people with diverse needs, desires and beliefs, from whom I learnt a great deal. I worked alongside midwives who were learned and wise and shared their knowledge built of years of experiential learning, which has been so valuable in shaping how I view knowledge today. After my degree and training in midwifery I have spent the last 20 years working in NHS Trusts throughout the UK. I undertook my Master's Degree and teaching qualification and moved into the area of combined teaching and practice. After moving to London and working again as a full time University lecturer for a year, and then as a clinical midwife in a birth centre, I subsequently moved to Brighton, and for the last 6 years have had roles that included teaching, management and midwifery clinical practice. My belief structure around childbirth aligns to the role of the midwife: I believe in the normality of birth until and unless proved otherwise; I believe that women should be empowered during and by their childbirth experiences; and I believe that midwives and women work in partnership to achieve an outcome that considers both her individual physical and psychological needs.

My interest in women's experiences and women's studies was demonstrated in my first research project undertaken during my degree which explored Asian women's experiences of labour care. This first tentative dip into research provided me with basic research tools, but also a considerable insight into myself: my pre (mis?) conceptions and beliefs. My Master's Degree research looked at clinical decision making using an action research approach working with midwives exploring how decisions were made and the experience of making them. A few years after this, I undertook a funded research project looking at Midwives' experiences of vaginal breech birth. The subject area of breech birth was roused



purely from my clinical work and experiences of providing care for women having breech births. These were rare occurrences, as most breech babies were being delivered by caesarean section, but the women I cared for on the whole had very straightforward, spontaneous breech births requiring little or no intervention; it was not traumatic or fearful for me – it was different but still ‘normal’ and ‘natural’. My experiences as a midwife differed from the information I had been told during my training, from the research I was reading and from the stories told to me, particularly by obstetric colleagues. I heard and read that breech birth was unsafe, dangerous, abnormal and generally regarded with fear. It was this disparity that led to a drive for further information and a better understanding and a need to know what this experience was like for others; women and clinicians alike.

Additionally, over the years pregnant women have wanted more information on which to help them make decisions about how to birth their breech babies but frustratingly there was little literature I could give them or knowledge to share; statistics on mortality and morbidity were available but women I talked to wanted to know more about the experience of breech birth: what did other women say it was like? In more recent years I have taken to asking women who have been through the experience to speak with pregnant women in similar situations, in an attempt to provide them with some of the information and subjective knowledge that they appear to desire. Anecdotally, this has been helpful; women say that it gives them a perspective that I was unable to provide in the research literature I could find.

Having been fortunate to receive funding for my doctorate, the decision on what subject area to research was clear to me; following my previous research into midwives’ experiences of vaginal breech birth, the next vital and previously unexplored area was women’s experience of breech birth, the meaning of this experience, and the influences upon it. I wished to learn about and better understand these experiences through the voices and perceptions of the women who had them. I also wanted to be able to share information with the women for whom I cared, who also desired to know more in order to help them make sense of their experiences and perhaps aid them in making decision about their birth choices. I hoped that the knowledge generated can improve women’s lives.

I’m naturally inquisitive and I like to challenge myself and others. I love to learn, it helps me to grow and be more able to understand myself.

This was my starting point for my research journey.

## Appendix 5: Reflexive Diary Extracts

Reflection year 2

28<sup>th</sup> August 2011

### Ethics and philosophy

This year has brought frustration and learning both with the content and processes that were involved. Predominately the year has revolved around ethical approval submission and the main feeling is one of ticking boxes, being dependent on other people and imposed systems that are time consuming, often perceived to me to be illogical or duplication of previous work.

However, having reached the end of this year there is a feeling of having moved forward; the depth of knowledge and consideration for the ethical principles and implementation of the research has ensured that I now go forth with more confidence about the robustness of the research. The consideration for every aspect of ethics has given me perspective on the experience for the participants with possible implications and consequences to a far broader level than I had considered before.

This learning ties in with the learning being gained around the philosophy of feminism and postmodernism but generally about the huge multiplicity of meaning, concepts and theories that has led to confusion but excitement. The idea of reading and learning not with the aim of finding the defined answer but more to find more and more doors to learning and ideas that constant evolve and have no end point is new to me. It challenges the scientific positivist in me that seeks to find solutions; but this way of thinking aligns more with how I view life; perhaps there are aspects of my studies as a midwife and working in an increasingly medical arena makes the seeking of facts more the norm, thus the constant tension between medical science and the art of midwifery and birth within and throughout my adult working life.

My readings, learning and reflections this year have generated considerable self-awareness; the desire to find the absolute truth is not what this research seeks to do, it hopes to explore, consider and open the experiences of breech birth with no fixed end point. I am required academically to explain the journey the research takes, why things happened, what route and with what foundation it started upon. The experience is central but the concepts of whose experience, the formation of relationships, choice, care and politics and identify will be explored to raise questions, pose theory and consider alternatives and difference.

The coming year will focus on recruitment and collecting data through interviews and documents. I hope to improve my interviewing skills, learn more about analysis and immerse myself to enable a deeper exploration of the information gathered. I have concerns about my ability to attain this level; will I have the skill to deconstruct the information; can I ensure the analysis is trustworthy and how will I demonstrate this academically; have I learnt enough about methodology and how do I ensure I can be consistent to my conceptual theory.

Reflective Diary Extract:

28/10/14

***Why are these findings important?*****1. The exile of the different, messy, uncertain vaginal breech birth 'other'; outside of the 'normal' birth space and expected maternal body**

(expectations of the constructed normality space and breech as other / difference / negative): medical discourse - VBB portrayed as unstable, unpredictable, uncertain and unsafe; the desire is for certainty which is presented by the surgical delivery expressed as being better for the baby (the mother's safety is less important here). Was reduced/ controlled to the point of near extinction. The messy VBB maternal body (doing something perceived as uncertain in a discourse of required certainty – look elsewhere for certainty (navigating relationships and social roles): How maternal bodies are portrayed (social roles): Feminine maternal bodies are there as a provision of a safe delivery of a child; undertaking a VBB de-stabilises the view of 'normal' maternal women who would be seen to always put the baby first regardless of their own safety (see in data – creating safe environment); they are considering themselves as well as their baby – wider views not just about mortality and morbidity. Personal agency not considered in maternity bodies – ownership of all however this data suggests that personal agency is central for these women (not all had this and the consequences were far reaching)

**2. Finding own routes and guides: The Authoritative Decision Maker (knowledge); navigating own pathways (nothing joined up, very lonely and not established) space and certainty.**

Other knowledge to the dominant discourse guides these women in VBB however it is known and echoed throughout their experiences. Data suggests conflict. Refer to vulnerability. Data suggests women want certainty and safe (high priority) but have wider lens too (creating a safe place) and seek alternative knowledge (within themselves, external, doctors, midwives) Knowledge and knowing. So they don't all need to have authoritative knowledge but all take the authority in the decision = making a decision to have a normal birth but there is no space for this (destabilises the concept) Data deciding on authoritative knowledge) vulnerability

**3. The re-placing VBB - Space tensions: The ultra-normality (embodiment) of VBB and its relationship with (in) childbirth**

