
**What are mothers seeking to achieve
when they write their birth plan?**

by

Charlotte Edun

MA by Research

The University of York

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Abstract

The birth plan has become commonly accepted as the format by which mothers can communicate and exert their choices about, and therefore control over, their birth experience. However, it is evident from academic research and anecdotal evidence that birth plans are inconsistent in facilitating positive births. They are critiqued as setting unrealistic expectations for mothers and being the locus for tension and conflict. Building on existing research into the benefits of relational maternity care and based on analysis of feminist literature of the body, this qualitative study seeks to identify what women intend to achieve when – despite these common tensions - they write their birth plan.

Five themes emerged from semi-structured interviews with four multiparous women, and analysis of their birth plans, and three experienced midwives. These were, (1) the birth plan does not communicate the breadth and complexity of maternal antenatal planning; (2) the birth plan is intended as a message to midwives; (3) mothers apply learning from their childbirth career; (4) mothers value certainty more highly than uninhibited choice; (5) mothers intend to avoid bureaucratic care. In this study I propose that maternal birth planning is heavily influenced by neo-liberal logic of choice and personal responsibility. I propose that the provision of compassionate, individualised care that mothers seek is inhibited by institutional pathologisation of birth, which arises from a medico-scientific basis in dualism, and I ground this within Irigaray's imaginaries of sexual difference.

Findings indicate that a shift in focus from 'choice' and 'control' to 'connection' and 'certainty' may improve the reputation of women's planning for labour and birth, the relationship dynamic between mothers and care providers, and in turn individual childbirth experiences.

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Authors declaration

I declare that this thesis is a presentation of original work
and I am the sole author.

This work has not previously been presented for an award at this,
or any other, University.

All sources are acknowledged as References.

What are mothers seeking to achieve when they write their birth plan



'The Delivery (Oh my baby! Oh! My baby!')

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www.amandagreavette.com

Introduction

While they are not universally written by mothers-to-be in the UK, the writing of a birth plan that outlines preferences for birth locations, support, pain relief and common intrapartum procedures, and offers the promise of choice and control, is now a common rite of pregnancy (Divall et al, 2017; DaBaets, 2016, Kitzinger, 2005). Despite this, birth plans remain an adjunct to standards of maternity care defined by National Clinical Guidelines (Frohlich and Schram, 2019; Scamell and Stewart, 2014; Whitford et al, 2014). Perhaps as a result, there is significant confusion among mothers, midwives and doctors regarding their purpose and value (Divall et al, 2017). Birth plans do not correlate highly with either improved birth outcomes or maternal satisfaction (Lothian, 2006; Lundgren et al, 2003; Whitford et al, 1998). They are critiqued for setting unrealistic expectations about the physiological realities of birth, the institutional realities of maternity care within the NHS and, further, as a source of tension between mothers and care providers (Hill, 2019; Divall et al, 2017; DaBaets, 2016). In light of these critiques, my research undertakes to identify what mothers are seeking to achieve when they write their birth plan. In this study I intend to interrogate the motivations of mothers who write birth plans, and to review the common approach to and format of birth plans in order to explore whether they are helpful to mothers, midwives and doctors. To do this, I will centre maternal experience and satisfaction, rather than the physiological outcomes which, in the course of the 'Birth Wars' have become fixed as the primary metrics for measuring and recording birth (Hill, 2019; Wolf, 2017) . I intend to augment the existing literature relating to the suitability of birth plans to facilitate the intrapartum needs of mothers and suggest a new perspective on maternal birth planning and communication between mothers, midwives and doctors.

Trevathan (1997) notes that the particular physiology of bipedal human birth, in which the infant emerges facing away from the mother, and so cannot be easily seen by her, or drawn upwards towards the nipple immediately post-partum, makes it an anthropologically social event. Further, Trevathan suggests that the seeking of companionship and support is an evolutionary adaptation to the potential for obstetric complications. As such, birth is not an individual pursuit, determined by and experienced by the mother alone. Rather it is a communal activity, dynamic and multi-axial, subject to the intersecting roles, responsibilities and perspectives of the mother and attendants supporting the birth. This history of birth as a communal activity lays ground for claims that mothers have always planned for their births (Kitzinger, 2005; Lothian, 2000), and yet the use and value of birth plans continues to be a contentious matter among, and between, mothers and healthcare providers (Hill, 2019; Simkin, 2007).

The last two centuries have seen knowledge about and control over birth transition away from traditionally female communities of midwives to the paternalistic sphere of medical institutions (Thomas, 2009). This model conceives birth as a high-risk, pathological event requiring active management (Conser Ferrer et al, 2016; Simkin, 2007) and is correlated with a marked increase in technological surveillance and management of birth from the mid-20th century onwards (Feeley, Thomson and Downe, 2020; Alcade, 2013). This trend was challenged in the charged political era of the 1960s and 1970s by the liberatory, activist women's health movement, focused on gaining control of women's reproductive rights. In 1973 this formidable movement won their most notable victory, the 1973 US Supreme Court decision on *Roe vs Wade*, classifying women's rights to access abortion care as fundamental, and effectively legalising abortion care across the US. Less acute, but no less meaningful, were activist efforts to improve women's experience of childbirth, leading to the establishment in the UK of the National Childbirth Trust (NCT) in 1956, and in 1960 the Association for Improvements in the Maternity Services (AIMS) in the UK and Lamaze International in the US. These movements were understood to be the *recovery* of women's lost knowledge about and control over their bodies and destinies from hegemonic and patriarchal models of care (DeBaets, 2016; Tuana, 2006). These activist groups lobbied for changes in attitude

and practice, repositioning women at the centre of models of health and wellbeing, humanising birth and with the freedom to choose intervention and the support of their partners (Roberts et al, 2016)

It was in this milieu that Simkin and Reinke published their pamphlet *Planning your baby's birth* in 1980 (Simkin, 2007), the birth plan was envisioned as an educational tool, intended to connect women with known care providers in order to make realistic and pragmatic preparation. Their pamphlet foreshadowed a new paradigm for maternity care, with mothers placed at the centre of decision-making about where and how their births happened, and with birth recognised as primarily physiological process. This relational model of care has now been recommended in the UK for nearly 30 years, from *Changing Childbirth* in 1993 to *Better Births* in 2016, via the International Conference of Humanisation in Brazil in 2000, which recognised that the humanisation of birth was an 'urgent and evident necessity' (Conser Ferrer et al, 2016). Within this, maternal choice, control and involvement in decision-making have been positioned as vital pivots to improve maternal experience (McAra-Couper, 2011; Hodnett, 2002; Lazarus, 1994). However, despite recognition by Baroness Cumberledge in *Better Births* that 'safe care is personalised care' (2016, p4), investment in maternity services in the UK has continued to be made in the direction of technology rather than relational care (Homer et al., 2017). As part of this humanised, relational model of care, birth plans are not intended as a standalone document, determining pre-defined and fixed intentions, but rather the output of an iterative process of discovery, education and discussion which also provided midwives with insight to mothers' uniquely situated anxieties and aspirations (Lopez Gimeno et al, 2021; Divall et al, 2017; DeBaets, 2016; Simkin 2007; Kitzinger 2005).

In the UK, birth plans are currently described by the NHS as '*...a record of what you would like to happen...*' (2021) and by the NCT as a format to '*...help mums decide how they'd like birth to be*' (2019). As the model of care remains largely fragmentary it is

remarkably rare for mothers to know the midwife who supports them during labour¹. Within this model the birth plan can be understood as a tool mothers can use to ease and expedite communication of values and preferences and assist in the development of rapport with her allocated midwife. As is evident from the six birth plans analysed in this study, and the birth plan templates referenced (appendices iii-x and xiii) the birth plan can better be described as a common conceptual phenomenon than a consistent standardised format. While they tend to be formulated to follow the sequential path of labour, and therefore the various options, choices and diversions that may occur along the way, they vary significantly in content, format and length.

The writing of birth plans has become so normalised that they are now recommended on the NHS website (see appendix iii) and by 'mainstream' birth and baby businesses (including Babycentre UK, see appendix iv). This appropriation of birth plans by institutions of care, and health and wellbeing brands, has witnessed the development of proforma birth plans (Kitzinger, 2005 and appendices iii., iv. and v.). Counterintuitively, a document intended to be the output of active, informed discussion with a known care provider, is now commonly formatted in a manner which suggests acceptance to or rejection of options from a menu of care (Dombroski et al, 2016; Kitzinger 2005).

There is ample evidence that birth plans hold the potential to cause friction between mothers and care providers (Divall et al., 2017; DeBaets, 2016; Yam, 2007). Some care providers may garner the false impression that mothers believe that, in the writing of a birth plan, they can control birth, are unwilling to yield to concerns, are unrealistic about the process and intensity of birth and are too greatly focused on aspects of birth which do not facilitate healthy outcomes (Lopez-Gimeno, 2021; DeBaets, 2016; Dombroski 2016; Whitford and Hillan, 1998). Birth plans are critiqued as being inadequate to encapsulate the complex bio-hormonal-environmental feedback loops between mother, human actors and non-human agents which influence the processes of

¹ Only 9% of women in the 2019 CQC *Survey of Women's Experiences of Maternity Care* had the same midwife through their 'maternity journey', despite recommendations from *Better Births* in 2016 that every woman should have a midwife who knows her and her family (p9).

birth (Dombroski et al, 2016). Some midwives and doctors lack faith in the positive effects and value of birth plans and DeBaets identified that 65% of her sample of doctors falsely believe that mothers with birth plans have worse outcomes. The issues of inappropriateness and intractability outlined above leads to the characterisation of mothers as 'birth-zilla's' (Hill, 2019; Tuteur, 2012). This perception is reinforced when birth plans contain requests for practices which are now largely standard (such as optimal cord clamping and immediate skin to skin) or carry paradoxical requests that are perceived to undermine professional judgement and skill, for example that consent will only be given to intervention when 'absolutely necessary' (Kaufman, 2017).

While maternal involvement in decision-making is a factor in maternal satisfaction (Drapkin Lyerly, 2010; Hodnett et al, 2002), it is notable that while mothers find birth plans helpful, there is no clear evidence to suggest that birth plans alone are reliable indicators of either outcomes or maternal satisfaction (Divall et al, 2017; Afshar et al, 2017; Lundgren et al, 2003; Brown and Lumley, 1994; Whitford and Hillan, 1998). The NCT, staunch advocates of women's knowledge about and autonomy in birth, note that it is '*...not clear yet whether birth plans can actually improve your birth experience...*' (NCT, 2019). Friction arising from birth plans works both ways, and there is evidence to suggest that when care providers do not adhere to the preferences outlined in the birth plan there is a detrimental effect to the relationship between mother and care provider (Divall et al., 2017). It is worth noting the correlating finding that mothers who do not write birth plans report higher levels of trust in health care providers, and less trust in birth plans due to concerns about the unpredictability of birth (Lopez-Gimeno, 2021). In these reported moments of discord, it is possible to identify how the transactional statements contained within birth plans fall short of facilitating mutual understanding, respect and empathy.

As well as undertaking postgraduate research, I am also a doula, working with mothers and families antenatally and intrapartum. My anecdotal experiences of supporting families who chose to write and deploy birth plans within a number of NHS Trusts in the South East of England reflect the findings in the literature. In my experience of my own clients and observing discussion in online antenatal groups, mothers are

sometimes unclear about the benefits of a birth plan and how it might influence their birth and improve their experience, while feeling it should form part of their antenatal preparation. Birth is unpredictable, and in the absence of continuity of carer and the opportunity for post-natal reflections on the birth mothers may be unclear about how and why their births followed the paths they did. In the absence of continuous perinatal care it is difficult for mothers to unravel the factors which influenced the physiology of their birth and the care, and they often take undue responsibility for their experiences.

Research aimed at improving maternal experience of childbirth matters because this qualitative outcome sets the groundwork for good maternal mental health, bonding and infant feeding (Conser Ferrer et al, 2016). These factors improve outcomes for the mother/child dyad and have benefits that, for the infant, extend through childhood and, for the mother, beyond the sphere of parenthood. This is hardly a niche issue. 45% of births are described as either unsatisfactory or traumatic (Beck et al, 2018; Thomson and Downe, 2016). 84% of women become mothers before they are 45 years old (ONS, 2021), and 100% of us were born.

It is generally assumed that mothers write birth plans because they intend to exert control over both the physiological process and the practice of their care providers. This is understood to be both a desire to regain control of the process of birth by making active choices, and also a rejection of medical risk assessments and a contributory factor to tensions between doctors and midwives. While much literature is focused on the benefits and roll-out of continuity of care models, in this paper I ask what mothers are seeking to achieve when they write their birth plan.

In qualitative, semi-structured interviews with four multiparous² mothers and three midwives with experience in various childbirth settings, I identify five key themes. Firstly, and in line with the literature, mothers 'do planning for birth', and they also

² Mothers who have given birth twice or more

write 'a birth plan', which may be the output of this planning. This is influenced by the common configuration of the birth plan, but does not convey the complexity and nuance of their planning. Secondly, the birth plan is a message from mothers to midwives, an opener to their relationship and an attempt to circumvent the lack of available relational care. Thirdly, mothers make careful, considered and complex plans for birth aggregating their own 'childbirth career', their experience of maternity care and testimony from their peers. Fourthly, mothers seek not only choice and control in their birth experience, but also confidence about the context of their birth, which is important to planning and for reassurance. To that end, some mothers are prepared to compromise their preferences to achieve certainty about the model of care and forms of support they will receive intrapartum. Finally, a key driver for mothers in the writing of their birth plan is to avoid bureaucratic care, which they have an intuitive concern will increase their risk of sustaining physical and psychological iatrogenic harm.

