Women's motivations for having unassisted childbirth or high-risk homebirth: An exploration of the literature on 'birthing outside the system'

Lianne Holten, RM PhD (Lecturer/Researcher), Esteriek de Miranda, RM PhD (Senior Researcher)

A Department of Midwifery Science, AVAG and the EMGO Institute for Health and Care Research, VU University Medical Center Amsterdam, Vlaardingelaan 1, 1059 GL Amsterdam, The Netherlands

B Department of Obstetrics & Gynaecology, Academic Medical Center, P.O.B. 22660, 1100 DD Amsterdam, The Netherlands

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Objective: to identify and analyze literature exploring women’s motivations to ‘birth outside the system’.

Design: scoping review and thematic analysis of (mostly) qualitative studies.

Findings: fifteen studies of women choosing an unassisted birth, homebirth in countries where homebirth was not integrated into the maternity care system, or a midwife-attended high-risk homebirth were identified from Sweden, USA, Australia, Canada and Finland. Five main themes emerged as the most important factors: (1) resisting the biomedical model of birth by trusting intuition, (2) challenging the dominant discourse on risk by considering the hospital as a dangerous place, (3) feeling that true autonomous choice is only possible at home, (4) perceiving birth as an intimate or religious experience, and (5) taking responsibility as a reflection of true control over decision-making.

Key conclusions: concerns over consent, intervention and loss of the birthing experience may be driving women away from formal healthcare. There is a lack of fit between the health needs of pregnant women and the current system of maternity care. Biomedical and alternative ‘outside the system’ discourses on authoritative knowledge, risk, autonomy and responsibility must be negotiated to find a common ground wherein a dialogue can take place between client and health professional.

Implications for practice: more research is needed to explore the scope of the phenomenon of women birthing outside the system and the experiences of midwives and obstetricians in the care of such women. This knowledge can be used to improve the maternity care system, so that fewer women will choose to withdraw from it.

Introduction

In 2013, lawsuits against three Dutch midwives spurred a discussion about women’s freedom of choice in maternity care and what to do if a woman chose to birth ‘outside the system’. The lawsuits all concerned homebirths of high-risk pregnancies (two twin births and one breech birth). The women had all expressed their wish to birth at home against medical advice. Ultimately, two of the midwives were reprimanded and one lost her license (although, after appeal, her verdict was modified to a temporary suspension by the Central Medical Council). What these lawsuits had in common was that the wishes of the women did not correspond to what the health professional (the midwife), according to protocol, could offer.

In the Netherlands, a group of midwives and women aim to protect birth against medicalisation by contextualising individual risk and preventing unnecessary interventions, thus departing from professional guidelines if necessary. A growing group of pregnant women choose not to adhere to the interdisciplinary agreements for referral from primary to secondary obstetrical care as stated in the nationwide guideline ‘List of Obstetric Indications’ (VII). This group includes women with a medical indication for secondary care who refuse obstetric interventions and/or insist on a midwife-attended homebirth. There are also women who withdraw from maternity care (the ‘system’) altogether.

*Corresponding author.
E-mail addresses: Lianne.Holten@inholland.nl (L. de Miranda).
1 The expression ‘birthing outside the system’ was first used by Jackson et al. (2012) in an article ‘Birthing outside the system: Perceptions of risk amongst Australian women who have freebirths and high risk homebirths’, that described the situation in Australia.
estimated that each year approximately 200 women have planned unassisted childbirth (also called freebirth) (Verbeek, 2013). The common ground for these choices is women taking control of their birthing experience.

This is not only a Dutch phenomenon. In 2013, in Australia, an enquiry was made into the deaths of three babies born at home in a state where publically funded homebirth was not available (Rigg et al., 2015). Midwives in Australia, the US, the UK, Finland, Sweden and Norway increasingly have to address demands for antenatal and perinatal care that fall outside professional norms and guidelines (Viisainen, 2001; Gasline 2007; Lundgren, 2010; Blix, 2011; Duckett, 2012; Dove and Muir-Cochrane, 2014). These show that midwives perceive a mismatch between maternity service delivery and what some pregnant women want. Midwives express concerns about rising litigation that results in midwives not providing services to women who refuse conventional care. This is a problem, not only because midwives fear litigation, also because they fear that women who birth outside the system are not receiving adequate, let alone optimal, care and that women’s rights to choose how, where and with whom to birth are not being respected. This is leading midwives to question their own professional and ethical boundaries.