(re-engaging with birthing): just doesn't fit the 'idea' of normal birth. Links to but doesn't fit into what normal birth is in society, Achieving something perceived as that they shouldn't have: Additionally they are normal birth but are given prefix of VBB; continue to be labelled as different / outside of normality (see in the data – loss of place), however – it is a normal birth (proof is the VBB) but in modern narrow parameters despite 'success' is still seen as dangerous and unsafe (lucky / stupid in data) despite proof (see in the data re-engaging with birthing and the embodied birth, making sense- participants have normal experiences that make sense to them but this is not the majority view). There is no place provided for VBB within the current discourse (or is very compromised position for women) so they have to adapt rather than the institution adapting to the needs of VBB and keep women and HP 'safe' provision of care, they are different VBB is different and there is a continued desire to exile them away from

## Appendix 6: Consent Form



University of Brighton  
Centre for Nursing and Midwifery Research

**Centre Number:**

**Study Number:**

**Participant Identification Number:**

### CONSENT FORM

**Title of research:** *Factors that influence women's experiences of vaginal breech birth*

**Name of researcher:** Jenny Davidson

**Please initial box**

1. The researcher has explained to my satisfaction the purpose, principles and procedures of the study and possible risks involved
2. I confirm that I have read and understand the information sheet dated.....  
(version.....) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
3. I understand I will be interviewed and that this interview will be recorded. I understand the data from the interview will be used by the researcher for this study
4. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.
5. I agree that should I withdraw from the study, the data collected up to that point may be used by the researcher for the purpose described in the information sheet
6. I understand and agree to anonymous quotations from interviews being used to illustrate research findings within publications and disseminated within the public arena

7. I agree to take part in the above study

Name (participant) .....

Dated (by the participant) .....

Signature .....

Name (researcher) .....

Date .....

Signature .....

1 copy to participant; 1 copy to researcher site file

## Appendix 7: List of documents included in documentary analysis

*Documentary analysis is being included to provide additional contextual and secondary data supplementary to the main data from the interviews.*

### Documents were included due to:

- Being mentioned as a source of information / influence by the participants during interview
- Clinical protocols being used at the time the births occurred – the clinical standards expected from the NHS based midwives and doctors

### List of documents

1. Waites, Benna. 2003. *Breech Birth*. Free Association Books
2. Home Birth Reference website:
  - a. <http://www.homebirth.org.uk>
  - b. Fonder: Angela Horn, mother and academic, UK
3. 'Giving birth naturally' website
  - a. <http://www.givingbirthnaturally.com>
  - b. Founder: Catherine Beier. Independent Childbirth Educator, USA
4. Evans, Jane. 2005. *Breech Birth. What are my Options?* Association for the Improvements in the Maternity Services (AIMS). AIMS booklet
5. Clinical Protocols
  - a. XXXXX NHS Trust (published 2006)
6. RCOG, 2006. *Guideline No. 20b. The Management of breech Presentation*. Royal College of Obstetricians and Gynaecologists.
  - a. <https://www.rcog.org.uk/globalassets/documents/guidelines/gtg-no-20b-breech-presentation.pdf>

## Appendix 8: Letter to Partner/Birthing Partner



University of Brighton  
Centre for Nursing and Midwifery Research

Dear

My name is Jenny Davidson. I am a midwife based in Brighton. I am currently setting up a research project as part of my doctorate study at the University of Brighton. In this research I plan to explore and understand the factors that influence women's experiences of breech birth. This will provide insight for childbearing women and for the health professionals who provide care and advice to maternity service users and add to the other information we have about breech birth.

Your partner/birth partner/friend/relative recently gave birth to a baby who was born bottom or feet first and she thinks that you may be interested in taking part in this study. You are under no obligation to volunteer but please read the enclosed information sheet before you make a decision.

If you do decide you would like to participate or wish to ask more questions about the study please contact me on my mobile: 07770704253

This research study, and this letter to you, have been approved by x and y.

Many thanks for taking your time to read this letter.

Best wishes

Jenny Davidson

PhD student, University of Brighton

## Appendix 9 : Interview Prompt Questions

Research tool

12/5/11

### Interview schedule 1

#### Service Users (mothers)

It is envisaged that due to the nature of the interview techniques employed that an initial open question will be followed by a number of exploratory prompts (examples below) that will cover the indicative content outlined.

*Please share with me your experience of the birth of your baby*

Indicative content	Exploratory prompts
Information & knowledge	<p><i>Can you describe what happened and how you felt when you were told your baby was coming bottom/feet first?</i></p> <p><i>How much did you know about breech babies before this moment?</i></p> <p><i>What information were you given or did you find about breech babies, breech births and your options?</i></p> <p><i>What would you share with other mothers/birth partners in similar situations?</i></p> <p><i>What would you share with health professional's caring for women in similar situations?</i></p>
Informed consent	<p><i>How did you come to the decision about where/how to have your baby?</i></p> <p><i>What did you base your decision on?</i></p>
Influences	<p><i>What and or who do you feel were the things that had the most impact, positive or negative, on this experience? Why?</i></p>
Trust	<p><i>Who or what did you trust during your experience? Why?</i></p> <p><i>Did your feelings change at points in your experience? Why?</i></p>
Beliefs and values	<p><i>What do you think this experience has had on you/your beliefs /values /relationships /views?</i></p>
Relationships	<p><i>Which people and how do you think they influenced your birth experience?</i></p> <p><i>Can you recall key moments/ sounds/ events/ information and how they made you feel?</i></p>



### **Interview schedule 3**

#### *Health Professionals*

It is envisaged that due to the nature of the interview techniques employed that an initial open question will be followed by a number of exploratory prompts (examples below) that will cover the indicative content outlined.

*Please share with me your experience of the birth of your/the baby*

Indicative content	Exploratory prompts
Information & knowledge	<p><i>Can you describe what happened and how you felt when you found out the baby/ies was/were breech?</i></p> <p><i>What do you know about breech babies?</i></p> <p><i>What sources of information did you use to share or inform the mother/s about breech birth?</i></p> <p><i>What would you share with other mothers/birth partners in similar situations?</i></p> <p><i>What would you share with health professional's caring for women in similar situations?</i></p>
Informed consent	<p><i>How did the mother decide on how and where to have the baby?</i></p> <p><i>What information did you think helped make that decision?</i></p> <p><i>Who was involved in the decision making and why?</i></p>
Influences	<p><i>What and or who do you feel were the things that had the most impact, positive or negative, on the mother's experience? Why?</i></p>
Trust	<p><i>Who or what do you think did the mother trust during the experience? Why?</i></p> <p><i>Who or what do you think did you trust during the experience? Why?</i></p>
Beliefs and values	<p><i>What do you think this experience has had on you/your beliefs /values /relationships /views?</i></p> <p><i>What do you think this experience has had on the mother/the mother's beliefs / values / relationships /views?</i></p>
Relationships	<p><i>Which people and how do you think they influenced the birth experience?</i></p> <p><i>Can you recall key moments/ sounds/ events/ information and how the mother reacted?</i></p>

## Appendix 10: Initial thoughts following interview

### Reflection on interview

#### Initial thoughts:

Long way to travel... may not have enough time / money to do as many interviews as originally wanted – consider as time continues

..... Ethics

Establishing trust and openness was difficult in short time – this is similar to modern midwifery work. Thought this was ok, but need to consider more techniques (how do i do this in practice)

Think that at times answers were 'what she thought i wanted to hear' – hesitant and didn't flow – lost train of thought – why? Nerves, distress as stress and issues for her around this time. Other terms quite strong even about emotional issues. We has to go back to things during the issue for her to build on what she said

Need to reassure repeatedly on the confidential nature of the interview ..... stopped her ..... may be due to who I was ie an NHS midwife, when she was being negative about NHS workers. Perhaps need to re-iterate this at the beginning – i am a researcher!