More broadly, I approach this research from the position that mothers seek appropriate, compassionate relational care. This humanised care is understood to be attainable via the expression of choices which can be accessed under the aegis of a birth plan, in line with neo-liberal attitudes to personal responsibility for accessing the best quality care/services. However, the systemic and structural biases against the physiological function of female bodies founded in mind/body dualism, and limitations on alternative frameworks and metrics for maternity care imposed by the male imaginary, mean that maternal choice and control are illusory, and the relational, salutogenic service that women seek is largely unattainable (CQC 2021). I argue that birth plans have been uncoupled from the principles of the relational care model, which foregrounded dialogue, rapport and trust. Instead, they have been essentialised to a modular, transactional menu of choices, lacking nuance and complexity, but in line with neo-liberal attitudes to personal responsibility and active choice as a route to the best outcomes (Saad-Filho and Fine, 2017; Dombroski, 2016).

Framing

GATENS DESCRIBES THE STRUCTURES OF SOCIAL BEHAVIOUR as running ‘below the threshold of conscious decision-making’ (1995, p3), and it is evident that the decisions mothers (and others) make about birth are mediated by a multiplicity of factors. My analysis of the literature on birth plans, and my experience of working as a doula supporting mothers as they plan to assert their values and preferences in birth, suggests that it is not possible to fully understand or evaluate contemporary birth plans without considering how the confluence of the following factors frame their writing and enactment.

In this chapter I will first explore the influence of neo-liberal attitudes on choice, control and personal responsibility in birth planning and birth plans. Secondly, I will identify the effect of dualist privileging of the mind and impugning of the body on attitudes to female reproductive bodies and the state of pregnancy and birth. Finally, I will frame both these factors within Irigaray’s philosophy of the masculine imaginary. I will propose that these concepts have practical implications to mothers in maternity care, and that the latter two – the scientific construction of the pathological female body, and the pervasiveness of the male imaginary in British culture – are factors which contribute to a state of cognitive dissonance relating to maternity care.

This dissonance creates tension. On the one hand, birth holds the potential to be a transformational human experience for mothers that has meaning and implications extending beyond the temporal space of the birth room (Olza et al, 2020; Kirkham and Lee, 2008). Simultaneously unconscious beliefs and biases fuelled by these three factors inhibit the ability of mothers, health care providers and the institution as a whole to create and sustain the salutogenic birth environments that mothers in my research seek. Further, the pervasive influence of neo-liberalism has attributed to mothers undue

responsibility for the outcome of their births and seeded unrealistic expectations about what they can reasonably influence and expect.

NEO-LIBERALISM HAS BEEN A DOMINANT FEATURE of the political, economic and social landscape in the UK throughout the second half of the 20th century and into the 21st. It has been particularly associated with the development and growth of international financial interests and the consolidation of power and wealth with elite groups (Saad-Filho and Fine, 2017; Monbiot, 2016; Phipps, 2014). Rather than a definable ideology, neo-liberalism can be described as a spectrum of ideas, an attitudinal approach to government, economic and social strategy of closely connected groups holding influence and power in the West and worldwide, some of which have contributed to direct and specific outcomes, for example the privatisation of certain areas of the NHS. However neo-liberalism is also the driver for highly complex abstract changes in culture which are felt, rather than seen, and which have rewritten aspects of the relational dependencies of the state, institutions and institutions (Evans, 2011; Saad-Filho and Johnston, 2004). Notably, this includes a concentration on agency and personal responsibility, which has turned focus away from structural inequalities and inhibited the potential for collective action (Saad-Filho and Fine, 2017; Monbiot, 2016). Alcade (2013) notes that while some effects of neo-liberalism echo aspects of feminist theory, particularly those that relate to bodily autonomy and control, this ideological dismissal of systemic injustices mark it as a particular challenge to women's health and wellbeing.

In a neo-liberal free market construction, the highest quality products and services, which most closely meet the consumers aspirations and needs, are those which gain greatest custom, drawing market share away from other, less effective, less robust or less popular products and services. Thus, follows the logic, when the individual consumer makes considered, foresighted choices which are appropriate to their need, these choices can be framed as being 'good' or 'sensible' choices which deliver the best results. In other words, the 'right' choices lead inexorably towards the best outcomes.

Under a succession of British Governments since the 1980s, and in line with the burgeoning influence of neo-liberalism in the United Kingdom, mothers have increasingly been conceptualised, in line with this model, as rational, decision-making consumers of maternity services (Dombroski et al, 2016; Alcade, 2013; Bumiller, 2008). This positioning places choices and control as the factors that offer mothers the potential to access the highest quality care, and therefore the best experience and outcomes (McAra-Couper, 2011; Lazarus, 1994). As such, they have been centred as necessary for best practice maternity care in two of the most significant maternity strategy recommendations in the past 40 years, *Changing Childbirth* in 1993 and *Better Births* in 2016. The NHS standard birth plan template (appendix i.) demonstrates how this logic of choice is realised in maternity care practice. This birth plan is clearly positioned as an addendum to standardised care pathways, within which a standardised menu of sequential options is offered. Should the mother choose wisely, her decisions (which, notably, are made in advance of labour, and are not, therefore, situational) can be expected to bring order and control in such a way that her individual needs and aspirations are met. In this way, through the neo-liberal lens, the birth plan is understood to be an aid to mothers.

It is notable that the birth plan serves a second neo-liberal objective. The lengthy, high time and cost investment of antenatal education and relational care is circumvented and made more efficient by the birth plan, in line with the neo-liberal desire to roll back the state (Richardson and Robinson, 2015). In this way, the embodied and psychic experience of birth is framed as a straightforward form of production, subject to the same rules and theories of the free market (Jones, 2021; Martin, 1989).

There is a dissonance in this perspective. In closely aligning a healthy body with 'good' decision-making, neo-liberalism makes the body totemic of personal responsibility and intellectual capability, an outward symbol that the available choices have been effectively navigated in the free market and a healthy, positive outcome achieved (Dombroski et al, 2016; Alcade, 2013). Simultaneously this perspective serves to disembodify, to disconnect what are perceived to be rational and unmediated choices from the materiality of the bio-psycho-social feedback loops of the body in the classic

Cartesian manner of privileging the mind over the body. (I present the specific implications of this for maternity services later in this chapter). This is doubly pernicious because of the heavy cultural load of the concept of the 'good mother' (Alcade, 2013).

THE ANALYSIS OF THE NEO-LIBERAL INFLUENCE on conceptions of choice and personal responsibility in birth planning make clear that decision-making is mediated by factors far broader and more foundational than those that are immediately associated with the process of birth. Beyond neo-liberalism, individual perceptions and expectations of the gritty realities of fertility, pregnancy, birth and motherhood are deeply entwined with cultural notions of how we, as sexed, gendered and social animals, navigate and interact with the world. Analysis of how female bodies are conceived in their own right, in relation to male bodies and on the basis of their reproductive capability is necessary to understand how scientific and social attitudes to, and cultures of, birth have developed. While these may be somewhat fluid and historically contingent, these historical, theoretical conceptions matter because they are woven into the fabric of our understanding about what women are, and form our understanding of how female reproductive bodies, birth and motherhood function.

The Platonic tradition of the eternal soul, bound within the confines of the imperfect form of the body and disrupted in its pursuit of perfection by the affective needs and desires of the body is the basis of the dualism on which I draw in this dissertation. This dualism is a response to the ontological problem of the nature of the relationship between the material and the conceptual, and how they are realised 'in the world' (Jones, 2022). The Cartesian proposition recognises that mind and body are in close alignment but defines them as fundamentally distinct and separate (Robinson, 2020; Cottingham, 1997). This conceptualisation of the mind and soul as limitless, unboundaried and capable of reason and judgement, is in polarity to the conception of the body as mechanistic, reactive and autonomic. This is the basis for a series of either/or binaries – nature/culture, instinct/science, feeling/abstraction (Jordanova,

1997) - which develop into socially constructed, restrictive gendered roles which ascribe behaviours, roles and values and which are used to limit women and girls from exploring and realising their full potential (Jones, 2022; Young, 1980). 'Maleness' comes to be associated with the mind, complex intellect and civilisation. 'Femaleness' with bestial physicality, the embodiment of nature. These binaries have formed the conceptual sub-structure for scientific modes of analysing, considering and interpreting the world (Tiles, 2011; Hekman, 2008) within which maternity care is contained. On this basis, female reproductive nature can be understood as problematic not due to its inherent nature (the messy corporeality of menstruation and birth), but by the cultural associations applied.

Female bodies have been perpetually synonymous with a wild and unpredictable nature, uncontrollably dynamic and capricious (Villarmea, 2021; Birke, 2017; Shildrick, 1997). The way that female bodies function in birth is an overt contradiction of philosophically contrived norms and standards of behaviour. Female bodies in birth flout the fixed oppositional boundaries that men embody. In an androcentric model where the male body is the norm - and therefore female bodies are a *disruption* from the norm - the healthy functioning of the female body is a problem simply because it is not what men's bodies do (Schiebinger, 2017; Shildrick 1997). In birth, the 'leaky boundaries' that Shildrick (2017) refers to, are not just conceptual, they are actual. The presence of blood, amniotic fluid, urine, faeces, tears and milk present a combination of taboos which force focus on the power of female sexuality, the opportunities and risks of reproduction and the existential anxiety of the mortality of our bodies. These taboos function to draw attention to the ambiguous and anomalous, and to codify female bodies as potentially dangerous (Brochmann and Stokken Dahl, 2017; Dammary, 2015). Female bodies represent both the promise and the fear of sexual power and reproduction and with it the potential for social and economic influence. In other words, the problems associated with menarche, menstruation, fertility, gestation, birth and motherhood are deeply rooted in philosophically somatophobic attitudes and can be located as a basis for the Western cultural discomfort with and pathologisation of birth (Crossley, 2017; Dammary, 2015; Shildrick, 2015). Pregnancy can be understood to be a particularly affronting paradox in this framework, a chimeric state where the body is

neither one nor two, where rights overlap, and where questions about humanity, spirituality and the nature and purpose of existence are sited (Shildrick and Price, 2017).

Bordo's identification of Western Philosophy as a 'project of disembodiment' (cited in McHugh, 2007, p. 29) is important, then. Her neat encapsulation of the Cartesian aspiration to slough off the unruly body in order to attain the cool, rational objectivity of the mind reveals how the philosophical disaggregation of body from mind, and conceptualisation of the female as corporeal and the male as intellectual, both forms and then justifies medical and cultural biases which assail and pathologise female bodies. While in birth the ceding of control to the power of the body is a physiological necessity, the didactic of the privileged mind/ repudiated body disqualifies mothers from mature personhood (Shildrick, 1997). The parallel with the totemic healthy body in the neo-liberal paradigm is notable. Recognition of the implications of these epistemological sex-difference stereotypes are central to understanding the biases against female bodies which underpin how science and medicine conceptualise, construct and anticipate female bodies.

DUALIST THEORIES OF THE MIND, BODY AND SEXUAL DIFFERENCE are not materially, but philosophically constructed and then culturally reinforced. Irigaray's asserts that Western culture has been defined under a masculine imaginary, in which the only subject is male, and the female is constructed in oppositional terms (Whitford, 1989; Jones, 2014). Irigaray suggests these binary concepts are informed in part by the materiality of our sexual difference, and further by the subtly varied psychic perspective on, understanding of and interactions with the world that sexual difference provides (Jones, 2014; Grosz, 2012, Whitford, 1986). Irigaray notoriously demands significant discussion and analysis so for this section I call primarily on the analysis of Whitford (1989, 1986) and Jones (2022, 2021, 2017, 2014).

To understand the pertinence of Irigaray's masculine imaginary, it is important to understand her motivation;

"...in psychoanalysing the philosophers, she claims to have discovered that the order of discourse in the West, its rationality and epistemology, are supported by an imaginary that is in effect governed unconsciously by... the phantasy that there is only one sex, that that sex is male, and that therefore women are really men, in a defective, castrated, version.'

Whitford, 1989

Here, Irigaray makes a primary claim for the fundamental phallogocentrism of Western culture, such that we exist entirely within a male imaginary. The male imaginary represents the world from the male vantage point and expresses the experiences and needs of the dominant male class. This is a 'top down' narrative which organises and categorises the world in a manner that is useful and beneficial to its material, economic and psychological comfort and success. Within the hegemonic masculine imaginary it is impossible to describe the feminine in and on its own terms. The feminine can be understood only in its interaction with the masculine, or by oppositional, binary projections of what the masculine is not. The feminine is marked only by lack (of masculine attributes) and submission (to masculine needs). Thus, the feminine in our consciousness is not a true representation of female desires or motivations at all, but is constructed from the characteristics, experiences and roles which have been disavowed and discarded by the masculine and projected upon the feminine.