The Royal Dutch Association of Midwives (KNOV) and the Netherlands Society of Obstetrics and Gynaecology are presently creating a guideline on how to manage women’s care needs that deviate from the norm. Before an adequate guideline can be developed, insight into the increasing lack of fit between the Dutch maternity system and Dutch women’s health needs is required. Therefore, the WONDER study (Why Women Want Other or No Delivery care), a mixed-methods study, will explore the motives of Dutch women who wish to ‘birth outside the system’, and the experiences of the health care professionals involved in their care (WONDER studie, 2015).

A medical anthropological approach was used in a thematic synthesis of the literature (Thomas and Harden, 2008). The design was a scoping study (Arksey and O’Malley, 2005), which addressed broad topics for which multiple study designs might be applicable. While Feeley et al. (2015) conducted a review of the literature on unassisted childbirth alone, our review had the broader topic of women wanting care outside of the norm of their maternity care system. While a systematic review aims to answer research questions from a relatively limited collection of research assessed for quality, a scoping study does not necessarily address specific research questions, nor does it evaluate the quality of selected studies. The aim of this literature exploration was to identify important or recurring themes on women’s motivations to birth outside the system. These themes will be used in designing a relevant survey and interview questions as part of the WONDER study.

Methods

Identification of articles

In July 2015, relevant literature on women’s motivations to choose unassisted childbirth, assisted high-risk homebirth or to refuse obstetrical interventions was identified. The search was iterative rather than pre-planned to seek all available concepts until conceptual saturation was achieved (cf. Tong et al., 2012). Computer searches of published and grey literature, hand searches of journals and a scan of reference lists of relevant papers were performed (cf. the COSI model; Bidwell and Jensen, 2012). The core search was done by both authors using available databases: Pubmed, MEDLINEComplete, PsycINFO, Academic Search Elite, Psychology, and Behavioural Science Collection. The following terms: home childbirth, home birth, midwife, unassisted (child) birth, freebirth, patient dropouts, patient acceptance of healthcare, treatment refusal, patient elopement, care avoidance, avoidance behaviour, informed refusal were used to search for articles published between 2000–2015 in English or Dutch with an abstract. Exclusion criteria were articles on maternity care in Africa or Asia, Southern (low income) countries often grapple with other problems than Western (high income) countries such as accessibility and quality of maternity care. Therefore literature from countries with a comparable standard of living were chosen. The review was updated in October 2015.

Because this was a broad search, many articles were identified on subjects such as satisfaction with midwifery models of care, women’s experiences of labour, antenatal counselling, and preference for place of birth. These articles were first screened by abstract and then full text for direct reference to the subjects of unassisted childbirth or high-risk home birth or home birth in countries where home birth is not institutionalised. Subsequently a search of references cited in retrieved articles and hand searching of key journals (electronic journals Birth and Midwifery) was undertaken. Additionally Pubmed and a general search engine (Google Scholar) was used to further focus on autonomy, risk (perception), decision making and maternal rights in maternity care. Ultimately, a search of the website of the KNOV, including the Dutch Journal for Midwives, was performed.

The search yielded (mostly qualitative) research articles, theses, editorials, book reviews and grey literature. These were assessed on their content and utility of the findings by both authors. Nine research articles (four by the same author) were found on women’s motives to birth at home in countries where homebirth is not institutionalised e.g. Finland, Sweden and the US, and one incorporated high-risk homebirths in Australia. Six articles on women’s motives to ‘freebirth’ (e.g. planned unassisted childbirth) were found for Australia, Canada, and the US. No academic literature was found on unassisted or midwife-assisted high-risk (home)birth in the Netherlands. Ultimately, 15 relevant studies (12 qualitative 1 quantitative and 1 mixed-methods) and 1 review were selected by both authors (see Tables 1 and 2).