Issues about the tape player – more information disclosed once the tape player is turned off. Is this about ownership of the information 'story' power? Or concerns about what i would do with this information. Some political / conflict issues raised – was she worried about my interpretation of this ..... - social constructs) impact of taped interview on the participant – makes it more formal? Less honesty and openness – look into this

Tension felt – conflict for her about how she felt about the NHS (she likes it and wanted to give it a chance) and how her midwife behaved / views (negative about the NHS) that prevented her from this access – power issues.

Interesting about how she felt that a certain point in pregnancy she 'shut down' to information – is this common – if it is it is vital to this particular issue as always discovered and decisions to be made at the end of pregnancy

Also resentful of having to do things to try and turn the baby - ? Distraction / issues of trust in baby / self challenged?

Feel that she had strong identify about self and about birth – this was the key and would have been at the fore in any situation. Clear ideas about what wanted.

My technique:

Better than with pilot! More confident with questions and where and when to lead, try move questions around

~~More open questioning and identified areas to probe further~~

Unsure at times when to dig deeper or not

Jotting notes very helpful – especially to go back to things that were said without stopping the flow of information

Thought the empathy and agreement phrases were encouraging but was this leading or provoking different responses?

Difficult to not be a 'midwife'. Responded to a question with factually correct information after the interview but did not challenge things during the interview

## Appendix 11: An extract of the documentary analysis

Developing a **critique and analysis tool** helped focus the documentary analysis and manage the vast amount of data. The tool, drawn from Critical Discourse Analysis, considered the following elements based on the research questions and linking to the data gathered from the interviews

1. To consider the authenticity and credibility of the documents
2. To consider the value/ status attributed to these documents by the participants when they were mentioned
3. To consider the sources of evidence and knowledge on which the information is based
4. To consider underlying assumptions the documents made about the nature of breech birth
5. To analyse the gendered constructs within the document
6. To analyse the social and cultural constructs within the documents

### Documentary analysis critique and analysis tool:

	<b>Authenticity and credibility</b>	<b>Benna Waites Book</b>	<b>Home Birth Ref Site</b>	<b>Giving Birth Naturally Site</b>	<b>AIMS booklet</b>	<b>Clinical protocol</b>	<b>RCOG guidelines</b>
1	Authorship - who conceived the material	Mother who had a breech baby	Mother who had births at home and hospital	Childbirth educator	Midwife	Obstetrician	Obstetrician
2	Form - what format is the data presented	Book	website	website	Booklet	Protocol	Protocol
3	Function - what is the stated purpose and is this clear	To provide information for women and HP	To provide evidence based information to women	To provide information to women	To provide information to women	To provide guidance to HP	To provide evidence guidance and standards of care to HP
4	Validity - was the content appropriate for the purpose	Yes	Yes	Yes	Yes	Yes	Yes
5	Meaning - is the data clear and comprehensible	Yes	Yes	Yes, although not easy to navigate	Yes	Yes	Yes
	<b>How did the participant 'find' the document</b>	<b>From midwife</b>	<b>On own, searching</b>	<b>On own, searching</b>	<b>From midwife</b>	<b>N/A</b>	
6	Self seeking or directed (by whom)	Directed	Self seeking	Self seeking	Directed	N/A	
	<b>What value did the participant give to the document</b>	<b>Highly, mother to mother</b>	<b>Valued experiential aspect</b>	<b>Valued experiential aspect</b>	<b>Did not express</b>	<b>Did not express value</b>	<b>Was important influence</b>

7	How many participants mentioned this document	1	1	1	2	1	3
8	What elements were valued / not valued	Personal experience valued	Personal experience valued. Likeminded	Personal experience valued. Likeminded	Well written, clear		
	<b>What sources of evidence and knowledge is the document based</b>	<b>References to research and personal reflections</b>	<b>References to research and shared stories from other mothers</b>	<b>Mainly stories with some information, less evidence of where this knowledge came from</b>	<b>References to research, personal reflection and storytelling</b>	<b>Reference to research, mainly RCOG guidelines</b>	<b>Reference to research</b>
9	What underlying assumptions are there about knowledge / knowing	Personal knowledge is important as well as research evidence	Personal knowledge is highly valued, but assumption we need to have research knowledge too	Assumption that knowledge comes from within and is individual and personal	Acknowledges personal journey but presents research knowledge and clinical experience	Research knowledge paramount, no reference to other knowledge sources	Research knowledge paramount, no reference to other knowledge sources
10	What type of evidence is used to support statements and how is this presented	References (academic), personal stories to illustrate points	References (academic), personal stories to illustrate points	Personal stories, + present evidence from research and government statistics	References (academic), personal stories to illustrate points	Referenced research, all quantitative	Referenced research, all quantitative
11	Is there consistency on how evidence and knowledge is considered in the text	Yes	Yes	Yes	Yes	Yes	Yes
12	How is meaning constructed from the evidence / knowledge	Applied to individual, considered alternatives. Multiple meanings	Though personal stories to illustrate	Though personal stories to illustrate points.	Describes implications from each element described	Single meaning based on evidence. Directional for standards of care	Single meaning based on evidence. Directional for standards of care
13	Meaning - is 'factual' data situated within theory and context	Yes	Yes	To a degree, but limited	Yes	Yes	Yes
	<b>What were the underlying assumptions of the nature of breech birth</b>	<b>That it is unusual but can be normal.</b>	<b>Can be a normal birth experience</b>	<b>Not specific for breech, but all birth can be normal healthy</b>	<b>That it is unusual but can be normal</b>	<b>High risk and obstetric led. Requires surgical birth. Deal with as an emergency if unplanned</b>	<b>High risk and obstetric led. Requires surgical birth. Deal with as an emergency if unplanned</b>
14	Are beliefs / paradigms about breech / birth explicit or implicit in the text	Yes, explicit	Yes, explicit	N/A	Not explicit but implicit	Not explicit but implicit	Not explicit but implicit