The female can only be understood, from the confines of the hierarchical male imaginary, in terms that can be recognised to mirror or oppose the male (Jones, 2014; Grosz, 2012; Whitford, 1986), to such a degree that the feminine ceases to exist in its own terms. Female bodies are conceptualised neither in their own right, nor as the dimorphic other. Rather, female bodies are judged against men's – set as the reliable, fixed, consistent standard - and found wanting (Martin, 2003);

“The feminine cannot signify itself in any proper meaning, proper name or concept, not even that of woman... The... (exact reversal of the Socratic relation)... would still be played out within the same, that sameness put into place by the economy of the logos.”

This Sex Which Is Not One, p156

This universalist formulation, generated from within the male imaginary, results in a competitive *either/or*, ‘phallic binary’ hierarchy (Green, 2012) in which one must be privileged over the other. Bodies must comply to the standards of contained order and continuity set by the male imaginary, divergence from the norm is pathologised as malfunction to be cured and restored, so the inhabiting and embodying of a functioning female body becomes a limiting factor in itself, the determinant of failure to comply to the metronomic, linear rules of behaviour defined by a male-sexed experience of the world and nature, and indicative of a problem to be solved³. Female bodies come to represent a disruption to the entire male imaginary, the culture it has founded and exists dominantly within (Schiebinger, 2017; Shildrick, 2017). The property bearing nature of female bodies positions them not within their fully embodied unalloyed materiality, but as a blank canvas upon which dominant (patriarchal) attitudes and perceptions are reflected. It is in this way that the female comes to be understood only in terms of absence and lack, filling the void where the masculine is not.

It is on this theoretical basis that Irigaray makes the claim that the masculine imaginary perceives that there is only one sex, there is only one subject. This is the phallic order. From within the dominance of the male imaginary, the sexually different female is catastrophically othered so much as to reduce her from a whole and extant being to a petty complement of the male standard which reflects the foundational Aristotelian conceptualisation of the female as a failed male (Gribble et al, 2022; Shildrick, 2017; Spelman, 2017; Grosz, 2012).

³ Pertinently for this thesis, Irigaray identifies ‘the subject of science’ as male, and the epistemology and language intended towards ‘mastery, control and domination’ are all from within the male imaginary (Whitford, 1989, p120).

There is a further facet to Irigaray's theory that is germane to this thesis. Lacan – Irigaray's former mentor – used the term 'imaginary' in a technical, psychoanalytic manner. In his description the imaginary develops in the individual further to a pre-linguistic phase, in which the child recognises an image of himself (and Jones (2014) notes that for Lacan the child is always male), and from this image formulates the idea of himself in response to context – his ego. In this formulation, the imaginary is distinct from perception. It is an imagining consciousness that mediates and creates forms of alignment between the internal and external worlds to create personal identity. For Lacan, this environmental feedback comes from a mirror (hence 'mirror-stage'). Irigaray's insight was to identify that the surface the psyche sees itself reflected against is not an inanimate mirror, but an entirely relational, foundational and interactive mother (Jones, 2014). The phallic objective to exist as separate, sovereign and self-made then becomes dependent on the erasure of the dyadic relationship with the mother that we are all subject to. In other words, the objective becomes to sever dependence on the 'dangerous, engulfing and overpowering' maternal body (Green, 2012). In Irigaray's reading "...all Western culture rests on the murder of the mother..." (quoted in Jones (2014) and Whitford (1989, p109).

Irigaray does not claim knowledge of quite what the female imaginary may be. However, Whitford (1989) draws our attention to one definition suggested by Irigaray : the feminine imaginary could perhaps be *'those components which cannot reflect themselves, in other words, the material of which the mirror is made'* (Irigaray, 1985, p108). The female imaginary then - if the mirror is not a mirror but the mother - connects the individual to a genealogy and makes them subject to the reality of their relationality. The mother, and the powerful, embodied, enmeshing work her female body does and represents, is a direct challenge to the aspiration of independence of the masculine imaginary. The female imaginary, which presents such existential threat to the masculine, is mitochondrial DNA. It is elemental, fundamental, material connection, which cannot be escaped or over-ridden, even by the imposition of patriarchal constructs such as marriage or primogeniture.

I contend that it is a significant factor in the cultural, intellectual, and physical incursion of the male imaginary into what is judiciously a female sphere, and its disruptive insertion into cultures of birth which would otherwise vertically connect generations of women. The male imaginary, in which the individual is self-made and self-aware, is challenged by the palpable, foundational and valuable work that female bodies undertake for the benefit of society and humankind, and to which they are subject. It is on this basis that it is not possible to build the relationality that mothers desire into maternity care. Motherhood cannot be valourised and relationality cannot be centred because to do so calls into question the central tenets of the phallic order. Thus, a phallogocentric imaginary holds authority over birth in the UK, and controls the institutions, but cannot conceive of what is necessary to accommodate them salutogenically.

The sexed and gendered dualism described in this chapter is not a phenomenon of the past, resolved by 21st century liberal attitudes to the body and greater access to health care. Problematic gendered stereotypes arising from historic, philosophical dualism and the impugning and pathologising of the female body deriving from the male imaginary, continue to make significant impact on contemporary interpretation of female bodies in medicine, and to actively punctuate the real birth experiences of British women in the 21st century. Martin (2017) describes the scientific habit of applying gendered biases to the biological functions of the female reproductive body, which is habitually characterised as passive and inherently flawed or failing. She uses as an example the anthropomorphising of conception, in which the female egg is characterised as passively floating in the fallopian tube awaiting the active, determined sperm to harpoon her (in fact, conception is a decidedly more complex operation than this, in which the ova plays an active role (Martin, 2017).

Women remain largely ignorant of the healthy form and function of their bodies. A survey report by the RCOG in 2017 noted that 43% of women do not know where their cervix is, despite it playing a meaningful and dynamic monthly role through their lives

from menarche to menopause and beyond. Brochmann & Stokken Dahl (2015, p14) highlight the variant social attitudes to the pliability of human soft tissue; in men it is expected, even celebrated, that the penis can expand and contract, but this same triumphalism is not accorded to the vagina and female perineum, which are pathologized to the extent that perineal trauma in birth is accepted as the norm⁴. Mothers' bodies in birth are far from pathological. They are active, connected and functioning, more akin with the 'dancing, running or erotic body' (Cohen Shabot, 2015).

I frame my findings and analysis in this research in light of these foundational concepts, and I identify this as evidence that the success of female reproductive bodies is not given credence. In a system which is designed to manage unruly, indecorous bodies, rather than to augment an efficacious physiological process, successfully birthing bodies have become the exceptions that prove the rules.

⁴ Frohlich and Kettle (2015) report that 85% of mothers delivering vaginally will experience some degree of perineal trauma. However, the Albany Midwifery Practice, providing midwifery care in the community within the Kings College Hospital NHS Trust, oversaw a 43.5% homebirth rate and reported that 62.2% of women delivering vaginally had no perineal trauma at all (Homer et al., 2017) – or to put it another way, only 37.8% of women experienced perineal trauma. This disparity might be understood to suggest that different practitioners tolerate different levels of perineal trauma as acceptable, and adapt their practice accordingly.

Literature review

In this literature review, I will build on the concepts that I defined in the framing and present the literature that investigates and analyses the various contexts and pressures on 'birth planning' and 'the birth plan' in the UK. In this literature review I will describe the historical and cultural transfer of birth knowledge from the female realm of artisanal, experiential midwifery to the male realm of managed, measured medicine. I will illustrate how this was closely associated with the de-legitimising of women's knowledge about their own bodies and agency in the perinatal period and correlated with the increase in significance and value of the birth plan. I demonstrate that maternal birth plans are the articulation of a complex assemblage of factors and suggest these are reduced and essentialised in the common form of the birth plan.

The literature I present is located primarily in the UK, the US, Australia and New Zealand. It is worth noting that while there are cultural similarities between these regions which make the literature relevant to my study, there are also significant cultural differences weighing on expectations of what is 'normal' and how birth happens, most notably in the US, where medically managed birth is the more common (Seijmonsbergen-Schermer et al, 2020). My research is phenomenological, with a primary focus on maternal experience. Therefore, I do not present any literature that intends to correlate clinical outcomes with birth planning or the use of a birth plan (although in relation to continuity of care I reference Sandall, Soltani, Gates et al (2016) who do present evidence for this claim)

I will categorise this literature review within four themes. I will start by reviewing the anthropological and social roles of birth planning, and how that developed through history into the conceptual and material birth plans mothers work with today. I will look at the role authoritative knowledge plays in the narrative and pragmatics between

mothers, midwives and doctors, the role risk plays in intrapartum decision-making and how this can divert plans. Finally, I will look at the specific charges laid against birth plans.

KNOWLEDGE ABOUT BIRTH, and the ownership of the rites and rituals accompanying it, have historically been held within the female sphere (Allison, 2021; Feeley and Thomson, 2017). Trevathan (1997) posits that the particularities of bipedalism are the basis for human birth as a social event, with knowledge ownership, practices and rites held beyond the mother. She describes how bipedalism caused anatomical changes to the pelvis which require the infant to emerge facing *away* from the mother (rather than facing towards the mothers' belly, as they are in other ape species). The result is the human mother is unable to reliably 'catch' their own baby and draw them upwards towards the nipple, without pulling against the angle of flexion (Lothian, 2017). Both natural selection for narrower birth canals (required for bipedalism but requiring a development for babies to be born facing towards the mothers' back) and large brains (requiring larger skulls and more dependant infants) may have substantially increased mortality for mothers and infants. To mitigate this, Trevathan proposes, an evolutionary 'trade-off' was made; mothers bodies adapted to accommodate both bipedalism and larger-skulled infants, and birth moved into the social realm, habitually supported and assisted. Furthermore, Trevathan posits that the intensity of childbirth, the anxiety and uncertainty it engenders, has an evolutionary purpose; to lead women to seek support. Thus, Trevathan locates that the process of birth developed from a solitary to a social endeavour at least 5 million years ago.

While the physiology of birth may have changed little since then, contemporary mothers prepare for their births in a significantly different manner. The 1980 publication in America of Simkin and Reinke's pamphlet *Planning For Your Baby's Birth* introduced the idea that mothers' should be in possession of informed knowledge and active engagement in birth to a milieu which constructed mothers passive recipients of maternity care (Frohlich and Schram, 2019; Shildrick 1997). Simke and Reinke were

moved to write at a time when international feminism was drawing increasing focus towards matters of health and wellbeing for women, not least in the context of the women's health movement. This epistemological and liberatory feminist movement drove to regain ownership of knowledge and raze away misogynistic and androcentric medical attitudes to women's bodies (Tuana, 2006). This was a response to paternalistic medical determination of health values, care pathways and outcomes, and in the field of reproductive health particularly, growing medical surveillance of pregnant women's bodies as bio-technical-medical model of birth increasingly took precedence. Here in Britain, nearly a quarter of a century earlier, the establishment of the NCT in 1956, its subsequent charitable status in 1961⁵ and the Abortion Act 1967 foreshadowed new ways of thinking about and controlling women's reproductive bodies.

Between the evolutionary developments in humans which changed birth from a solitary to a social endeavour, and the establishment of campaigning movements acting to assert women's desires, needs and values in birth, is the history of the slow transfer of ownership and knowledge of birth from the female realm to the male. For centuries the rites of pregnancy, birth and puerperium were performed by a locally approved, and later licensed, 'midwife' (the term deriving from the old English meaning 'to be with woman'). Until the 'accoucheur', or male midwife, became a more common birth attendant in large European cities in the early 17th Century, mid-wives were the only recorded attendants at births in the UK (Allison, 2021). It was only from the later 17th Century onwards, as scientific & philosophical discourse, and the aspiration to control and manage the world through scientific endeavour during the Enlightenment began to change metropolitan attitudes and perspectives to health, the body and childbirth, that men were able to 'claim the keys to the birthing chamber' (Thomas, 2009). The conceptual developments of the Enlightenment heralded schisms along those dualist Cartesian factures which have been described in the Framing chapter, and which form sites of tension within birth; male/female, art/science, nature/culture. Midwifery had traditionally been understood as an artisanal trade, a way of interacting with the

⁵ The same year that the newly available contraceptive pill became available to married women. It would be 1974 before single women would benefit from it.

natural world which was developed through observation and experience (Whiteley, 2019). This transition can be observed in the shift from mnemonic 'birth figures' to the anatomically accurate drawings of the 18th century. The earlier birth figures are conceptual, connected to intuitive ways of knowing, expressing the way in which the unseen internal was interpreted and mapped. The literal medical diagrams of the 17th century, illustrate how the acute analytic focus on body parts also acted to disembodify the person from the medical task and drew conceptual distance between patient and doctor. In these diagrams, the mother is absent, erasing the context and value of the physical, psychological and emotional connections of the mother/child dyad, critical for sustaining life *in utero*, and for healthy growth and development in the early years (Whitely, 2019).

Both Thomas (2019) and Whitely (2019) caution not to presume malicious intent in these modifications to approaches to bodies and birth. Both contextualise these transitions of knowledge and influence within a material, interconnected world. This is not a straightforward picture of transfer of power from female to male spheres, but is complicated by broader, seemingly unconnected issues, and analysis is best understood within these conditions. Simultaneously the vernacular of the increasingly powerful and affluent commercial world seeped into the language of reproduction. Thomas (2009) identifies a shift from the analogous reflection of the natural world, with pregnant women 'ripening like a nut', to the literal description of pregnant women as metaphorical containers, their value defined by their safe delivery of young, with midwives imagined as unloading valuable cargo from their bodies.