This sample was purposive rather than exhaustive because the intention was an interpretive explanation. This interpretive exploration of the (mostly) qualitative literature was not a systematic review. The findings cannot be pooled to examine associations of certain factors. Rather, themes were identified to provide insight into the phenomenon of ‘birthing outside the system’. Because this is a scoping study, we did not prioritise research designs or assess study quality, but rather emphasised the studies’ insight into women’s motivations to birth outside their country’s system of maternity care (cf. Arksey and O’Malley, 2005).

Data synthesis

The method of data analysis was thematic synthesis. This method is useful when primary studies do not address the review question directly as in the case here (Thomas and Harden, 2008). Thematic synthesis entails three stages: text coding, development of descriptive themes and generation of analytical themes. Coding and comparison of the results sections of the studies was undertaken by both authors. The descriptive themes (e.g. trust, risk, trauma, intuition, autonomy, choice, resistance, control, responsibility, interventions, faith and family) that emerged from the inductive analysis of the literature were used to answer the review question: what are the motivations of women to birth outside the system? Through this process, more abstract or analytical themes emerged.

Because our aim was to reach conceptual saturation, after thematic synthesis, we examined grey literature and literature whose main topics were not planned unassisted birth or high-risk...
Table 1
An overview of research articles on women’s motivations to have an unassisted childbirth.

<table>
<thead>
<tr>
<th>Author research</th>
<th>Country</th>
<th>Aim of the Study</th>
<th>Methodological perspective</th>
<th>Data collection sample size</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeley et al., 2015 review</td>
<td>UK</td>
<td>To integrate the findings of current literature on the phenomenon of freebirthing</td>
<td>Qualitative meta-ethnography meta-synthesis of primary qualitative work</td>
<td>3 US and 1 Australian study (n = 272 women)</td>
<td>Four key themes: (1) rejection of the medical and midwifery models of birth, (2) faith in the birth process, (3) autonomy, and (4) agency</td>
</tr>
<tr>
<td>Cameron 2012 thesis</td>
<td>Canada</td>
<td>To describe the framing of risk and expertise in discourses on unassisted childbirth</td>
<td>Qualitative feminist discourse analysis</td>
<td>Written public and professional media on unassisted childbirth 1994–2012</td>
<td>Conceptualization of risk and safety differs between physicians, midwives and unassisted-childbirth advocates</td>
</tr>
<tr>
<td>Jackson et. al., 2012 journal article</td>
<td>Australia</td>
<td>To explore perceptions of risk amongst Australian women who have freebirths and high-risk homebirths</td>
<td>Qualitative thematic analysis</td>
<td>Semi-structured interviews (n = 20) freebirth (n = 9) high-risk homebirth (n = 11) In-depth interviews (n = 21) birth stories on internet (n = 127)</td>
<td>Three main themes about perceptions of risk: birth always has an element of risk, the hospital is not the safest place to have a baby, and interference is a risk</td>
</tr>
<tr>
<td>Miller (2012) journal article</td>
<td>US</td>
<td>To examine how advocates of unassisted childbirth manage stigma</td>
<td>Qualitative ethnography, thematic analysis, narrative analysis</td>
<td>In-depth interviews (n = 21) birth stories on internet (n = 127)</td>
<td>The women identified four strategies to manage stigma: choosing silence, passing, selective disclosure, and evangelism</td>
</tr>
<tr>
<td>Miller (2009) journal article</td>
<td>US</td>
<td>To explore how women make and explain their choice for unassisted homebirth</td>
<td>Qualitative grounded theory, narrative analysis</td>
<td>In-depth interviews (n = 6) birth stories on internet (n = 127)</td>
<td>Factors influencing women’s choice for unassisted childbirth were: internet communities, rejection of the biomedical model of birth, autonomy, and surrendering to God or the natural body</td>
</tr>
<tr>
<td>Freeze (2008) thesis</td>
<td>US</td>
<td>a ‘scholarly inquiry’ into unassisted birth</td>
<td>Qualitative thematic analysis</td>
<td>Essay response surveys (n = 61) Telephone interviews (n = 17) Internet fora (10,000 posts)</td>
<td>Themes: past birth experiences, intuition as authoritative knowledge, reframing safety, and risk and responsibility</td>
</tr>
</tbody>
</table>
Table 2
An overview of research articles on women’s motivations to have a home birth outside the system.