15	What language is used to describe the nature of breech birth	Some medical terms, some colloquial terms	Mainly non medical	N/A	Mainly medical framework, but has maternal stories throughout	Medical	Medical
	<b>What were the gendered constructs within the document</b>	<b>Acknowledges tensions and power paradigms</b>	<b>Some reference to challenges to achieve the birth you want</b>	<b>Highly values women knowledge and power to birth</b>	<b>Acknowledges tensions and domination of obstetrics on breech</b>	<b>Assumption of medical superiority, limited acknowledgement of women's choice</b>	<b>Assumption of medical superiority, limited acknowledgement of women's choice</b>
16	What language is used that relates to power and equality / inequality	Describes communication	Challenges to the established 'norms'	Extols women's choice and own knowledge as vital. Outlines refusal to routine procedures	Use of 'allow' highlighting control over women with breech delivery.	Lack of choice, Omissions of considering individual circumstances	Limited maternal choice.
17	Are there assumed gendered roles or gendered behaviour	Some about medics / masculine	Home is more gendered female and protective / safe	Assumption that natural birth is positive for women	Some about medics / masculine	Passive patient role	Passive patient role
18	Is there consideration of social and cultural context within the text	Yes, context to family life	Yes, context to relationships and life after birth	Limited, but does consider place of birth	Through personal stories, but limited	Limited and only in terms of hospital culture	No

## Appendix 12: Summary Letter of Approval

### **NRES Committee South East Coast - Kent**

Room 12, 4<sup>th</sup> Floor West  
Charing Cross Hospital  
Fulham Palace Road  
London  
W6 8RF

Tel: 020 3311 0103

Fax: 020 3311 7280

Ms Jenny Davidson  
Practice Development/Audit Lead Midwife  
Brighton & Sussex University Hospitals NHS Trust  
Royal Sussex County Hospital  
Eastern Road  
Brighton  
BN2 5PE

Dear Ms Davidson

**Study title:** What are the factors that influence women's experiences of birthing full term, singleton and vaginal born breech presenting babies

**REC reference:** 11/LO/1497

**Protocol number:** 11/014/DAV

The Research Ethics Committee reviewed the above application at the meeting held on 28 September 2011. Thank you and Professor Valerie Hall for attending to discuss the study.

### **Ethical opinion**

1. The committee asked for clarification of the recruitment procedure, whether it would be 10 participants from the NHS, 10 private patients and 10 Health Care Professionals and would there be 5 partners from the NHS and 5 private or would they be recruited on a first-come, first-served basis. You explained that it would be on a first-come, first-served basis, initially because of the timescale and the PIS specifies they need to recruit as many participants as possible.
2. The committee asked whether you would still go ahead if you were unable to recruit 10 participants. You said yes, although you would like to recruit 10 participants.
3. The committee queried the answer to question A23 of the REC application form "Will interviews / questionnaire or groups discussion include topics that might be sensitive, embarrassing or upsetting, or is it possible that criminal or other disclosures requiring action could occur during the study?" and asked whether the participants will be distressed and is it appropriate for families. You explained that the midwives agreed it was suitable for families, because it will involve women and partners.

4. The committee asked what if just partners are involved and you explained there would be support offered for family members also.
5. The committee explained that the PIS needs to be amended; the confidentiality section states that it will be confidential, which could be incorrect, as you will be using anonymous direct quotes, the PIS and consent form need to include information that there is a small risk the participant could be identified by their quote. Also the word “practical” has been misspelled. You agreed to these changes.
6. The committee asked whether you would be suitably supported and meet this person regularly. You confirmed you would be suitably supported, as you have 3 supervisors and meet them regularly.
7. The committee asked about the role of the gatekeeper and how it will be decided which gatekeeper is involved and whether they will be prepared. You explained you had approached the Head of Midwifery and Trust and asked who would be suitable. They suggested someone who had research experience; both are clinicians and can access data. They will be prepared as you will explain the expected inclusion and exclusion criteria and process; you have met one gatekeeper face-to-face already and have spoken on the phone to the other, but will meet again and give all the correct paperwork and go through the inclusion and exclusion criteria again.
8. The committee asked whether the gatekeeper will approach participants and you confirmed this is correct.
9. The committee informed you it thought this study was good and very well presented.

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

### **Ethical review of research sites**

#### **NHS Sites**

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see “Conditions of the favourable opinion” below).

### **Conditions of the favourable opinion**

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

*Management permission (“R&D approval”) should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.*

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.



*Where a NHS organisation’s role in the study is limited to identifying and referring potential participants to research sites (“participant identification centre”), guidance should be sought from the R&D office on the information it requires to give permission for this activity.*

*For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.*

*Sponsors are not required to notify the Committee of approvals from host organisations*

1. Include a sentence in the Participant Information Sheet and Consent Form “Direct quotes will be anonymised in the report, but there is a small chance that the participant may be identified.”
2. Change the wording in the confidentiality section of the Participant Information Sheet to “I will follow ethical and legal practice” rather than practical.

**It is responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).**

**You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. Confirmation should also be provided to host organisations together with relevant documentation**

#### **Approved documents**

The documents reviewed and approved at the meeting were:

<i>Document</i>	<i>Version</i>	<i>Date</i>	
Advertisement	1	14 March 2011	
Covering Letter		24 August 2011	
Evidence of insurance or indemnity		04 July 2011	
Interview Schedules/Topic Guides	1: Interview Schedule 1 - Service Users (Mothers)	12 May 2011	
Interview Schedules/Topic Guides	1: Interview Schedule 2 - Family Members and Birthing Partners	12 May 2011	
Interview Schedules/Topic Guides	1: Interview Schedule 3 - Health Professionals	12 May 2011	
Investigator CV	Jenny Davidson		
Letter from Sponsor	Email from Prof Julie Scholes	28 June 2011	
Letter of invitation to participant	1: Women	25 March 2011	
Letter of invitation to participant	1: Partners	25 March 2011	

Other: Academic Supervisor CV	Prof Valerie Hall		
Other: Student CV	(Same as CI CV)		
Other: Confirmation of Pre-Engagement Check	1: To East Sussex Healthcare NHS Trust	11 July 2011	
Other: Confirmation of Pre-Engagement Check	1: To Western Sussex Hospitals NHS Trust	11 July 2011	
Other: Emails from Data Collection Sites Confirming Support		17 March 2011	
Participant Consent Form	1	15 March 2011	
Participant Information Sheet: for Women	1	15 March 2011	
Participant Information Sheet: for Partners	1	15 March 2011	
Participant Information Sheet: for Health Professionals	1	15 March 2011	
Protocol	1	12 May 2011	
REC application		18 August 2011	

### **Membership of the Committee**

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

### **Statement of compliance**

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

### **After ethical review**

### Reporting requirements

The attached document “After ethical review – guidance for researchers” gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

### Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

**11/LO/1497**

**Please quote this number on all correspondence**

With the Committee’s best wishes for the success of this project

Yours sincerely

**Dr Ray Godfrey**  
**Chair**

Email: [Sharon.Busbridge@nhs.net](mailto:Sharon.Busbridge@nhs.net)

*Enclosures: List of names and professions of members who were present at the meeting and those who submitted written comments*