From the 18th century onwards, while 'lying in' hospitals were instituted in cities and large towns in England and afforded some mothers access to high status doctors, the majority of births in the UK were still attended by midwives (Allison, 2021). Midwifery remained a profession reserved for women until 1975, when men were afforded admittance to schools of midwifery, by which time the knowledge hierarchy had been institutionalised and fundamentally established; (male) doctors validated as elite and experienced, (female) midwives below them in a hierarchy which undermines their expertise and skills. The forbearance, expertise, witness and reflection that informed

the art of midwifery had been superseded by measurable, quantitative medical evidence. The establishment of the NHS in England in 1947 which finalised the conventional ownership of birth away from women and into the patriarchal mode of obstetric care. The 1970 *Domiciliary, Midwifery and Maternity Beds Needs Report* followed by the *Peel Report* 1971, recommending that facilities should be provided for 100% of births to happen in hospital, moved birth almost wholesale into hospitals.

The literature presents a picture of birth as an anthropologically social and supported process, held within the female sphere. Forms of social support suggest communication and preparation for, and coordinated action during, birth which was congruent with both the physiology of birth and the events and transitions which accompany it (Trevathan, 1997). The objective of progressive science was to bring order and control to maternity care and to decrease risk and mortality⁶. However, the appropriation of birth knowledge into the privileged male imaginary was the beginning of the systematic removal of women's knowledge, credibility and control over their own bodily processes. As birth moved wholesale into hospital, the process was physically removed from common view, preventing access to the normal physiological process by younger generations of women, cementing ownership away from 'normal' women and within the male imaginary⁷. It would seem an unlikely coincidence that as this was happening in the 1950s onwards, the Women's Health Movement was growing, the NCT and AIMS were being established and interest in the concept of birth planning and use of birth plans was increasing.

⁶ It is notable that an early side effect of this pursuit of improvement to women's maternity care by male doctors was higher mortality rates for mothers (Best and Neuhauser, 2004)

⁷ I suggest here drawing a parallel with the effects of the appropriation of knowledge and norms of menstruation by the menstrual care industry, as described by Dammary (2015). She notes that the sanitising and clearing away of this normal physiological process removed it from view, and made a theoretical rather than an observed experience, which undermined female confidence and increased shame

OVER A PERIOD OF APPROXIMATELY TWO AND A HALF CENTURIES authoritative knowledge about childbirth was uncoupled from the traditionally relational and situational female forms of tacit understanding into a male framework of disembodied, disassociated observation and measurement (Jordan, 1997). The structural mechanism of authoritative knowledge acts to determine which knowledge systems hold greater value than, and therefore dominance over, other alternative ways of understanding and interpreting the world. Authoritative knowledge systems take primacy when they provide a more effective or compelling answer than the pre-existing knowledge forms (Jordan, 1997; Trevathan, 1997), and the effectively interlink power and governance into culture. As the 'new normal' is standardised, and legitimised, other existing knowledge forms are simultaneously de-legitimised and devalued. Once the new structures are rigidly established, this becomes self-perpetuating, as authoritative knowledge serves to make alternative ways of operating impossible to imagine (Shildrick, 2017). These power shifts are achieved through multiple means, including active management of processes and procedures, control of the lexicon, the gradual wearing down of spectrums of experience and an institutional estate which is landscaped to reflect the primary concerns and interests of the dominant dynamic⁸ (Elliott-Mainwaring, 2021; Dombroski et al, 2016; Probyn, 2005). Authoritative knowledge in the maternity services of the NHS, shaped by dualism, neo-liberalism and the male imaginary, has become indivisible from the organisational structure, institutional estate, policies and analytic appraisal. In practice this works to create deeply entrenched discourses which both reflect and reinforce attitudes and behaviour (Elliott-Mainwaring, 2021; Shildrick, 2017). Authoritative knowledge therefore can be understood to represent the social structure and reflect a social contract, so that ownership of authoritative knowledge is a signifier of control, power and status.

⁸ In NHS maternity care this happens in both overt and covert ways, including the wearing of uniforms to denote expertise hierarchies, the positioning of technology in labour rooms, and the height of the maternal bed, both of which are positioned for the ease of the health professional required to intervene, than to augment the physiology of labour or for maternal comfort and ease.

Authoritative knowledge is not aggressively imposed and enforced; it is secured by the powerful social urge to comply. The subtleties of normalisation and reiteration of beliefs and practices associated with the knowledge form, come to shape and direct individual expectations and behaviours until they come to be understood as the common-sense way to understand, interpret and interact with the world. This comes to be shared by everyone which both makes the culture easier to navigate and overshadows alternative ways of operating outside this common knowledge form. Opportunities to behave in different ways and make alternative choices become inaccessible as hegemonic attitudes and practices that fall in line with the new normal prevail (DiQuinzio, 1999; Shildrick, 1997). This it is not a 'top-down' affair; the dominance of authoritative knowledge is acknowledged and deferred to by all parties regardless of their role in the dynamic, which then functions to set norms of behaviour which corral and boundary individual attitudes, behaviours and expectations (Scamell, Stone and Dahlen, 2019; Crossley, 2017; Shildrick, 2017). Authoritative knowledge is perpetuated in a cycle in which 'the exercise of power perpetually creates knowledge and, conversely, knowledge constantly induces the effects of power.' (Foucault, cited in Shildrick, 1997, p15).

An effect of this in maternity care is to define a clear demarcation between the expert holders of authoritative knowledge, recognised as experienced, rational holders of formalised, encoded knowledge and lay-people. Significantly, the lay-people who possess only ambiguous, embodied, feelings are mothers (Clancy, 2020; Crossley, 2017; Scamell and Stewart, 2014). I suggest this distinction is ideologically connected to a culture of medicalisation of female bodies in which knowledge is academized, limited, privileged and standardised (El Kassar, 2018; Tuana, 2006; Greer, 1999; Jordan, 1997) and what Dammary (2016, p. xi) describes as the Anglo-Australian 'tradition of learned silence surrounding bodily processes'.

This ignorance is confirmed at an epistemic level by the function and framework of the institution. This constitution of authority via the interplay of dominant knowledge and clinical practice can be seen in the performance of the vaginal/cervical examination (VE) routinely offered to all women arriving at birth centres and hospitals to 'diagnose'

labour, regardless of how the mother describes or expresses (consciously or unconsciously) the sensations she is experiencing (Scammell and Stewart, 2014), or whether she seeks the insight and reassurance a VE may provide. While consent is required before a VE can take place, it is often positioned as contingent for appropriate and effective care to be delivered, while alternative options for confirming active labour are not offered (Nelson, 2020)⁹. This confirms the hierarchical position of the care provider over the mother and illustrates how maternal lack of knowledge regarding both the physiological process and the drivers for clinical practice compromise informed consent and enforce compliance. This has the effect of undermining the mothers' somatic experience of her own body, siting the health professional as the dominant actor, reducing the mother to the owner of a disembodied organ and framing undisturbed labour as a risk factor in itself (Scamell and Stewart, 2014). Thus, the birth plan itself becomes evidential of maternal ignorance.

Modular, transactional birth plans, with decisions defined and fixed in advance, formulated as a selection of disconnected choices, to be constructed and deconstructed in order to achieve the desired result, rather than offering a schema to flex and make appropriate situational decisions, reinforce the idea that mothers have flawed expectations of the realities of birth and intrapartum decision-making. Complex interactions between intrapartum endogenous neuro-hormonal processes (Olza et al, 2020), tiredness and the effects of intense physical effort, and maternal sense of security contribute to bio-psycho-social sensations of pain and suffering (Leap, Newnham and Karlsdottir, 2019), and can contribute to appropriate diversions from the plan. Birth can be unpredictable, and a range of indications through pregnancy and intrapartum contribute to clinical recommendations towards unplanned interventions and procedures. These multi-axial and concomitant factors contribute to the lack of clarity about how closely and appropriately choices defined in birth plans are followed

⁹ Anecdotally, from my practice as a doula, I can attest to how consistently VE is required for admission via triage to hospital delivery suites and birth centres. This is in contrast to community midwives attending labours at home, who are, in my experience, more likely to balance an integrated assessment of observations with the potential risks of VE. This correlates with Scamell's (2011) description of how midwives balance benefits and risks.

intrapartum and is further complicated by the intricate and nuanced relationship mothers share with midwives (Westergren et al, 2019).

Mothers look to midwives to provide reassurance and encouragement, and this trusting relationship is a vital factor in intrapartum decision-making. However, midwives may recommend and implement standard pathways of care without providing mothers with sufficient information about the implications of interventions and procedures (Coates et al, 2019). Midwives offer monitoring, pain-relief and intervention using language and risk perceptions which suggest a high expectation of compliance and consent (Jackson et al, 2016). Mothers may feel that they have given informed consent because it felt necessary, or that consent was implied because they did not object, when in fact the dominant hegemonic practice is so endemic and normalised that mothers do not recognise where they are limited and boundaried. This form of practice may be motivated by mothers perceived best interests, the midwives' sense that mothers are unable to make active decisions intrapartum, or that there isn't time to communicate the full implications of dependencies and knock-on effects (Farnworth et al, 2021; Coates et al, 2019), and works to encourage mothers to comply with clinical recommendations. It is variously described as 'coerced consent' (Villarme and Kelly, 2019), 'informed compliance' (Frolich and Schram, 2019) or 'coercion with kindness'. The net result is care aligned with guidelines and protocols rather than maternal choices and control (Coates et al, 2019; Westergren, 2019). This dynamic is both intensified and revealed by the idiosyncratically passive vernacular of mothers in birth, '*...am I allowed?...*' (Naylor Smith et al, 2018).

It is these compromises of choice and control that, in part, the continuity of carer, or relational, models of perinatal support recommended by Better Births in (2016, p43) attempts to resolve;

Women should be able to make decisions about their care during pregnancy, during birth and after their baby's birth, through an ongoing dialogue with professionals that empowers them. They should feel supported to make well informed decisions through a relationship of mutual trust and respect with health professionals, and their choices should be acted upon

The relational model of care provides mothers with direct contact with a named midwife who is responsible for coordination and care throughout the perinatal period (AIMS, 2018; Sandall et al, 2016). This 'non-dichotomous' model (Darra, 2018) has the potential to flatten the hierarchy and offers a framework to redistribute knowledge, privileging varying knowledge bases with the same value and crediting mothers with the ability to parse the information available to them. It facilitates antenatal planning and preparation which is iterative and in concert with care providers, during which mutual trust is established, and mothers have the opportunity to consider, investigate and discuss the physiology and process of birth, the standard care pathway offered and alternative options, coping strategies and possible contingencies. It is notable that continuity of care models are also associated with reduced rates of intervention (Sandall, Soltani, Gates et al, 2016). This model is related to the practice of 'shared decision-making' common in other healthcare disciplines (see appendix x.) which incorporates best available evidence, maternal values and preferences as well as professional judgement (Feeley, Downe and Thomson, 2020). Frohlich and Schram (2019) note that in this model mothers' benefit from the potential for both informed decision-making and informed refusal. Research evidences that continuity of care models facilitate the deep embodiment which is correlated with qualitative studies of maternal satisfaction (Olza, 2020; WHO, 2018; Conser Ferrer et al, 2016 Drapkin Lyerly, 2014).

While authoritative knowledge undermines maternal credibility and defines maternal bodies as sites of risk, it also does the work of positioning medical management in clinical environments as the only option for risk management and safety (Tracy and Page, 2019). Care providers are constructed as being in possession of leading-edge knowledge and expertise required to oversee and manage the uncertainty and unreliability of mothers' bodies (Scamell, Stone and Dahlen, 2019). The control and management of knowledge and information, whether it is procedural, clinical or contextual, is the apparatus which perpetuates the hierarchies between mothers, midwives and doctors described by Kirkman and Lee (2008). However, these risk assessments are not objective and unmediated, but socially and professionally constructed, and subject to pre-existing beliefs, biases and judgements (DeBaets, 2016).

The endorsement of these risk assessments as methods to mitigate risk and reduce mortality are validated within the medico-scientific domains own intrinsic frame of reference, using hierarchies of knowledge that are defined as credible within its own terms (Appendix xii.) Scamell, Stone and Dahlen (2019) critique the validity of these frameworks on the basis of both underlying bias and the adoption into maternity care of inappropriate assessment tools and practices developed for practice with healthcare users with significantly different risk profiles. Furthermore, these do not correlate with the situated, dynamic and pluralistic decision-making schema used by mothers (Crossley, 2017; Wolf, 2017). Thus, conceptions of risk and their application in clinical practice carry credibility and the power to both influence and restrict maternal decision-making antenatally and intrapartum (Scamell, Stone and Dahlen, 2019; Frohlich and Schram, 2019). This is the case even where the prioritisation of risk management increases the risk of iatrogenic harm to the mother and is therefore incoherent with the stated aim of minimising risk (Curtin et al, 2021; Scamell, Stone and Dahlen, 2019). This lack of objectivity can be evidenced in the common

recommendation¹⁰ for continuous cardiotocography (CTG)¹¹ which is associated with increased rates of intervention (Cochrane, 2017), as well as highly charged attitudes to home birth, which is constructed as risky despite evidence to the contrary (DeBaets, 2017; Warwick, 2012; The Birth Place Study, 2011; Cahill, 2000).