<table>
<thead>
<tr>
<th>Author research</th>
<th>Country</th>
<th>Aim of the study</th>
<th>Methodological perspective</th>
<th>Data collection sample size</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Murray-Davis et al., 2012 journal article</td>
<td>Canada</td>
<td>To explore why Canadian women choose to give birth at home</td>
<td>Qualitative grounded theory approach</td>
<td>Semi-structured interviews (n=34) women from Ontario (n=16) and British Columbia (n=18) who planned to give birth at home</td>
<td>Motivation for home birth: to optimise choice, comfort and control, and have family involved in the birth. The desire to have a personalised birth experience</td>
</tr>
<tr>
<td>Lundgren (2010) journal article</td>
<td>Sweden</td>
<td>To describe women’s experiences of giving birth and making decisions whether to give birth at home when professional care at home is not available</td>
<td>Qualitative Phenomenological study</td>
<td>Interviews with women who had planned a homebirth (n=7) women gave birth at home unassisted (n=4), women delivered at hospital (n=3) Questionnaires (n=797) women who had a planned home birth (n=671) and women who had a planned caesarean based on maternal request (n=126)</td>
<td>Perceived risks about hospital birth were all related to the loss of autonomy.</td>
</tr>
<tr>
<td>Hildingsson et al., 2011 journal article</td>
<td>Sweden</td>
<td>To compare background characteristics of women opting for a home birth or requesting a caesarean section in a culture where vaginal birth in a hospital is the norm</td>
<td>Quantitative logistic regression secondary data analysis of a sample of women who gave birth from 1997 to 2008</td>
<td>Women who had a planned homebirth felt more involvement in decision making and had a more positive birth experience than those who had a requested, planned caesarean</td>
<td></td>
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<tr>
<td>Lindgren et al. (2010) journal article</td>
<td>Sweden</td>
<td>To describe women’s perceptions of risk related to homebirth and the strategies for managing these perceived risks</td>
<td>Mixed methods thematic content analysis of open questions and descriptive statistical analysis of Likert scale questions</td>
<td>Questionnaires (n=1025) a nationwide study including all women who had given birth at home in Sweden</td>
<td>Perceived risks related to a home birth were associated with a sense of being beyond help</td>
</tr>
<tr>
<td>Lindgren and Erlends-son (2010) journal article</td>
<td>Sweden</td>
<td>To describe the factors experienced as empowering during a planned home birth</td>
<td>Qualitative content analysis and descriptive statistics of written birth stories</td>
<td>Questionnaire (n=1025) women who had a planned home birth between 1992 and 2005. (same dataset as Lindgren et al., 2010)</td>
<td>The categories identified were: sensations, guidance, tacit support, and overcoming dis-empowering conditions. The overall theme was finding rest in acceptance of the process.</td>
</tr>
<tr>
<td>Boucher et al. (2009) journal article</td>
<td>US</td>
<td>To describe the reasons why women in the US choose home birth</td>
<td>Qualitative content analysis was conducted on a previously collected dataset</td>
<td>Online survey (n=160) women who were US residents and planned a home birth at least once</td>
<td>The most common reasons given for wanting to birth at home: safety and better outcome, avoidance of unnecessary medical interventions, a previously negative hospital experience, more control, comfortable environment, and trust in the birth process.</td>
</tr>
<tr>
<td>Cheyney, 2008 journal article</td>
<td>US</td>
<td>To examine motivations of women who choose to circumvent the dominant maternity care paradigm by delivering at home</td>
<td>Qualitative critical medical anthropology, grounded theory analysis of home birth narratives</td>
<td>Participant observation, and open-ended, semi-structured interviews from a theoretical sample of women (n=50)</td>
<td>Five categories were identified as counter-balancing the risk of possible complications: (1) trust in the woman’s ability to give birth, (2) trust in intuition, (3) confidence in the mid-wife, (4) confidence in the relationship, and (5) physical and intellectual preparation</td>
</tr>
<tr>
<td>Lindgren et al., 2006 journal article</td>
<td>Sweden</td>
<td>To describe home-birth risk assessment by parents</td>
<td>Qualitative phenomenological approach</td>
<td>Interviews with five couples who had planned home births</td>
<td>Reasons for and experiences of planning a home birth: self-determination, control, and trust in one’s intuition and resistance to the biomedical model of birth</td>
</tr>
<tr>
<td>Viisainen, 2001 journal article</td>
<td>Finland</td>
<td>To explore decision-making about place of birth</td>
<td>Qualitative narrative analysis of birth stories</td>
<td>Interviews with 21 women and 12 men (n=33)</td>
<td>Three predominant themes: in participants’ narratives (1) redefining authoritative knowledge, (2) embodying personal power/agency, and (3) creating connection/intimacy in the birthplace.</td>
</tr>
</tbody>
</table>
homebirth, but that mentioned these topics in the text. We took this approach to determine if the additional literature supported the themes found in the analysis of the selected studies (cf. Thomas and Harden, 2008).