*“After ethical review – guidance for researchers”*

*Copy to: Mr Scott Harfield, Brighton & Sussex University Hospitals NHS Trust*

### NRES Committee South East Coast - Kent

#### Attendance at Committee meeting on 28 September 2011

**Committee Members:**

<i>Name</i>	<i>Profession</i>	<i>Present</i>	<i>Notes</i>	
Dr Ray Godfrey (Chair)	Statistician	Yes		
Dr Jim Appleyard	Retired Paediatrician	Yes		
Mrs Carole Brooks	Psychotherapist	Yes		
Mrs Helen Burn	Head of Pharmacy	Yes		
Mr Neal Clifton	Teacher	Yes		
Mrs Beverly Donaldson	Midwife	Yes		
Professor V M Mathew	Consultant Psychiatrist	No		
Mrs Liz Moorut	Chief Biomedical Scientist	Yes		
Ms Lynda Pearce	Membership Engagement Manager	Yes		
Dr Brijender Rana	Consultant in Public Health	No		
Mrs Amanda Richardson	Neonatal Sister	Yes		
Mrs Sue Rogers	Managing Director of a Trade Association	No		
Dr Amit Saha	Consultant Rheumatologist	No		
Mrs Heather Salzer	Ultrasound Clinical Specialist I	Yes		
Mr John Skilton	Senior Biomedical Scientist	No		
Mr Mike Tatlow	Health Informaticist	No		
Mrs Maureen Williams	Senior Lecturer Midwifery	No		

**Also in attendance:**

<i>Name</i>	<i>Position (or reason for attending)</i>	
Miss Sharon Busbridge	Co-ordinator	

From NHS Trust



[REDACTED] NHS Research Consortium

Research Consortium Office

[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
Tel: [REDACTED]  
Fax: [REDACTED]  
[REDACTED]

Ms. Jenny Davidson  
Practice Development/Audit Lead Midwife  
Brighton & Sussex University Hospital NHS  
Trust  
Royal Sussex County Hospital  
Eastern Road  
Brighton  
BN2 5PE

29/08/2013

Dear Ms. Davidson,

**Our ID: 1460/NOCI/2011**

**TITLE: What are the factors that influence women's experiences of birthing full term, singleton and vaginal born breech presenting babies.**

Thank you for your application to the [REDACTED] NHS Research Consortium for research governance approval of the above named study.

I am pleased to inform you that the study has been approved, and so may proceed. This approval is valid in the following Organisations:

- [REDACTED] Hospitals NHS Trust

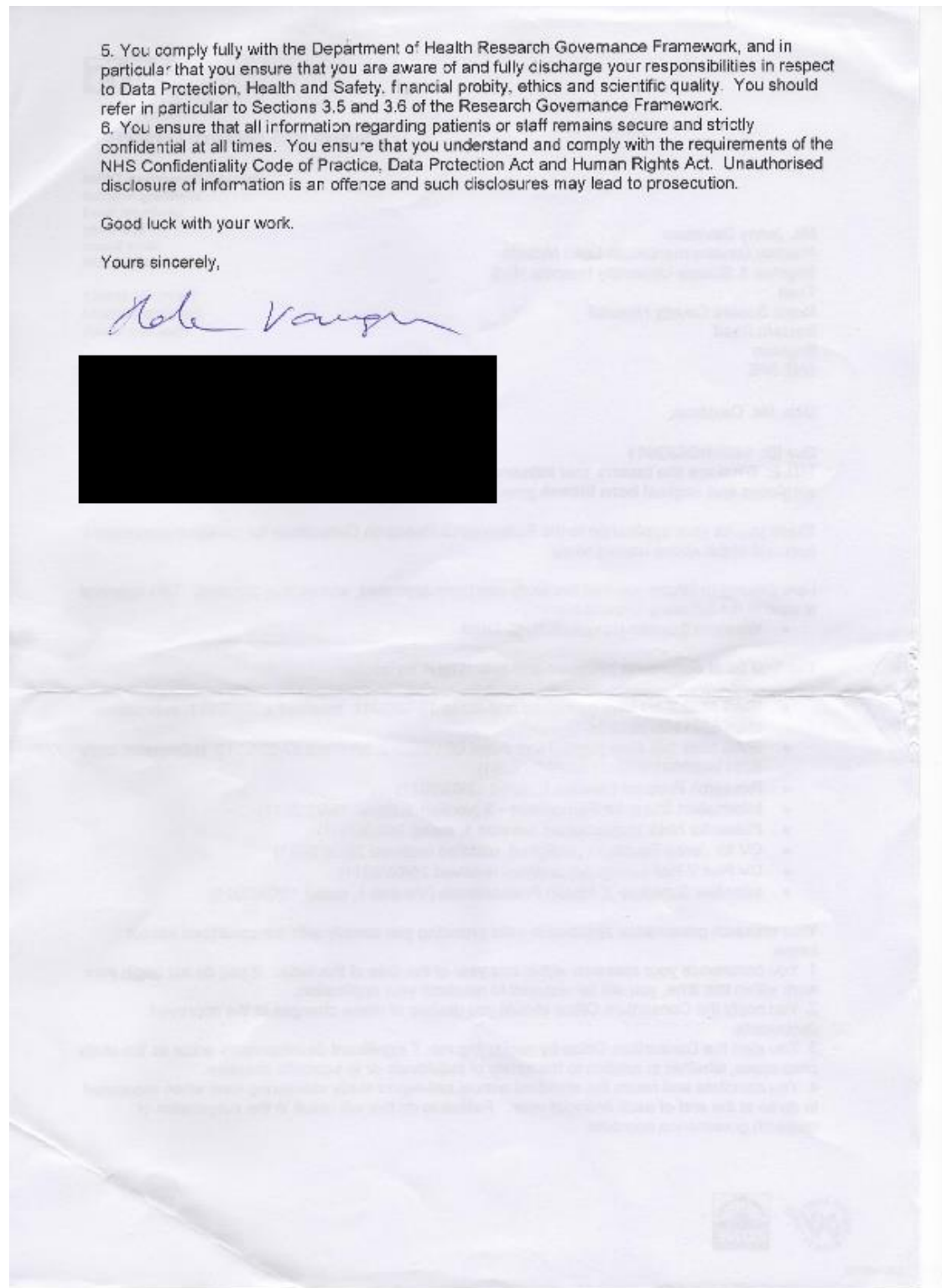
The final list of documents reviewed and approved is as follows:

- IRAS NHS R&D form (unsigned and dated 18/08/2011, received 25/08/2011: submission code 62511/243613/14/1)
- IRAS NHS SSI form (signed and dated 05/08/2013, received 27/08/2013: submission code 62511/485881/6/661/116669/278261)
- Research Protocol (version 1, dated 12/05/2011)
- Information Sheet for Participants - 3 (version 1, dated 15/03/2011)
- Poster for NHS professionals (version 1, dated 14/03/2011)
- CV for Jenny Davidson (unsigned, undated received 25/08/2011)
- CV Prof V Hall (unsigned, undated received 25/08/2011)
- Interview Schedule 3, Health Professionals (Version 1, dated 12/05/2011)

Your research governance approval is valid providing you comply with the conditions set out below:

1. You commence your research within one year of the date of this letter. If you do not begin your work within this time, you will be required to resubmit your application.
2. You notify the Consortium Office should you deviate or make changes to the approved documents.
3. You alert the Consortium Office by contacting me, if significant developments occur as the study progresses, whether in relation to the safety of individuals or to scientific direction.
4. You complete and return the standard annual self-report study monitoring form when requested to do so at the end of each financial year. Failure to do this will result in the suspension of research governance approval.