The factors of neo-liberalism and dualism outlined in the Framing chapter, and this risk-averse, defensive, hegemonic practice conjoin to rationalise and justify practices are the basis from which maternity care in the NHS can be described as ideological (Braun, 2003; DeQuinzio, 1999). Practice and pathways of care are developed to accommodate these risk-based inclinations (Conser Ferrer et al, 2016; Simkin, 2007) and are legitimised by the absence of significant alternative pathways of care. In this model, value parameters are set and risk is constructed by the dominant class and therefore investment and resources are oriented towards the definable and measurable (for example, routinely offering induction of labour to prevent intrauterine death (NICE, 2021) or the obstetric anal sphincter injury bundles of measures (AIMS, 2021)) while the risk parameters defined by mothers (for example, availability of continuity of care, quality of midwifery care or availability of home birth services) are dismissed.

Crossley (2017) draws attention to the conditions required to make free genuine choices; a complete and thorough understanding of the integrated situation and an adequate and known framework for decision-making. In the current fragmentary model, in the absence of relational care and with the pressures of hegemonic practice, mothers ability to enact the choices and preferences in their birth plans, or otherwise,

¹⁰ While NICE provide guidelines around the use of CTG in my anecdotal experience as a doula attending births in two NHS Trusts in the south-east of England, I observe the recommendation for continuous CTG in hospital births more regularly than not. In fact this has been in the case in the last 5 births I supported in hospital.

¹¹ The 2017 Cochrane review of the use of CTG was associated with a reduced rate of neonatal seizures, already rare events, but not with cerebral palsy, infant mortality or other measures of neonatal wellbeing. The review also identified that CTG is significantly associated with increased rates of assisted instrumental and caesarean births. In other words, CTG provides reassurance of a small reduction in negative outcomes for babies and, conversely, the significant risk of intervention and surgery for mothers.

are severely compromised and limited (Feeley, Thomson and Downe, 2020). Having considered values and preferences antenatally and defined them in their birth plan, maternal freedom to make active choices and decisions intrapartum is compromised in practice (Tracy and Page, 2019).

THE IMPLICATIONS OF RISK PERCEPTIONS FOUNDED IN BIAS against the female body (Shildrick, 2017), extend far beyond the interactional dynamics between mothers, midwives and doctors. They present significant institutional and practice implications which affect the conditions into which mothers deploy their birth plans. Under successive Governments since the 1980s there has been a significant shift within the NHS away from clinical autonomy¹² and towards clinical governance. The system of clinical governance introduced by the New Labour government in 1997 was designed to consolidate and codify knowledge across the NHS estate, to systematise practice and to regulate clinical decision-making by bringing together the best available quantitative and qualitative data and expert opinion (Frohlich and Schram, 2019; Scamell and Stewart, 2014). The new, evidence-based National Clinical Guidelines introduced to maternity services clear protocols which clinicians could be both compliant with and scrutinised against. This response was intended to flatten risk and avert unavoidable harms related to unlimited, unscrutinised professional judgement and personal expertise. As well as the ethical, Hippocratic responsibility to provide the best possible care, in pragmatic terms adverse outcomes also represented a high-cost exposure as a result of increasing culture of litigation against the NHS (Clancy, 2020; Scamell and Stewart, 2014)¹³.

¹² In which the practitioner is presumed to exercise appropriate conduct reflecting the standards and expectations laid down in implicit and explicit professional codes (Shildrick, 1997)

¹³ Litigation claims against maternity care in the NHS are not insignificant, accounting for 50% of total claims against the NHS and 90% of pay-outs (Clancy, 2020)

However, these standardisations of clinical practices, in concert with funding cuts since 2010, had a counter effect. This was to affect a habit towards bureaucratic care driven by adherence to guidelines. In turn, this legitimised adherence to more restrictive, defensive practices in an atmosphere of risk aversion and litigation avoidance (Frohlich and Schram, 2019; Scamell and Stewart, 2014). While this increase in bureaucracy may seem at odds with the neo-liberal reliance on choice described within the framing, it is in fact consistent with what Monbiot (2016) described as ‘pettifogging’ bureaucratic processes and measurement necessary to ensure workforce conformity to standards that deliver the consistently high products and services required for success in the conceptual free market.

The result to midwifery practice has been the on-going formalisation of midwifery practice as risk management (Clancy, 2020; Scamell and Stewart, 2014; Martin, 1989), which is significant, as midwives are the health care providers who are primarily recipients of the birth plan (Divall, 2017). In this construction the role of midwife is primarily as manager of the intrapartum period, in compliance with proscribed guidelines on surveillance, monitoring and adherence. Midwives are made responsible for clinical measurement rather than holistic observation. For individual midwives this presents a tension between the clinical responsibilities of risk management¹⁴ and the relational responsibilities of being ‘with woman’ and supporting maternal experience. Midwives are faced with the choice to practice in one of two ways; either to practice defensive routine surveillance, which is compliant, but which compromises their values (Kirkham, 2015), or they act under the radar, pushing boundaries of standardised care and practicing the ‘responsible subversion’ (Barrett, 2015, p63) of the ‘safe maverick’ (Clancy, 2020). Both these approaches can present difficulties for midwives. Those who ‘toe the line’, prioritising protocols and guidelines which may not be in the best interests of the individual mother, but which do meet their responsibilities to their Trust, must reach a settlement within themselves. These settlements have consequences to the individual in a profession where the major source of job satisfaction is reported to derive from relationships (Mainwaring Elliot, 2021). In turn

¹⁴ The tension between ‘too much too soon’ and ‘too little too late’.

this affects overall staffing, as statistics reporting 80% of departed midwifery staff may return to practice if there were a change in culture (Mainwaring Elliot, 2021).

The alternative is to practice the tacit, relational midwifery care which takes the view of the whole woman in context, although this more intuitive approach makes midwives vulnerable in an organisation which has institutionalised risk surveillance and management. In this dynamic, midwives use intuitive skills to 'read the room' and make quick, contextual dynamic assessments (Clancy, 2020; Scamell and Stewart, 2014; Kirkman and Lee, 2008). They do this in the context of an institution which has no framework for intuition, but which defines, measures and records (Scamell and Stewart, 2014). Those who do not adhere to bureaucratic administration must be constantly alert to the implications of practicing care that pushes the boundaries of proscribed practice within a blame culture, under fear of litigation (Clancy, 2020). This drives individualised, tacit care underground – which in turn hides it from the system, preventing development and improvements (Scamell and Stewart, 2014). This is just one factor which limits the possibility of compassionate, individualised care. Demands on already stretched time and resources, and a system which does not reward the energy investment required to provide humanised care, work in conjunction with an institutional lack of supportive management to inhibit and restrict mother-centred midwifery (Elliott-Mainwaring, 2021; Clift and Steel, 2015; Kirkham, 2015)

My analysis of the literature relating to birth plans identifies a number of complex, nuanced and interrelated themes. Firstly, the written birth plan is representative of a historic and contemporary imbalance of knowledge and power in birth. They reflect a narrative of hierarchical and oppositional binaries which intersect personal, practical and political paradigms which privilege codified decision-making over tacit, relational care. These beliefs and biases are complicated by the physiology of birth, which is vulnerable to context and environment, and is also both the effective evolutionary solution to reproduction and unpredictable and potentially fatal. These themes locate

the birth plan at the centre of a complex web of conflicting and competing positionalities between mothers and care providers.

Even though birth happens to and through women, in 21st century Britain knowledge about it is overwhelmingly held by formally trained health professionals. The contemporary birth plan – an optional format through which mothers can express their choices and engage in their care, rather than a standard element of care - is a tacit acceptance of this. Through a feminist lens and taking into account the history of the transfer of knowledge and power over birth from the female to the male sphere, the birth plan can be understood as a way for mothers to regain engagement and status. However, this is done in the shadow of deeply embedded discourses which position care providers as the holders of credible authoritative knowledge and constructs the knowledge and perspective of mothers as nebulous, dynamic and unrealistic. These forces work together to both evidence and perpetuate hegemonic pathways of care which do not conform to the needs and desires of mothers.

The birth plan has become a site of conflict in what has come to be known as the 'Birth Wars' (Hill, 2019; Wolf, 2017; Dombroski, 2016), an ongoing ideological conflict between managed and physiological framings of birth. This discourse positions pharmacological, technological and surgical interventions as an over-reach of medical management which undermines female physiology and women's capacity to meaningfully and rationally engage in their intrapartum care (Kirkman and Lee, 2008). The opposing perspective is that physiology-first, or salutogenic, models of intrapartum care fall for the 'naturalistic fallacy' that everything natural and physiological is better than technology (Lucas, 2015). These two positions have become polarised epistemic binaries in which the tensions lie between the technological and physiological, risk and potential, outcomes and experience, and has created unhelpful stereotypes of different types of mothers, midwives and doctors (Green, Kitzinger, and Coupland, 1990). These black and white binaries are not representative of the neuro-hormonal-physiology of birth, which is complex and multi-faceted, and which both benefits from, and is vulnerable to, context and environment.

This confluence of conditions - hierarchies of knowledge and maternal determination to control certain aspects of their birth experience via the birth plan - gives doctors a concern that mothers have an unrealistic expectation that they can control birth, and the belief that mothers with birth plans are inflexible, unwilling to yield to concerns, unrealistic about the process and intensity of birth and unduly concerned with minor matters. (Lopez-Gimeno, 2021; DeBaets, 2016; Dombroski 2016; Whitford and Hillan, 1998). Further, the literature suggests that an ambition for choice and control via the current common formats of the birth plan is not synonymous with the physiological reality of birth, nor is it attainable in the context of those systemic and structural pressures. This suggests that the birth plan is unequal to the task of facilitating active informed choice intrapartum. Overall, this witnesses a story of hierarchical binaries, each encouraging parallel but opposing uni-directional expectations of birth.

It is these attitudinal factors which limit the ability of individual birth plans to facilitate the individualised, compassionate intrapartum care that mothers consistently define as a primary objective. However, despite consistent recommendations for this over the last 30 years in the UK, it remains unforthcoming. Analysis of the literature suggests this is related to institutional biases against female reproductive bodies as sites of risk, and clinical guidelines which incline towards defensive practice in order to mitigate litigation. Birth plans continue to be a significant factor in the antenatal preparation and intrapartum communication for mothers. While much of the extant literature focuses on the benefits and implementation of continuity of care models, I intend this study to augment the canon by providing insights into how mothers prepare for birth, and approach choices and decision-making.

Methodology

THESE QUALITATIVE SEMI-STRUCTURED INTERVIEWS took place in July 2021. By this date maternity services had been subject to Covid-19 measures for at least 16 months, and midwifery services, already stretched as a result of the midwifery crisis, were experiencing additional pressure of staff absences due to Covid-19 self-isolation. Each of the mothers in this research delivered their last baby within the previous six months, and therefore experienced maternity care subject to some form of Covid-19 service adaptation.

OAKLEY (1981) DESCRIBES ANTHROPOLOGICAL RESEARCH as 'getting inside the culture', and I undertook this research as someone already thoroughly embedded in the culture of childbirth. I am the mother of three children, and it is perhaps relevant that, extremely unusually, I received care from the same two midwives through all three of my own pregnancies and home births between 2010 and 2015.. I am the daughter of a mother who suffered birth trauma in the mid-1970s. I am a member of various peer communities of mothers - my three sisters, my friends, the local community of mothers with similarly-aged children and the mothers communing nationally in online groups - each of whom share different attitudes to and experiences of pregnancy, birth, their bodies and mothering. Finally, I am a doula and have been present as an antenatal and intrapartum confidant and supporter for numerous diverse families since 2018. In the time that I have been writing this thesis I have attended six births (three at home, one in an on-site birth centre and two in two different hospitals) and supported a further 11 women antenatally¹⁵.

¹⁵ My ability to be with women during labour was compromised for much of the coronavirus pandemic, as the number of birth partners allowed to support labouring women remained limited in many Trusts. One of my clients observed the injustice that while she was unable to rely on the support of a second known and experienced birth supporter during her birth, people in England were able to drink in pubs and attend football matches. These inconsistencies in

In my work as a doula, I observe and interact with the relational, institutional and personal aspects of birth which ground this research. I have witnessed the full spectrum of birth experience, from the joyful, empowering and healing, to the frustrating, painful and traumatising, and - more frequently - the complex and multifarious experiences between these poles. I have observed how different care providers affect the birth room and questioned my own agency, influence and responsibility. This position as mother-doula-researcher augments my ability to identify and categorise the experiences described by interviewees. It provides a rich frame of reference, from within which I can confidently distinguish common threads of meaning. This makes my interviews particularly 'subject-subject'. In revealing my doula alter-ego to interviewees, I frame myself and my ability to parse their experience in a particular parallel and relational way. It locates my interest in them and their stories as distinctly humanised and might suggest to them that they are not 'objectified as functional data sources' (Oakley, 1981), but engaged in the research *with me*. Further, the semi-structured interview format institutes a dynamic in which interviewees actively partook in directing the research, covering territory and issues they themselves understood to be meaningful and valuable. All interviewees asked to see the completed research on publication, which I consider evidences their interest in maternity care, and the part they may have played in improving it.