Findings: motivations to birth outside the system

The main analytical themes that emerged from the thematic synthesis of recent literature of women’s motivations for choosing an unassisted birth or homebirth (in a country where homebirth is not common or is considered to be high risk) were: trusting intuition during birth, an alternative conceptualization of birth risk and safety, autonomous choice during birth is only possible at home, intimacy of the birthplace, placing birth in God’s hands and taking responsibility.

Resistance to the biomedical model of birth: trusting intuition

Resistance to the biomedical model of birth is a recurring theme in the literature on women’s motivations to birth outside the system (Viisainen, 2001; Miller, 2009; Dahlen et al., 2011, Feeley et al., 2015). The biomedical model of birth is perceived as not meeting women’s emotional or social needs or their basic human rights (Gaskin, 2003; Nolan, 2008). Some respondents appear to have a growing mistrust in midwives because they are seen to be taking over the technocratic model of health care (Hart, 2003, Lynch, 2007; Jackson et al., 2012; Cameron, 2012). Sometimes midwives’ interests are not perceived to be the same as women’s interests because midwives are seen to intervene to protect themselves from litigation (Surtees, 2010; Vogel, 2011). These women perceive professional guidelines as too instrinsic and serving the needs of health care professionals rather than individual women (Fraser, 2008; Nolan, 2008; Wickham, 2008) Women who birth outside the system have an overall low satisfaction with maternity care (Chalmers, 2011). They are critical of midwives’ risk-based approach to childbirth and believe that speaking of risks brings fear into the birthplace (Hart, 2003). Furthermore, freebirthers see midwives as unnecessary; they interfere with a woman’s natural ability to birth (Hessel, 2002; Freeze, 2008; Cameron, 2012).

Intuition often functions as authoritative knowledge among women who choose to birth outside the system (Lindgren et al., 2006; Cheyney, 2008; Freeze, 2008; Walsh, 2008). Own-body knowledge is perceived as superior to medical knowledge and professional care. Intuitive experiences during birth include ‘instinctual physical movement during labour, sudden thoughts or feelings, direct communication with the unborn baby, and religious/spiritual/supernatural experiences’ (Freeze, 2008: 27). Listening to, acting upon and trusting one’s intuition are crucial because intuition is given the highest authority above other forms of knowledge (Viisainen, 2001; Boucher et al., 2009; Lundgren, 2010; Feeley et al., 2015).