5. You comply fully with the Department of Health Research Governance Framework, and in particular that you ensure that you are aware of and fully discharge your responsibilities in respect to Data Protection, Health and Safety, financial probity, ethics and scientific quality. You should refer in particular to Sections 3.5 and 3.6 of the Research Governance Framework.

6. You ensure that all information regarding patients or staff remains secure and strictly confidential at all times. You ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice, Data Protection Act and Human Rights Act. Unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

Good luck with your work.

Yours sincerely,

*Ade Vaughan*



**From Independent Midwives**

>> From: [REDACTED]  
>> Sent: 29 December 2011 16:42  
>> To: Davidson, Jenny  
>> Subject: Re: Breech birth research

Hi Jenny

Just got in and was about to press send on the draft email below (wrote it on the train but didn't have internet access) when your message came in - great minds and all that.....

Hope you have had a lovely Christmas, I am pleased to report that the Board is in full agreement that IM UK should facilitate our members involvement in your research proposal and I've confirmed that [REDACTED], our database co-ordinator, is able and willing to select the relevant information out of the database.

I think the next step is for me to send out an email to the whole membership letting them know this has been agreed and that any midwives identified as fitting into the criteria will be contacted in due course by the gatekeeper, currently me but I am considering asking [REDACTED] - who has agreed to the project as an IM UK Board member - if she will fulfil this role as I am just embarking on a very challenging period with our [REDACTED] project. Does it make a difference who the gatekeeper is from your point of view?

Also, do you have any objections to me sending out your proposal in full to any of our members interested in reading it?

best wishes

[REDACTED]

## Appendix 13: Information Sheet



University of Brighton  
Centre for Nursing and Midwifery Research

### Taking Part in Research – Information Sheet for Participants (1)

I would like to invite you to take part in a research project. Here is some information to help you decide whether or not to take part. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything you do not understand or if you would like more information. Take time to decide whether or not you wish to take part.

#### ***What is the research for?***

This study is part of my doctorate study and aims to explore the factors that influence women's experiences of vaginal breech birth (babies that are born bottom or feet first)

#### ***What will I be trying to find out?***

I want to identify, explore and understand the factors that influence women's experiences of vaginal breech birth. This will provide insight for childbearing women and for health professionals providing care and advice to maternity service users and add to the other information we have about vaginal breech birth.

#### ***Why have I been invited?***

You recently gave birth to a baby who was born bottom or feet first and I hope that you may be willing to share your experiences. This information sheet will tell you more information to help you decide.



### ***Do I have to take part?***

It is up to you to decide whether or not to take part. You do not have to; this is a voluntary process. If you wish to discuss taking part in the research you can call me to ask questions, my details are at the bottom of this information sheet. A midwife colleague helping me to recruit to this study will call you in about a week to ask you if you would like to take part. If you decide not to take part you just need to tell the midwife and you will not be contacted again. If you wish to call the midwife before this time to tell them you do not want to take part please call 01273 696955 ext xxx.

If you do decide to take part the midwife colleague will pass on your contact detail to me and I will call you to discuss the research further and arrange a time to meet. You will be given this information sheet to keep and be asked to sign a consent form.

If you decide to take part you are still free to withdraw from the study at any time and without giving a reason. A decision to not to take part will not affect any future relationship you may have with me or your present or future care within the health services

### ***If I agree to take part will I definitely be part of the study?***

I am hoping to interview about 10 women to this research study so most of the women who volunteer will probably be included.

I will need to ensure that each of the people who volunteer fit the criteria to be included in the study (this will be things like when you had your baby, how you had your baby etc). I will check with you prior to the interview that you fully understand your involvement in the study and that you fit the inclusion criteria. If you do not fit the inclusion criteria you may not be recruited, but you will be thanked for your offer to volunteer. I can provide you with a resource list with information about where you may receive support and information should you require it.

### ***What will happen to me if I take part?***

If you decide to take part I will call you to arrange a mutually convenient time and place suitable to come and interview you

I would like you to tell me about your childbirth experience and answer some general questions about what happened and how you felt about it. I would come to a place of your choice, your home or elsewhere, where we would talk for about an hour. I would record the interview but it would only be heard by me and no one else would hear what was said unless I am legally bound to share it (for example if you disclose criminal activity). I have had training for undertaking research and have had experience of doing research interviews before so what you say will be private and used just for this study. I will ensure that all the information you share with me will be kept confidential as it will be kept securely and no names or locations will be used when the study is written up.

After the first interview I will look at the information you have given me. Within the following 4 weeks I will ask for another meeting with you in person or by phone to discuss my understanding of what you told me at the first meeting. I may need to do this several times.

I will be able to pay any travel expenses you may have if you need to travel to the interview.

At the end of the interview/s I will ask you to think if there was any family member or friend who was particularly influential during your birth experience. I will ask you if you would consider passing on an information sheet and invitation to the family member or friend inviting them to be interviewed for this study to share their experience of the birth. If you cannot think of anyone or would prefer not to invite anyone it will not be a problem or affect your own participation in the study.

***Will taking part affect me in any way?***

The interviews and discussions will take up some of your time. You will be asked to give up about an hour of your own time to be interviewed initially. The follow up discussions may take a varying amount of time but no longer than an hour each time.

I will ask you to share your childbirth experience with me which could be emotional or distressing. If you do get upset I will be understanding and offer you support and you will have the option of continuing or stopping the interview. If you want me to I will put you in touch with other support available.

***What are the advantages of taking part?***

By participating you will contribute to helping to provide a better understanding for maternity service users & health professionals providing care before and during a birth of a baby coming bottom or feet first.

You may find it helpful to share your birth experience with me as you revisit a momentous event in your life. Talking about an event like birth can potentially lead to a better understanding of what it meant for you and those around you.

***Will my taking part in the study be kept confidential?***

Yes. I will follow ethical and legal practical and all information about you will be handled in confidence.

### **What if there is a problem?**

If you are unhappy about anything relating to this study you can speak to me and I will do my best to answer your questions. If you remain unhappy you can talk to Angie Hart (independent researcher) at the University (tel: 01273 644051) or you can talk to a Jude Piper (a Supervisor of Midwives) (tel: 01273 696955 ext 4385) both of whom have agreed to talk to anyone about this study and are independent from this study.

### ***What happens when the research stops?***

At the end of the research I will write a report and share the findings with maternity service users, their families and health professionals though publication in journals, discussions at conferences and teaching.

If you would like I will send you a summary of the research when it is completed

### ***Who is doing the research?***

I am doing this research as a research student on an academic course at the University of Brighton. A midwife at the NHS Trust where you had your baby is helping me find the women like you who have had a bottom first baby, but no one will know if you have decided to join the study except me.

There is no funding for this research. The research is going to be carried out by myself under supervision of Professor Val Hall at the University of Brighton. Before any research goes ahead it has to be checked by a Research Ethics Committee. They make sure that the research is fair. This project has been approved by the Research Ethics Committee.

If you want to know more please contact me: *Jenny Davidson* (Mobile 07770704253 or e-mail: [jenny.davidson@bsuh.nhs.uk](mailto:jenny.davidson@bsuh.nhs.uk)).