This positionality also presents a challenge, however, in that in the meanings I have made from the data in this study is not separate to my situated position as a doula and cannot be disaggregated from the experiences and knowledge gained in my work (Berger, 2016). With reflexivity in mind, I am mindful that my positionality shaped interviews and drove the direction of discussion in some ways, as well as limiting or obscuring others. My positionality is present at least in my choice of research questions, interviewee recruitment channels as well as my interpretation of interview data as it is filtered through my own experience.

coronavirus restrictions have been the focus of the campaign #butnotmaternity supported by charities AIMS, Birthrights, Doula UK, the Fatherhood Institute, Make Birth Better and the Birth Trauma Association.

IN 2019, SOON AFTER I HAD COMPLETED TRAINING AS A DOULA, I discussed with a colleague whether maternity services were intrinsically misogynistic. I contended 'yes', because so high a proportion of women are harmed during a common, evolutionary, physiological process, which is unique to half the population. She thought 'no' because the same funding issues and paternalistic care models prevail throughout the NHS and also harms men. What I was trying to articulate – but lacked the vocabulary to adequately describe – is that maternity services are not appropriately structured to accommodate this common female experience *because* it is a female experience. It is as a result of this early impression – and my subsequent experiences in the birth room – that I ground my thesis in Irigaray's work on the materiality of sexual difference and the female imaginary.

My colleague was accurate in one way. All NHS services are predicated on evidence-based research which is measurable, quantifiable and designed to ease or resolve diseased and/or damaged bodies. What is evidently problematic about this approach for maternity services is that the bodies in their care are neither diseased nor damaged (although they can behave unpredictably), but are active, dynamic and energetic, as described by Cohen Shabot (2015). This overt discordance is one which begins to suggest the foundational dissonances between the organisational framework and the bodies which traverse it. Moving beyond the post-modern despatching of the material in favour of discourse, and returning the maternal body to the fore, Irigaray provides a schema which recognises the conceptual and quotidian perspectives our flesh-and-blood sexed bodies inspire, the contrasting *understanding-of* and *relationship-with* the world that results from sexual difference. Irigaray termed these different personal and population level expectations, values and needs the 'female imaginary' (Whitford,

1989)., and Grosz describes the implications thus;

The ontology of sexual difference entails sexually different epistemologies and forms of pragmatics, that is, different relations to subjects, objects and the world itself

Grosz, 2012, p72

The female sexed experience of the world, embodied in menarche, menstruation, fertility, pregnancy (and its loss), birth, lactation, mothering and menopause, does not simply represent the homeostatic workings of individual bodies, alone-in and separate-to the world¹⁶. It is foundational to the sense and order we make of these functions (and mal-functions), our whole human selves, each other and, particularly and uniquely for pregnant women, the embedded body within their own . This legitimizing of the reciprocity between *mind-body-world* foregrounds the vital knowledge that our bodies - in birth in particular - are relational. Birth is not merely an event to be objectively observed, but an amalgamated neuro-psycho-social affair which is both affected and augmented by appropriate social context (Olza et al, 2020; Trevethan, 1997). I take the position that the material body itself is without prejudice. It simply is. It is also, however, the canvas upon which cultural and environmental conditions are actively applied and, at best unwittingly, reflected. It is a social construction that the male imaginary has been centred as the norm, while the female imaginary has been de-valued, constrained within the domestic sphere and regarded in terms of comparison, exchange or use. This male imaginary is embedded in time, culture and psyche and foundational to scientific knowledge (Criado-Perez, 2020; Grosz, 2012; Martin, 2003). It is from this perspective that I position British maternity care as phallogocentric: that is, so tightly woven onto the structural warp of the hegemonic male-sexed conception of the world, that the needs and values of the female body have become de-privileged.

While this centring of both the sexed-female body and reproductive function, process and experience has been critiqued as opening an arena for essentialising (Gatens,

¹⁶ In contrast to the archetypal male who's objective is to be self-made and unmediated by another (Jane Clare Jones, 2014; Whitford, 1986)

1995), I consider that acknowledging the traits and tendencies which accompany material sexual difference is not in itself reductive. To recognise reproductive reality need not be to define the value of all women in this mode. Further, I contend that in stepping away from the material body we risk falling into the trap Martin (2003) describes as 'comparison by equivalent standard', because in the male imaginary 'equivalence' doesn't mean 'different but equal', it continues to mean 'judged against the standardized male'¹⁷.

Read through foundational androcentric language, mindset and institutions, the functions of the female reproductive body have been so distorted and disrupted, it has come to be understood as inherently problematic, risky and taboo. Women's bodies are therefore managed, measured and assessed in anticipation of their failure, and the requirement for medical intervention to protect women and babies from risk. Medicalised, managed birth can therefore be understood as a social construct, ideological, reflecting and perpetuating a narrative which both facilitates and absolves oppression of women in birth in various forms, from cultural imperatives mediating birth choices to obstetric violence. By contrast, a feminist reading draws attention to the patriarchal nature of these beliefs and biases *and* identifies them as iatrogenic, i.e., the very pathways of care inhibit the physiological process and cause greater pathology (Braun, 2003; DeQuinzio, 1999). In my view this impasse – otherwise known as the 'Birth Wars' (Hill, 2019; Wolf, 2017; Dombroski, 2016; Glosswitch, 2016) - is itself a reflection of the male imaginary. In this fixed, universalist dynamic opinions about the most appropriate ways to deliver maternity care are oppositional and hierarchical (Whitford, 1986), giving one position greater credibility and validity than the other. This limits our ability to move from epistemology to ontology (Hekman, 2008), providing too simplistic and too binary a pair of perspectives to adequately capture the chaotic, messy, inter-related reality of the birth room.

¹⁷ And I would argue as a doula that as women suffer greatly from lack of knowledge about how their bodies work and their ability to make informed perinatal choices about their bodies, feminist perspectives that centre the materiality of the body and sexual difference are vital to our daughters.

This research is not intended as 'Grand Theory' (Jackson, 2001), but instead to identify the various forces – or 'diverse assemblages' (Dombroski et al, 2016) – which influence actions, outcomes and experiences in the birth room. In this I follow Pickering's metaphorical mangle, (Hekman, 2009), which flattens the distinction between the agency and influence of discourse, human scientific endeavour and the material world, and proposes these multiplicity of human and non-human factors can influence attitudes, experiences, outcomes and perceptions. In taking this qualitative, phenomenological approach I intend to connect meaning and significance to the richness of the personal experiences of mother and midwives and, perhaps, to offer new perspectives which can improve relationships between mothers, doctors and midwives.

MY INTENTION FOR THIS QUALITATIVE, ETHNOGRAPHIC RESEARCH was to gain rich insight into mothers' experiences of writing and sharing birth plans. When I planned this research, I began by considering what *change* in their care mothers sought when they wrote their birth plan. This was based on a hypothesis I developed during my work as a doula, that multiparous mothers who wrote birth plans were unhappy with the baseline care they had experienced in previous childbirth experiences and intended their birth plan to effect a direct change to the mode and pathways of care they received from their care provider. However, while each of the mothers interviewed as part of this study expressed some level of dissatisfaction with aspects of care in previous births, none of the mothers expressed an intention for their birth plan to effect change in their care, nor did any of the midwives interviewed suggest it was a feature of the birth plans they received in practice. As I result, and in consultation with my supervisor and TAP advisor Dr. Clare Jackson, I broadened my research question to ask '*what do multiparous mothers seek to achieve when they write their birth plan?*'.

I chose to interview multiparous mothers as their experiences of at least two births provides them with insight to and context of their own experience of labour, variations in practice, and the relation between writing and employing their birth plan. I selected mothers who were within 6 months of their last birth to ensure their reflections were

relatively unmediated by time, and their experiences were topical. Interviews with midwives provide the balance (the 'intersubjective community, Englander, 2012), offering accounts of the intrapartum role of birth planning and birth plans, observations and interpretations of alternative midwifery approaches to birth plans and insights to the broader contexts of clinical responsibility and working within protocols and guidelines determined by the NHS and the individual NHS Trust.

Ethics approval was granted by the University of York Centre for Women's Studies Ethics Committee on 4th June 2021, along with approval for my participant information forms (one version for multiparous mothers and one for midwives) and participant consent forms (see appendix i.). The study was designed to accommodate 3 multiparous women, 3 midwives and a Head of Midwifery – for this study data saturation was not sought. At the outset of research, I had intended to interview midwives who were currently working in various birth settings, including obstetric-led units, birth centres and community midwives attending home births. This would have given perspective on the similarities and differences in how birth plans are perceived and deployed in different settings. I did not receive any expressions of interest from midwives currently working in an obstetric-led unit, and without approval from the Health Research Authority (see footnote 22), I was unable to approach midwives directly via their Trusts. It is also for this reason that I was unable to interview a Head of Midwifery. Ultimately, I was able to interview one midwife currently working in the NHS in an on-site birth centre, and two independent midwives (IMs). It is notable that the IMs work with a particular cohort of mothers – those who are actively seeking to avoid care within the NHS – and that this may well influence their perceptions of physiological birth and also limit their exposure to a breadth of attitudes towards and experiences of birth and it is fair to note that these midwives each described a strong commitment to physiological birth and woman-centred care, which may not be present in the same way for midwives working in busier, more challenged birth locations. To some extent this was overcome by the NHS career experiences of both IMs interviewed, however a development to this research would be to include midwives who work in consultant-led hospital units.

Recruitment for both mothers and midwives was achieved via Facebook & Instagram, with public posts on my doula business page, in one regional and two national Facebook groups for mothers, and two national Facebook groups for midwives. Potential interviewees were asked to express their interest via my University of York email address. Once I received their signed and dated consent form dates for interview via the University of York zoom account were agreed, at their convenience.

Serendipitously, interviewees were located across the UK with the most northerly in Scotland and the most southerly in Kent. Each interviewee therefore had experience of giving birth in different birth locations under different NHS Trusts, which gives this research useful breadth (particularly given the relatively small number of interviewees). The only selection criteria I applied to the group of mothers was place of birth; the first interviewee to return signed consent forms for each birth setting/care model (a consultant-led hospital setting, an alongside-birth centre¹⁸, a home birth supported by NHS community midwives and a home birth supported by an independent midwife (IM) was accepted. I did not intend this research to draw conclusions about the relationship between socio-economic demographics and attitudes to and behaviours in birth planning, and so I did not request information about mothers' employment, educational attainment or economic status (not least because my anecdotal and personal experience of mothers in the midst of their child-bearing and rearing years suggests such flux in their working lives that this may not be a useful indicator). Green, Kitzinger and Coupland (1990) identify that the socio-demographic status which suggest social stereotypes of mothers in maternity care (and which Hill (2019) identifies as still prevalent) are not helpful categorisations to indicate attitudes towards or expectations of birth or birth plans. Haines, Rupertsson, Pallant and Hildingsson (2012) claim attitudinal insights as the better perspective from which to anticipate behaviours.

¹⁸ A birth centre sited within, or alongside, a hospital with a consultant-led birth unit, and therefore in proximity to obstetric support if required. This is distinct to a 'stand-alone' birth centre, which is sited in the community, where ambulance transfer to hospital is required to access obstetric care.

It is notable that all interviewees (mothers and midwives) were white, at a time when racial injustices in birth remain a critical factor in outcomes for mothers¹⁹. This research is not intended to address the specific intersectional hurdles faced by mothers disadvantaged by systemic and structural factors, including black and brown mothers (Homer et al, 2017), mothers from migrant and traveller communities, mothers with English as a second language, young mothers, disabled mothers, mothers from within the lesbian and transgender communities and others. However, I hope that findings would augment further research in those areas.

All births took place during the Covid-19 pandemic, and so were influenced by a global health crisis. When interviews took place in July 2021 maternal choices regarding place of birth and birth supporters had already been significantly restricted for 16 months, with intermittent suspension of home birth services and the closure of some birth centres in response to Covid security measures and a midwifery shortage exacerbated by Covid isolation guidelines. In the midst of writing, in November 2021, a 'March for Midwives' took place in various public locations across the UK as a response to the national midwifery crisis (BBC, 2021).

Mothers sent their birth plans to me prior to interview, which I used to shape a picture of the mothers overall attitudes to birth plans and to the birth described in particular (see appendices v., vi., vii., viii., ix.). These birth plans enabled me to identify emerging themes in advance of the interviews (for example, requests to midwives and doctors to avoid intervention unless 'necessary', as described in the Finding, p55) and suggested similarities and differences in approach which offered me prompts for further areas of discussion during interviews . This was a revealing exercise from my position as a doula, as I was able to perceive the birth plans as a midwife might, without the context gained during the planning process I am often party to.

¹⁹ The MBRRACE report 2018, covering data gathered 2014-2016 identified that black women in the UK are five times more likely to die in the perinatal period than white women, and Asian women are twice as likely. This statistic has led to increased campaigning on this issue by grass roots pressure group 'Five Times More' and the human rights in birth charity Birthrights, who completed interviews informing a forthcoming national study in January 2022.

Each interview was scheduled to take an hour, and took place in July and August 2021 (see appendix ii.). While interviews were unstructured, I began each with a general question about their wellbeing and their new baby. I then reminded them of the purpose of the interview, how their interview would be used and their opportunity to withdraw. I referred to their birth plan to ask some specific questions in interviews, but overall, the interviews followed the path of experiences both mothers and midwives chose to share, thus covering topics and issues they understood to be most relevant.