Challenging the dominant discourse on risk: the hospital as a dangerous place

Another common theme is the conceptualisation of risk and safety. For unassisted childbirth advocates, childbirth is inherently safe and risk is located in professional interventions. (Freeze, 2008; Boucher et al., 2009; Cameron, 2012; Jackson et al., 2012). According to Shanley, a well-known leader in the natural-birth movement in the US, birth is inherently safe and relatively painless provided there is no physical or psychological interference. She argues that the problems often related with birth can be traced to three main factors: poverty, unnecessary medical intervention, and fear. When these problems are removed, most women can give birth alone (Shanley, 2012). An ‘undisturbed birth’ is seen to provide maximum safety for mother and infant (Buckley and Dip, 2003).

In a context of excessively high rates of medical intervention in the hospital (e.g. caesarean rates of approximately 30% in the US and Australia, and up to 50% for primiparous women in some private hospitals), the risk of complications during a hospital birth is perceived as higher than the risk of a (unassisted) homebirth. Women fear a ‘cascade of interventions’ once they cross the threshold of the hospital. The hospital is thus perceived as a dangerous place (Newman, 2008; Dahlen, 2010; Jackson et al., 2012). Many women who choose unassisted birth have had a previously traumatic birth experience (Walsh, 2008; Boucher et al., 2009; Lundgren, 2010). Some women experience the over-medicalisation of maternity care as abusive (Chalmers, 2011) and some look back on obstetrician- or midwife-attended births ‘feeling traumatised, disempowered or even birth-raped’ (Cameron, 2012:149) While this is most probably not the norm, it does indicate a failure to deliver sensitive, caring, respectful maternity care and can lead women to choose an unassisted birth (Beech, 2008).

Autonomous choice is only possible at home

Autonomy is another important theme in the literature (Viisainen, 2001; Boucher et al., 2009; Murray-Davis et al., 2012; Feeley et al., 2015). Some women believe that true informed consent is not possible in the hospital (Cheyney, 2008). In the hospital, women’s choices are limited and their decisions are not supported; they have a ‘choiceless choice’. Shared decision-making with health professionals is seen as an illusion and midwives are said to be ‘permission-givers’ and pregnant women ‘permission-askers’ (Hill, 2014). In a midwife-attended homebirth, women believe they can optimise their choices, and feel more autonomous and in control than in a hospital. Although for some women, true autonomy is only attainable without a professional present at the birth (Freeze, 2008).

Women who have had a home birth often feel empowered by the experience (Lundgren, 2010; Edwards and Kirkham, 2013). This can be part of a woman’s identity work, and as such, birth can be transformative, redemptive or can heal past trauma (Cheyney, 2008).

Positive first choice: birth as an intimate or religious experience

The choice for homebirth is not always motivated by negative opinions about current maternity care; it can also be a positive choice (Edwards and Kirkham, 2013). A recurring theme is the importance of intimacy, privacy and comfort in the birthplace, which is easier to realise in the home than in a hospital (Cheyney, 2008; Boucher et al., 2009; Murray-Davis et al., 2012).

In some (generally grey) literature on unassisted childbirth, birth is portrayed as a sexual, potentially ecstatic, experience—as a sensual, private encounter between a husband and wife (Hessel, 2002; Buckley and Dip, 2003). Women who choose an unassisted birth may feel that a midwife’s presence detracts from the ‘couples’ sacred unity’ by disturbing the love and flow of natural oxytocin necessary for a uncomplicated birth (Griesemer, 2007:137-8; see also Dahlen et al., 2011).

Some women choose to birth unassisted on religious grounds (Edwards and Kirkham, 2013). In certain Christian religious communities in the US, the ideal birth is an unassisted birth, characterised by devout surrender to the will of God. For these women, seeking medical care during birth reflects ‘a breach of faith and an unwillingness to fully trust God’s will’ (Miller, 2009: 63).
Taking responsibility is true control over decision-making

Women who choose unassisted birth take full responsibility for the outcome of their decision, good or bad. They do not place responsibility for their pregnancy in the hands of a midwife or doctor, but rather they retain their power and autonomy during the birth process. They have control over decision-making at birth and this includes the possibility of death. They acknowledge that in every birth there is an element of risk and that there are no guarantees for a perfect outcome even when assisted by midwife or obstetrician (Freeze, 2008; Symon et al., 2010; Cameron, 2012).