**Thank you for reading this information sheet and for taking time to consider**



## Taking Part in Research – Information Sheet for Participants (2)

I would like to invite you to take part in a research project. Here is some information to help you decide whether or not to take part. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything you do not understand or if you would like more information. Take time to decide whether or not you wish to take part.

### ***What is the research for?***

This study is part of my doctorate study and aims to explore the factors that influence women's experiences of vaginal breech birth (babies that are born bottom or feet first)

### ***What will I be trying to find out?***

I want to identify, explore and understand the factors that influence women's experiences of vaginal breech birth. This will provide insight for childbearing women and for health professionals providing care and advice to maternity service users and add to the other information we have about vaginal breech birth.

### ***Why have I been given this information sheet?***

Your partner/birth partner/friend/relative recently gave birth to a baby who was born bottom or feet first. She thinks that you may be interested in taking part in this study. This information sheet will tell you more information to help you decide.

***Do I have to take part?***

It is up to you to decide whether or not to take part. You do not have to; this is a voluntary process, you can approach or phone me if you wish to discuss taking part in the research. If you do decide to take part please contact me on the telephone number at the bottom of this form. I will ask to meet with you to discuss the research study and your involvement and ask you to sign a consent form.

If you decide to take part you are still free to withdraw at any time during the study and without giving a reason. A decision to not to take part will not affect any future relationship you may have with me or your present or future care within the health services

***If I agree to take part will I definitely be part of the study?***

I am hoping to interview about 10 partners/birth partners/friends/relatives in this research study and will continue to recruit until sufficient numbers have been reached or as time allows. I can provide you with a resource list with information about where you may receive support and information should you require it.

***What will happen to me if I take part?***

I would like you to tell me about your partners/friends/relatives childbirth experience from your point of view. I would come to a place of your choice, your home or elsewhere, where we would talk for about an hour. I would record the interview but it would only be heard by me and no one else would hear what was said unless I am legally bound to share it (for example if you disclose criminal activity). I have had training for undertaking research and have had experience of doing research interviews before so what you say will be private and used just for this study. I will ensure that all the information you share with me will be kept confidential as it will be kept securely and no names or locations will be used when the study is written up

After the first interview I will look at the information you have given me. Within the following 4 weeks I will ask for another meeting with you in person or by phone to discuss my understanding of what you told me at the first meeting. I may need to do this several times.

I will be able to pay any travel expenses you may have if you need to travel to the interview/s

***Will taking part affect me in any way?***

The interviews and discussions will take up some of your time. You will be asked to give up about an hour of your own time to be interviewed initially. The follow up discussions may take a varying amount of time but no longer than an hour each time.

I will be asking you to share personal experiences with me which could be emotional or distressing. If you do get upset I will be understanding and offer you support and you will have

the option of continuing or stopping the interview. If you want me to I will put you in touch with other support available.

***What are the advantages of taking part?***

By participating you will contribute to helping to provide a better understanding for maternity service users & health professionals providing care before and during a birth of a baby coming bottom or feet first.

You may find it helpful to share your personal experiences with me as you revisit a momentous event in your life. Talking about an event like birth can potentially lead to a better understanding of what it meant for you and those around you.

***Will my taking part in the study be kept confidential?***

Yes. I will follow ethical and legal practical and all information about you will be handled in confidence.

***What if there is a problem?***

If you are unhappy about anything relating to this study you can speak to me and I will do my best to answer your questions. If you remain unhappy you can talk to Angie Hart (independent researcher) at the University (tel: 01273 644051) or you can talk to a Jude Piper (a Supervisor of Midwives) (tel: 01273 696955 ext 4385) both of whom have agreed to talk to anyone about this study and are independent from this study.

***What happens when the research stops?***

At the end of the research I will write a report and share the findings with maternity service users, their families and health professionals though publication in journals, discussions at conferences and teaching.

If you would like I will send you a summary of the research when it is completed

***Who is doing the research?***

I am doing this research as a research student on an academic course at the University of Brighton. There is no funding for this research. The research is going to be carried out by myself under supervision of Professor Val Hall at the University of Brighton. Before any research goes ahead it has to be checked by a Research Ethics Committee. They make sure that the research is fair. This project has been checked by the Research Ethics Committee.

If you want to know more please contact me: *Jenny Davidson* (Mobile - 07770704253 or e-mail: [jenny.davidson@bsuh.nhs.uk](mailto:jenny.davidson@bsuh.nhs.uk) )..

**Thank you for reading this information sheet and for taking time to consider participating in this study**



## Taking Part in Research – Information Sheet for Participants (3)

I would like to invite you to take part in a research project. Here is some information to help you decide whether or not to take part. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything you do not understand or if you would like more information. Take time to decide whether or not you wish to take part.

### ***What is the research for?***

This study is part of my doctorate study and aims to explore the factors that influence women's experiences of vaginal breech birth (babies that are born bottom or feet first)

### ***What will I be trying to find out?***

I want to identify, explore and understand the factors that influence women's experiences of vaginal breech birth. This will provide insight for childbearing women and for health professionals providing care and advice to maternity service users and add to the other information we have about vaginal breech birth.

### ***Why have I been given this information sheet?***

Within the last 4 years you have provided care for a women or women having vaginal breech births. You have shown interest in taking part and I hope that you may be willing to share your experiences. This information sheet will tell you more information to help you decide.

### ***Do I have to take part?***



It is up to you to decide whether or not to take part. You do not have to; this is a voluntary process, you can approach or phone me if you wish to discuss taking part in the research. If you do decide to take part please contact me on the number at the bottom of this sheet. I will arrange a time and place to meet you and ask you to sign a consent form.

If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to not to take part will not affect any future relationship you may have with me or your present work.

***If I agree to take part will I definitely be part of the study?***

I am hoping to interview about 10 health professionals to this research study.

I will need to ensure that each of the people who volunteer fit the criteria to be included in the study (this will be things like when the breech birth experiences occurred, where they occurred etc). I will check with you prior to the interview that you fully understand your involvement in the study and that you meet the inclusion criteria. If you do not meet the inclusion criteria you may not be recruited, but you will be thanked for your offer to volunteer. I can provide you with a resource list with information about where you may receive support and information should you require it.

***What will happen to me if I take part?***

I would like you to tell me about breech birth experience/s from your point of view. I would come to a place of your choice, your home or elsewhere, where we would talk for about an hour. I would record the interview but it would only be heard by me and no one else would hear what was said unless I am legally bound to share it (for example if you disclose criminal activity). I have had training for undertaking research and have had experience of doing research interviews before so what you say will be private and used just for this study. I will ensure that all the information you share with me will be kept confidential as it will be kept securely and no names or locations will be used when the study is written up

After the first interview I will look at the information you have given me. Within the following 4 weeks I will ask for another meeting with you in person or by phone to discuss my understanding of what you told me at the first meeting. I may need to do this several times.

I will be able to pay any travel expenses you may have if you need to travel to the interview/s

***Will taking part affect me in any way?***

The interviews and discussions will take up some of your time. You will be asked to give up about an hour of your own time to be interviewed initially. The follow up discussions may take a varying amount of time but no longer than an hour each time.