Interviews with all four women and three midwives took place via Zoom. They were recorded via Zoom and then uploaded to NVivo where they were auto-transcribed and then coded by me. I used a systematic grounded theory approach to interview analysis, enabling me to identify patterns and themes as they emerged from each iterative review. I transcribed each interview in NVivo, coding experiences, ideas and motifs. Simultaneously I collated my personal reflections on interviews and the emergent themes in a research diary. Once all interviews had been transcribed I returned to them and studied the themes in turn, ultimately collating each theme into higher level groups, until the five themes presented in the Findings were consolidated. It is notable that a number of other themes and concepts emerged from interview which offer fertile territory for further research, including the nuanced intrapartum dynamic between mother and midwife, the tension between a woman's legal right to consent or decline treatment intrapartum and how this plays out in practice and the barriers to compassionate midwifery care. Emerging findings were discussed with my supervisor at monthly supervision meetings, and at two TAP meetings on 2nd July 2021 and then 8th December 2021.

To preserve anonymity, I use pseudonyms for my interviewees. For the four multiparous mothers I chose the top four girls names as listed in the article *Top Baby Names of 2021* on Babycentre.co.uk (November 2021), allocated in order of interview (with the top name allocated to the first interviewee, and so on).

Interviewee 1, *Olivia*.

Olivia's third baby was born in an along-side birth centre in South London, six months prior to interview. *Olivia's* first two babies were also born in the same along-side birth side. *Olivia* sustained a significant but temporary birth injury after her second baby which influenced her planning for her third birth.

Interviewee 2, *Sophia*.

Sophia's second baby was born in a consultant-led hospital maternity unit in Scotland, approximately 6 weeks prior to interview. *Sophia's* first baby was born at a different consultant-led hospital unit and spent some time in the newborn intensive care unit (NICU). *Sophia* does not describe this birth as traumatic, but her experiences were significant to her planning for her second birth.

Interviewee 3, *Lily*

Lily's third baby was born at home, supported by community midwives, approximately four months prior to interview. *Lily's* first baby was born in the consultant-led maternity unit of her local hospital. Her second baby, a daughter, died in pregnancy, and was stillborn at her local hospital (it's important to note that *Lily* reflects positively on this birth of her daughter, and describes how her birth gave her confidence in her body).

Interviewee 4, *Amelia*

Amelia's second baby was born at home, supported by a private midwife approximately two months prior to interview. *Amelia* experienced a highly traumatic first birth, further to which she remains engaged with her NHS Trust and the Parliamentary and Health Services Ombudsman.

Midwife *Ali*

Ali is an Independent midwife (IM) working in the North of England. She trained and worked in the NHS before moving to independent practice

Midwife Bridget

Bridget is an Independent midwife in the South East of England. She also trained and worked in the NHS prior to independent practice.

Midwife Carla

Carla works as a midwife in the NHS. She has worked on consultant-led labour wards, midwifery-led birth centres and community teams. She was a midwifery lecturer and now supports birth in an on-site birth centre.

All these women are hand-raisers, they volunteered to take part in this research which indicates they had a perspective they wanted to share. Their decision to take part in the study suggests they were both inclined and able to talk about their births. The interviews did not require much steering from me, as the women interviewed had much to share about their experiences and perceptions. There were occasions where a question from me prompted a perspective they had not previously considered, but largely each interviewee, mothers and midwives, shared their experiences of writing and employing their birth plans clearly and without hesitation. They are not women who found birth meaningless nor women who are deeply traumatised. They are women who chose to write birth plans which suggests that they expected to actively engage in their birth experiences. They all asked to see the thesis on completion, which suggests they have an on-going interest in the findings and the role they have played in this research.

Ethics in this area need to consider the potential emotional effect of discussing birth. Birth is an emotional and transformative experience and women often do not have the opportunity to reflect on their experiences. In my experience women sometimes are not clear on the chronology of their birth, and may remain unsure of what happened and why decisions were made, indeed why they consented in the moment. In the information-sheet given to mothers, I noted that discussing birth can raise potential emotionally intense and powerful thoughts and feelings. I noted that interviews can be ceased at any time and either resumed within the time available, at another date or not at all. At the end of each interview, I offered signposting to further support if required.

None of the women interviewed felt they required any further support or signposting post interview. I prepared similarly for interviews with midwives, aware that they, too, are under significant pressure in their role generally and particularly at the point of interview, practising during a pandemic and a midwifery crisis. None of the midwives interviewed felt they required any further support or signposting post-interview

Given the evident tensions between mothers, midwives and doctors, and my proposal that structural factors influence the quality and modality of care mothers receive, two further perspectives would have augmented this research. I had proposed to interview a Head of Midwifery in order to access their experiences of the practical, political and policies realities of NHS maternity care influences on care. However, this was not possible²⁰. The addition of obstetrician experience to the research set would have enriched the discussion of the role of the birth plan when birth deviates from the norm. However the scope of this research thesis does not accommodate more interviewees.

²⁰ Contacting midwives and Heads of Midwifery through their Trusts requires research approval from the Health Research Authority. I was unaware of this requirement when planning this research project, and by the time I was made aware, time constraints prevented me from pursuing this.

Findings

OVERALL, MOTHERS IN THESE INTERVIEWS reflected the findings in the existing literature relating to birth plans, in that mothers have a preference towards individualised, humanised care, from a known midwife in a continuity of carer model²¹. *Lily* described why this is important;

'...having continuity of care with somebody who you resonate with and your preferences and how you feel makes you feel comfortable...'

Midwife Ali described how continuity of carer benefits and improves her practice;

'...because we know each other, I know what they want, so oftentimes that is not something that they feel a need to be putting in plans...'

My analysis of the interview data identified five key themes. Firstly, that the complete, considered and complex planning that mothers' make antenatally is not reflected in the common (although not universal) format of the formalised birth plan. The approach to birth planning described by mothers in interviews is more flexible and nuanced than the written birth plan reflects.

Secondly, mothers intend their birth plans to be the beginning of their conversation with their midwives, to ease and expedite communication intrapartum, at a time when

²¹ A 'continuity of carer' is in contrast to the 'continuity of care' model currently proposed by the NHS. The former is structured so that mothers have a named midwife they can expect to see throughout the perinatal period. The latter describes a team-based model of continuity, in which mothers may see any midwife from a named team at perinatal appointments.

they anticipate they will be less able to converse. This positions birth plans as a form of 'work-around' the absence of relational care. Further, while the birth plans express preferences, they are not indicative of fixed positions on consent or decline for particular procedures which mothers recognise may diverge from their preferences. Rather they are intended to communicate a mode or style of care.

Thirdly, when writing their birth plan, mothers apply learnings from their previous 'childbirth career', and the narratives of their peers, to their planning and their plans. These findings are both high-level, relating to their beliefs about their bodies and the nature of birth, and pragmatic, aggregating experiences of the process and practicalities of maternity care.

Fourthly, while choice and control is important to mothers, they are more concerned with this in relation to their environment and the philosophy of care they receive, than procedures, which they are happy to consider in context. Further, some mothers are prepared to compromise their preferences to attain measures of certainty about the environment and level of support they can expect to receive. This certainty enables them to prepare appropriately, which in turn, provides them with greater control intrapartum, even if, paradoxically, it represents a compromise

Finally, avoidance of bureaucratic and de-humanised care is a definite and recurring theme. Mothers consistently are concerned to avoid care driven by generalised policies and guidelines, rather than by their situated beliefs and expectations, and contemporaneous information about their labour.

Theme 1 : 'Planning' vs 'The Plan'

Key finding : Mothers 'Do Planning' for birth. They also write a 'Birth Plan, which is the output of this planning, but does not comprehensively express the complete range of their considerations and planning.

THE BIRTH PLANS SHARED BY RESEARCH INTERVIEWEES bore strong similarities and substantial differences (see Appendices iv. to viii.). Helpfully for this study, they offer significant variation in complexity, format, length and style²². *Sophia* used the NHS birth plan template; *Olivia* formatted hers in a short, hand written table; *Lily* typed a detailed one page plan and supplemented this with 'at a glance' bullet-points; *Amelia* shared both the birth plan she wrote for her first, ultimately traumatic, birth and the significantly abridged version she wrote for her second birth, at home with an independent midwife (IM) (from this point on I intentionally separate this birth plan from comparisons with the other plans submitted for this research. *Amelia's* particular position as a mother who experienced her first birth as extremely traumatic, planning a home birth with the support of an IM, give this second plan a significantly different context).

Each of the plans incline towards undisturbed physiological birth, and so contain similar preferences for pain relief, comfort measures, positions for birth, and the first hours after birth. They are formatted along the sequential path of birth, starting with preferences for early labour, through second stage (delivery), contingency plans, third stage (delivery of the placenta) and 'the Golden Hour' immediately after birth. Bullet-points are used in all but one of the plans, presumably to provide briefly summarised, intuitive flow of information. The plan which does not feature bullet points is *Sophia's*, which is presented in the NHS tick-box proforma, laid out in a similarly easy to follow multiple-choice check-list format.

²² This selection of birth plans alone demonstrates the variety of birth plan any individual midwife may encounter during a single shift. Midwives need to adapt to accommodate these variances and make assessments about how the birth plan is presented, how well informed the plan is, the intention that has motivated the birth plan and how prepared for flexibility and change the mother is.

None of these plans were written in conference with a care provider or as part of a continuity of care(r) model. *Sophia's* community midwife enquired whether she had written her birth plan during an antenatal appointment, and '*strongly suggested*' that she did, otherwise the birth plans were not discussed with midwives or other maternity care providers antenatally. These birth plans then are clearly not part of a dialogue of iterative education and planning forming a sub-structure to relational care described in the literature review. Interviewees described the influences to the format and content of the birth plan included the NHS birth plan template (see Appendices i. and v.), National Childbirth Trust (NCT) classes, hypnobirthing courses (undertaken by all four interviewees), suggestions and recommendations from peers and from their own prior childbirth experiences.

In the short-form and definite expressions of preference in each of the birth plans we can recognise what Dombroski et al (2016) described as 'simplistic binaries of choice'. These include;

'I would like to give birth at home/in a midwifery unit/in a maternity unit in hospital' (Sophia)

'calm, dark, quiet, only essential monitoring' (Olivia)

'I will ask for Entonox if I need it...I would prefer to avoid other forms of medicated pain relief' (Lily)

*'In particular, **I would like to use a birthing pool for pain relief...**' (Amelia's first birth plan, bold emphasis her own).*

The neat precision of these statements belies the dynamic, unpredictable realities of the birth room, which these mothers recognised, and which *Lily* described;

'...a sense of...control is possibly the wrong word, because, you know, what happens will happen...'

While these short format birth plans are recommended to make the content of the birth plan simple and easy for care providers to absorb and respond to (NCT, 2019; Logan-Banks, 2019), it is this brevity which opens mothers to criticism for creating plans which fail to encapsulate the full complexities, dependencies and nuances in the birth room (see Appendix ix.).

Sophia was the only interviewee to use a pro-forma birth plan, choosing the NHS template available via their website (Appendix v.). In providing an array of multiple-choice options, this birth plan in fact defines and limits the choices which are available to mothers, in a way Kitzinger (2005) described as 'marginalisation'. In other words, in presenting a spectrum of available choices this birth plan simultaneously defines what is *not* available or optional. This policing of what mothers should or should not include in their array of choices is achieved through various subtle means which suggest there are options which are appropriate, mainstream and normal (Kitzinger 2005). In *Sophia's* NHS template birth plan presumption that mothers will consent to foetal monitoring of some form is achieved by the use of the phrase '*all babies are monitored*' prior to the opportunity to provide a comment regarding this procedure (Appendix v.). This excludes the possibility that some mothers may wish to decline foetal monitoring intrapartum, and is notable in light of Frohlich and Schram's (2019) assertion that in order for mothers to be able to give informed consent, they must also be able to give informed refusal.

The NHS template also positions birth squarely through the lens of 'medical risk'. This is achieved by first drawing focus first to risk contingencies at p2 (Appendix v.), before considerations for augmenting the physiology of birth are addressed (from page five onwards). There is little distinction between clinical issues (e.g., relating to surveillance, technology, procedures and intervention) and physiological or instinctive issues (e.g., defining a preference for immediate skin-to-skin contact with their baby, where removal of the baby from the mother might be considered to be an intervention). These

subtleties indicate that the birth plan is indeed a 'novel intervention' (Whitford, 2014), an adjunct which offers mothers limited and proscribed variations of care within an otherwise fixed and standardised care pathway (Frohlich and Schram, 2019). These examples can be recognised as in-practice illustrations of maternity care providers, as holders of authoritative knowledge, reinforcing hegemonic practices as described in the literature review (Scamell, 2016).

Three of the mothers in this research employ phrases and statements which evidence care providers concerns that birth plans are a vehicle to challenge and undermine professional judgement as described, by Yam et al (2017), DeBaets (2016) and Simkin (2007);

Sophia's birth plan

'Please don't ask to use continuous monitoring, scalp monitors or fetal blood samples unless you believe there is danger to the wellbeing of myself or the baby should these checks not take place.'

Olivia's birth plan

'Interventions : Only when absolutely necessary.'