Women who homebirth outside the system are often well educated and fully informed about their options and have often prepared themselves by reading obstetric textbooks and taking midwifery courses. Some women who ‘freebirth’ are midwives (Jackson et al., 2012; Edwards and Kirkham, 2013). There are websites and support groups that women can turn to for information. Women who choose unassisted childbirth are often part of an internet community and could be considered as a ‘minority culture’ (Boucher et al., 2009; Miller, 2009).

For some women, taking this responsibility is a lonely process (Lundgren, 2010). Women who choose to birth outside the system may be considered deviant because they reject mainstream birth expectations and expose themselves to stigma and social sanctions. This, in turn, motivates some women to keep their choice a secret (Freeze, 2008; Miller, 2012).

In sum, the literature on birthing outside the system shows that there is a gap between risk perception and the needs of health care professionals on the one hand and those of pregnant women on the other hand. The personal needs of some women are so compromised by the system that they cannot conform (Nolan, 2008). Concerns over consent, intervention and loss of the birthing experience may be driving women away from formal healthcare (Dannaway and Dietz, 2014). Birthing outside the system is sometimes a positive first choice, but more often it appears that negative opinions of or experiences with maternity care is the determining factor.

Discussion

From this literature review, contrasting perceptions on autonomy and risk seem to cause the most friction between caregivers and women who want to birth outside the system.

Informed refusal: fetal-maternal conflict

Women who choose to birth outside the system desire a high degree of autonomy in childbirth and they take full responsibility for their decisions. Autonomy is a medical ethical principal that health care professionals also accord much importance, but these professionals sometimes have difficulty managing cases of informed refusal because of a perceived fetal-maternal conflict.

In the literature on healthcare professional’s perceptions of pregnant women going against medical advice, recurring themes are legal issues and ethical dilemmas (Cuttini et al., 2006; Weaver et al., 2007; Danerek et al., 2011; Deshpande and Corrina, 2012; Duijst et al., 2013, Ecker, 2013; Minkoff et al., 2014). Legally, competent women are free to decline medical advice and treatment, even if they or their fetus suffer death or injury as a consequence. As in many countries, Dutch law is clear that the unborn child has no independent status and that the wishes of a mentally competent expectant mother must take precedence (Duijst et al., 2013). The health professional is responsible for giving good care, but the mother is responsible for her unborn child.

There is a perceived conflict between maternal autonomy and rights of the fetus (Chervenak and McCollough, 1985, Flagler et al., 1997, Cahill, 1999, Harris, 2000, Chervenak et al., 2011). Here there appears to be a conflict of the ethical values of beneficence and autonomy. The model of perceiving a mother and child as one person has shifted to a two-person model that perceives the fetus as a potential patient. New technology (e.g. ultrasound and intrauterine operations) has provided a new ability to assess and treat the fetus. As a consequence, the fetus can now be seen as a patient and some find it ethically justifiable to intervene against the wishes of the mother if the life of the fetus is thought to be at risk. On the other hand, although the mother has obligations of beneficence toward her fetus, she nevertheless has the right to bodily integrity and may refuse medical intervention. Therefore, persuasion and not coercion or manipulation remains the only non-controversial option (Cuttini et al., 2006; Deshpande and Corrina, 2012). Professional guidelines favouring women’s autonomy have not solved this conflict. Healthcare professionals find it difficult to adhere to informed refusal when the life of the fetus is at risk. Some caregivers are inconsistent in their support of a woman’s right to autonomous decision making and some go so far as to involve child protection services or to seek a court order for a caesarean section (Symon et al., 2010, Kruske et al., 2014).