I will be asking you to share experiences with me which could be emotional or distressing. If you do get upset I will be understanding and offer you support and you will have the option of continuing or stopping the interview. If you want me to I will put you in touch with other support available.

**Will my taking part in the study be kept confidential?**

Yes. I will follow ethical and legal practical and all information about you will be handled in confidence.

***What are the advantages of taking part?***

By participating you will contribute to helping to provide a better understanding for maternity service users & health professionals providing care before and during a birth of a baby coming bottom or feet first.

You may find it helpful to share your personal experiences with me as you revisit an unusual birth experience. Talking about an event like birth can potentially lead to a better understanding of what it meant for you and those around you.

**What if there is a problem?**

If you are unhappy about anything relating to this study you can speak to me and I will do my best to answer your questions. If you remain unhappy you can talk to Angie Hart (independent researcher) at the University (tel: 01273 644051) or you can talk to a Jude Piper (a Supervisor of Midwives) (tel: 01273 696955 ext 4385) both of whom have agreed to talk to anyone about this study and are independent from this study.

***What happens when the research stops?***

At the end of the research I will write a report and share the findings with maternity service users, their families and health professionals though publication in journals, discussions at conferences and teaching.

If you would like I will send you a summary of the research when it is completed

***Who is doing the research?***

I am doing this research as a research student on an academic course at the University of Brighton. There is no funding for this research. The research is going to be carried out by myself under supervision of Professor Val Hall at the University of Brighton. Before any research goes ahead it has to be checked by a Research Ethics Committee. They make sure that the research is fair. This project has been approved by the Local Research Ethics Committee.

If you want to know more please contact me: *Jenny Davidson* (Mobile - 07770704253 or e-mail: [jenny.davidson@bsuh.nhs.uk](mailto:jenny.davidson@bsuh.nhs.uk)).

**Thank you for reading this information sheet and for taking time to consider participating  
in this study**

## Appendix 14: Overview of locally reported breech births

### National Data

NHS Maternity statistics 2010-11

<http://www.hscic.gov.uk/catalogue/PUB03071/nhs-mate-eng-2010-2011-rep.pdf>

Description	2010/11	2009/10	2008/9
Spontaneous vertex	404,373	394,348	392,692
LSCS elective	65,760	63,386	61,805
LSCS emergency	96,760	93,970	93,009
Breech	2,535	2,544	2,365
Breech extraction*	294	385	344

\*breech extraction is full manipulation of the baby, often including instruments, by the health professional to deliver the baby vaginally

### Locally reported breech numbers from (anonymised) NHS Trust

	2010/11	2009/10	2008/9
Total number of births	5968	5979	5868
Total number normal vaginal births	3521	3426	3286
Total caesarean section deliveries	1722	1719	1792
Total number vaginal breech births*	16	25	19

\*there was no data available to distinguish between breech birth and breech extraction

## Appendix 15: Resources Sheets



### Resources for women & birth partners

If you would like to talk to someone about your birth please contact your local maternity unit and ask to speak to a **Supervisor of Midwives**. A Supervisor of Midwives is an experienced midwife who has undertaken an extra course in order to fulfil this role. Supervisor of Midwives can act as a resource and assist in discussions with women and provide advice and support.

If you had your pregnancy and birth care with an NHS Trust you can also contact the **Patient Advice and Liaison Services (PALS)**. PALS ensure that the NHS listens to patients, their relatives, carers and friends, and answers their questions and resolves their concerns as quickly as possible. The website link is: <http://www.pals.nhs.uk> or you can phone the main switchboard of the Hospital and ask for the PALS office.

*The following are other sources of information and support that you may find helpful.*

#### **Books on breech birth**

*Breech Birth: A Guide to Breech Pregnancy and Birth* by Benna Waites. Published by Free Association Books in 2003. ISBN 9781853435638

*Breech Birth – Woman Wise* by Maggie Banks. Published by Ace graphics in 2004. ISBN: 0-473-04991-0

#### **Support and information:**

National Childbirth Trust: offer antenatal and postnatal courses, local support and reliable information to help all parents. Telephone: 0300 330 0773. Website: <http://www.nct.org.uk/home>

The Birth Trauma Association (BTA) was established in 2004 to support women suffering from Post Natal Post Traumatic Stress Disorder (PTSD) or birth trauma. Postal address: Birth Trauma Association, PO Box 671, Ipswich, Suffolk. IP1 9AT. Website: <http://www.birthtraumaassociation.org.uk>

General information about breech birth and links to other breech websites: <http://www.pregnancy.com.au/birth-choices/breech-birth/index.shtml>

Guidelines from the Royal College of Obstetrics and Gynaecology about breech presenting babies: <http://www.rcog.org.uk/womens-health/clinical-guidance/breech-baby-end-pregnancy>



## Resources for Health Professionals

### **Midwives:**

If you have any clinical or professional questions or concerns that have arisen from participating in this study please contact your Supervisor of Midwives for further support and discussion. Local Supervisors of Midwives have been informed that this research is taking place

### **Obstetricians:**

If you have any clinical or professional questions or concerns that have arisen from participating in this study please contact your Educational Supervisor or Head of Department for further support and discussion.

*The following are other sources of information and support that you may find helpful:*

### **Books on breech birth**

*Breech Birth: A Guide to Breech Pregnancy and Birth* by Benna Waites. Published by Free Association Books in 2003. ISBN 9781853435638

*Breech Birth – Woman Wise* by Maggie Banks. Published by Ace graphics in 2004. ISBN: 0-473-04991-0

### **Articles and research on breech birth**

Guidelines from the Royal College of Obstetrics and Gynaecology about breech presenting babies: <http://www.rcog.org.uk/womens-health/clinical-guidance/breech-baby-end-pregnancy>

Goffinet F, Carayol M, Foidart J, Alexander S, Uzan S, Subtil D and Breart G. (2006). Is planned Vaginal Breech Presentation at term still an option? Results of an observational prospective survey in France and Belgium. *American Journal of Obstetrics and Gynaecology*. 194:1002-11

Walton, L (2009). Power, Places and spaces: issues for women in labour. *Midwifery Matters* 3: 12

Hannah ME, Hannah WJ, Hewson SA, Hodnett ED, Saigal S, Willan AR. (2000) Planned caesarean section versus planned vaginal birth for breech presentation at term; a randomised multicentre trial. *Lancet*. **356**: 1375–1383

## Appendix 16: Poster for NHS Professionals

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Have you been the lead health professional at a vaginal breech birth?

Then I'm a doctoral student interested in talking to you!

If...

**The birth/s occurred between January 2006 & September 2010**

**The baby was singleton, full term & alive at birth**

**The case is not under current legal or professional review**

And...

You are interested in taking part in a qualitative research study into **women's experiences of vaginal breech birth**

*You are willing to share your professional experiences in confidential one to one interviews.*

Then please contact me for further information & details:

Jenny Davidson mobile: 07828182737 e-mail: [jd230@brighton.ac.uk](mailto:jd230@brighton.ac.uk)

*Many thanks for your time and support*