Locating risk

Cameron (2012) found that doctors, midwives and unassisted childbirth advocates have a disparate conceptualization of risk and safety. Where doctors see birth as risky and locate risk in the birthing body, unassisted childbirth advocates believe that childbirth is inherently safe and risk is located in professional intervention. Cameron argues that ‘the concept of risk itself should become part of the dialogue that occurs between a client and a caregiver so that safety in the birth process can be preserved while also maintaining the dignity and autonomy of the birthing woman herself’ (2012:148). A dialogue is needed on the various perceptions of what constitutes the most risk, or the most acceptable risk in childbirth.

Negotiating biomedical and alternative ‘outside the system’ discourses

How to understand this lack of fit between the health needs of pregnant women and the current system of maternity care in high-income countries, like the Netherlands? Medical anthropologists have shown that meaning is produced through the intersubjective experience of health and illness (Pool, 2003). A medical discourse gives meaning to illness, determines the role of health professionals and patients, produces concepts of the normal and abnormal, and generates strategies for prevention, treatment and care. The negotiation between alternative and biomedical discourse takes place during moments when pregnant women and midwives reflect on what is good medical practice. Qualitative research is needed to understand the biomedical and alternative ‘outside the system’ discourses on authoritative knowledge, risk, autonomy and responsibility. The themes listed above can guide the construction of questions for in-depth interviews. In addition, discourses used among health professionals could be explored.

Health care professionals can use the abovementioned themes in dialogue with their clients wherein both biomedical and alternative discourses are negotiated to find common ground—an overlap—a strategy for childbirth that fits both discourses. When this overlap is found, an obstetrical intervention may be acceptable to both parties.
Future research and implications for practice

Research is needed to understand the motivations and actions among not only women who actually withdraw from traditional maternity care offered in the Netherlands, but also women who are sceptic, but remain inside the system. Furthermore, research is needed to explore the scope of women birthing outside the system and the experiences of the health care professionals (midwives and obstetricians) caring for these women in the Netherlands.

This research would provide health professionals with background information on the women’s rationale for their ‘exceptional’ health needs and motivation for their choices. The knowledge may help to reduce the lack of fit between the health needs of pregnant women and the Dutch system of maternity care. Strategies can be developed to initiate and continue open communication with these women about their individual health wishes in order to provide individually tailored maternity care. Additionally, recommendations may emerge on how to improve the system so that fewer women choose to withdraw from it.

Research on birthing outside the system in the Netherlands will have relevance in other high-income countries because they too will have to search for solutions to address this phenomenon within their own (birth) culture and maternity care system. As Wickham pointedly states: ‘It may be uncomfortable to realise that ‘we’ can also be seen as an intervention, but if we can find ways of listening carefully to what this minority of women are saying we may be able to find ways of improving the experiences of all women.’ (Wickham, 2008: 5).

Limitations

We assessed the quality of our studies with regard to the degree to which they represented the motivations of their respondents to birth outside the system and thus were able to answer our research question – and not necessarily the quality of the primary studies themselves. In the case of the included studies, some methodological limitations need to be noted. Freeze (2008) and Cameron (2012) were unpublished PhD dissertations, they were included due to the paucity of scientific literature on this subject. The respondents of several studies (e.g. Jackson et al., 2012, Miller, 2012) were obtained through snowball samples increasing the chance that women with similar views were interviewed. Only articles published between 2000–2015 in English or Dutch were included in the assumption that most researchers seek to publish in an international English language journal. This could be considered a limitation and possible source of information bias. While it is apparent that the findings need to be treated cautiously, the authors trust that the studies provide a useful insight into this phenomenon.

Conclusion

Analysis of studies in this scoping review has generated the following themes on women’s motivations to birth outside the system: resisting the biomedical model of birth by trusting intuition, challenging the dominant discourse on risk by considering the hospital as a dangerous place, feeling that true autonomous choice is only possible at home, perceiving birth as an intimate or religious experience, and finally, taking responsibility as a reflection of true control over decision-making. Further research is needed to understand the lack of fit between pregnant women’s health needs and the current system of maternity care in high-income countries. Biomedical and alternative ‘outside the system’ discourses on authoritative knowledge, risk, autonomy and responsibility must be negotiated to find a common ground wherein meaningful dialogue can take place between clients and health professionals.

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References


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