Preference against episiotomy / ventouse / forceps'

Lily's birth plan

'I would like internal examinations and physical interventions kept to a minimum unless you think they are necessary for the safety of me or my baby'

The request to limit intervention 'unless necessary' presumes that interventions may be recommended without due diligence thereby challenging professional judgement. These statements are based in concerns about the potential for bureaucratic care practices, which I'll address later on in this chapter.

Further on in these three birth plans I identified examples of what DeBaets (2017) described as 'outdated concerns' (specifically relating to delayed cord clamping and

immediate post-natal 'skin to skin'). However, it was notable that there is no reference on any of the birth plans to the relatively recent OASI (obstetric anal sphincter injury) bundle of protocols which includes, as standard, a rectal examination immediately after birth. Some aspects of this bundle are controversial (AIMS, 2021), in part because mothers are unaware that this is now likely to be offered (as evidenced by the lack of reference to it in either these written birth plans or in interviews with mothers). *Midwife Shelia* also noted this in relation to her IM caseload, and called into question whether mothers are able to give full and informed consent to these invasive procedures if they are not aware of the bases for their recommendation or the implications for consent, or their right to decline, in advance of labour;

'The whole OASI protocol thing... some trusts have written into employment contract that, you know, you're expected to do this for every woman unless she opts out proactively and then, of course, you know... discussion for someone to decide whether they want to have an OASI intervention or not it's a complex and long and nuanced one and who has time for that?'

It is notable that none of the issues defined in these birth plans played any significant role in the interviews. As interviewees recounted why they had written their birth plans, what made birth 'good' for them and which aspects of their past experiences made their births particularly positive or problematic, there was significantly little discussion about pain relief options, positions for birth or managed vs. physiological third stage. Instead, mothers reflected on how important it was to have their concerns and desires taken seriously, to have their previous experiences taken into account, and to have rapport and trust with care providers.

In interviews, mothers described complex forms of antenatal planning. Each of the mothers used the birth plan as stimulus for discussion with partners regarding forms of support they desired in both best- and worst-case scenarios, and their preferences for contingency measures, such as caesarean birth. I will describe these complex forms of planning more completely within the theme of the Childbirth Career, later in this chapter. This dissonance between what mothers expressed in interviews and what is

recorded in their birth plans is, I suggest, an indication that the common birth plan framework is not adequate to mother's needs. Within the common birth plan format, which focuses on maternal acceptance or refusal of standardised interventions and procedures, there is no commonly recognised format or vernacular available to express a desire for personalised care. *Olivia* reflected that the birth plan template given to her by her midwife in an earlier pregnancy could have been 'more fulsome', while *Sophia* said of her NHS template plan;

'...I thought it was a bit clunky. I didn't love the template of it. But, as I said, I had limited energy and I was like, this is what I've got, so I'm just going to stick with it'

None of the mothers suggested they had considered alternative formats to communicate their planning to care providers, and I suggest that because there is no other frame of reference, mothers are unable to conceive of alternative ways of communicating their desires. These issues might be described as a 'failure of formatting', which makes birth plans appear to be a superficial sequence of disconnected choices. I further suggest that the combination of this failure of formatting with the absence of continuous, relational care is the nexus for critiques of mothers with birth plans as unrealistic and ill-prepared for the birth room. That is to say, that the format and flow of the birth plan is neither an indication of how well informed or considered a mother is, nor is necessarily an accurate representation of her true motivation and meaning.

In light of these findings I suggest that the limited composition of the birth plan (recommended for the ease of use of the care provider) is in fact the very thing which limits her ability to adequately express her position, knowledge base and desires *and* diminishes her credibility. The complex, pragmatic and flexible planning that mothers undertake antenatally is not reflected in the restricted format of the birth plan, which foregrounds 'choice' and 'control', but has no framework to communicate mothers' emotional anxieties and desires and hesitations in what is fundamentally a human experience.

Theme 2 : A Message to Midwives

Key finding : The birth plan is not intended as a route map, but the first step on the path to connection and rapport with their intrapartum midwife.

THIS THEME DESCRIBES THE POTENTIAL FOR THE BIRTH PLAN to affect the relationship between mother and care provider. It is axiomatic that birth plans are a way for mothers to communicate information to their care provider, and ultimately, for all interviewees, this is what the output of the process of reading, discussing and writing is; a message to their midwives. A request to be seen, heard and recognised as a unique individual. IM *Ali*, reflecting on the birth plans she worked with in her tenure as an NHS midwife says '*...I don't know how to express it but it's someone's message to you...*'.

In the current fragmentary system, even at planned home births attended by community midwives who also provide antenatal care, mothers are unlikely to have met the midwives who attend labour, so birth plans offer the benefit of communicating essential information to a new midwife in short order, at a time when the neuro-hormonal processes of birth may make it more challenging for mothers to communicate clearly. Both *Olivia* and *Lily* reference this as an application of the birth plan and *Lily* describes;

'...(it's)... for everyone else to work within as well because you don't know the midwife that's going to turn up so (I'm) able to say, actually here's my birth plan, and this is... what I want, without me having to explain it to you...'

The message is somewhat coded however. Mothers are not intending that the 'letter of the birth plan' is adhered to, but rather the 'spirit of the birth plan' is recognised and respected. As I reference in the first theme, while maternal birth plans describe their preferred outcomes, they also recognise that needs may change during labour. The birth plan is not a list of things mothers do or do not want, the mothers are conveying a coded message about how they want to be engaged in their care, and their attitudes to and hopes for their birth. *Midwife Bridget* defines this;

'... so it's where they want to give birth, the atmosphere they want, who it is that they want in there, that kind of thing'.

Mothers are sensitive to discourses around birth, and mindful of how they may be characterised. This is evidenced when *Lily* reflects;

'...I also didn't want to make - and I know it sounds silly - but I didn't want to make the midwives feel uncomfortable I didn't want them to turn up read my birth plan and think, oh she's one of these women that's all... (pause)... sort of airy fairy and quite, uhm ... (pause)... that I was just being really aggressive and anti-midwife because I'm not at all, I really rely on their... I really relied on their support when they were there, and so it was almost saying, these are the things that I want, but I also understand that you have your limits and your remit as well.'

Here, *Lily* appears to be working a nuanced set of considerations into her birth plan. She is mindful of the potential for her birth plan to raise tensions with her care providers and is simultaneously aware of the hierarchies of credible knowledge that may influence how they perceive her and her plan, and the effect this might have on rapport and quality of care. This is further evidence of the gulf between the breadth of issues that mothers consider during birth planning, and the superficiality of the birth plan, leaving abundant scope of interpretation by different parties.

I suggest the use of coded language in birth plans, and maternal awareness and tentative management of potential tensions and conflicts with care providers, are two factors which present specifically in fragmentary maternity care models, and which are absent in continuity of carer models precisely because of the established relationship with a named midwife (Sandall, Soltani, Gates et al, 2016). Access to a named midwife in a relational model of antenatal care offers mothers the opportunity to express the forms of care they want and need, and to discuss the nuanced implications of this to standardised midwifery practice within guidelines. Further, it facilitates individualised care-planning and risk assessments and the potential for realistic and appropriate

contingency planning, and has the potential to improve clinical outcomes as well as maternal experience (Tickle, Gamble and Creedy, 2022; Sandall, Soltani, Gates et al, 2016).

Theme 3: Childbirth career

Key finding: Mothers aggregate and synthesize learnings from previous birth experiences and apply these learnings to their overall planning, and to their formalised birth plan

IN DESCRIBING THEIR BIRTH PLANNING AND PLANS for second and subsequent births, mothers reflected on an iterative process during which they applied reflections on specific positive and negative experiences which influenced their expectations for what birth could and should look like. This correlates with the situational variability of Leff's attitudinal profiles, or 'orientations', described in Haines, Rubertsson, Pallant and Hildingsson (2012), which she describes as being fluid, and influenced differently by different pregnancies and contexts.

While all interviewees had attended antenatal education in one form or another in their first pregnancies, they described how this theoretical knowledge was inadequate to prepare them for the complex and intense realities of the birth room. *Olivia* described how she didn't know any mothers well enough to have a '*detailed conversation*' about birth during her first pregnancy and the effect that had as she planned her first birth with limited familiarity with the practical realities of birth, leaving her unprepared;

'...and I think...I think through my inexperience, I just simply, I just thought this is how hard it has to be...'

Each of the mothers applied their enjoyment or dislike of particular moments from their previous births, to inform their planning for this latest birth. *Lily* reflected on how her

experience of institutional care throughout her first labour in hospital informed her plans to labour at home for as long as possible;

'...I didn't want the experience (again) of crawling around corridors...being told, right, the showers over there, go on... so kind of evolving from that first experience, definitely.'

The planning mothers did for birth increased in complexity with each pregnancy and mothers made additional calculations to accommodate the practicalities and wellbeing of older siblings. In this study, Covid-19 measures increased the complexity of planning, specifically considerations for the care of older siblings during labour, and uncertainty about when birth partners would be able to join mothers intrapartum. *Olivia*, reflecting on her recovery from an injury sustained during her second birth described this;

'...I was really scared of that again, because.... just how difficult that is, particularly with two other children to run around after...'

I suggest that what mothers are describing directly contravenes the notion of mothers with birth plans as inflexible and unrealistic (Lopez-Gimeno, 2021; DeBaets, 2016). What is evidenced here is that the birth plan is not intended to generate an idealised outcome. Rather it is acutely realistic, built on real experiences, both positive and negative, and intended to provide the best experience, whatever the path of labour and outcome. This is particularly notable when *Lily* describes the birth of her still-born daughter and how, despite her distress and grief in loss, the birth of her daughter increased her confidence in her body's ability to birth and her determination to create the appropriate environment for this;

'...(her birth)... gave me that confidence, this time around, to say actually I've done this twice now, you know... my body did exactly what it needed to do and I have that confidence in myself now...'

While for some mother's previous experiences of childbirth are generally benign and allow them to refine their expectations and plans positively, other mothers hold distinctly traumatic memories and in these scenarios the birth plan can be described as 'defensive'. This is affirmed by midwife *Carla*, who notes that '*...multips²³ tend to know exactly what they **don't** want...*'. These defensive birth plans can be described as those intended to actively and very specifically control contexts and events intrapartum because trust and faith in baseline care has been eroded. Frohlich and Schram (2019, p124) state;

'...the traumatizing events of labour surface with absolute clarity when the women is pregnant again and she knows with absolute certainty that she cannot and will not be subject to that same lack of control again.'

Sophia, having not written a plan for her first birth, decided to do so for her second. When I asked *Sophia* if her second birth plan was an acknowledgement that she had not been happy with the baseline care she had received in her first birth, she replied without hesitation; '*Absolutely. Yeah*'. As part of *Sophia's* plan for her second birth she also transferred her care to a different Trust, in order to avoid being exposed to the same cultures of care she experienced during her first birth.

For *Amelia*, the trauma she experienced was so profound she opted out of NHS care entirely, retained the services of an IM and planned to have her baby at home. She says;

'I think you could make a club out of Mums who had a second birth as a home birth, and I think almost all of them would say, I just thought, I'm never going into hospital to give birth again, I can't repeat that experience...'

At this point in the interview *Amelia's* voice expresses the anger she still feels at the treatment she was exposed to. In an academic context it is possible for this insight to be

²³ Diminutive of *multiparous*, meaning a woman who has given birth at least once.

intellectualised, however it is important to report, recognise and respect the long-term physical and psychological effects of the traumatizing treatment *Amelia* suffered.

Amelia explored various options for her second birth, including free birth²⁴. Her consideration of this as an option is indicative of her determination to ensure she and her baby were not exposed to the same, de-humanised treatment she had experienced in her first birth. *Amelia* described an interaction with an obstetrician during her first labour, as she attempted to negotiate a return home and was being coerced into staying;

'(He said)...'No one's keeping you here... you're free to leave whenever you want. You can go home and free birth...if you stay here and let us induce you I can guarantee you a child that will see his first day at school... and if you go home and do what you want, I cannot make that guarantee.' So that was an absolutely dreadful thing to say to someone in my situation. ...I was very indignant because...I had no intention of free birthing and is that what he thinks of me, that I'm the kind of nutty... do it on my own in the woods, you know, this is, this is an extreme position and how dare you lump me in with these kinds of people...'

Amelia's description of this interaction foreshadows a significant shift in *Amelia's* attitude to risk assessment in birth planning. In investigating options for the birth of her second baby, in order to avoid the same risk profiles she was exposed to during her first hospital birth, *Amelia* is prepared to consider an option – free birth – which she had previously considered to be far beyond her boundaries of comfort and risk. Her experience of direct and overt coercive control by care professionals adds a new dimension to her planning and increases her range of options.

Further to extensive discussions with her partner *Alicia* settled on a home birth with an IM as a way to bring more certainty and control to her birth. In this private maternity care arrangement, rapport, trust and iterative planning form the most prominent modes of care, and considerably more time is available to mothers to discuss anxieties,

²⁴ 'Free birth' is to labour and deliver at home in the planned absence of midwifery support.

aspirations and options with their midwife. In preparation she spent time with her IM discussing plans, the history of her first birth, preferences and contingencies. It is notable that the plan she wrote for this second birth (Appendix vii.) was not intended to function as a communication tool between her and her IM. Instead, it was written as a contingency for sharing with NHS care providers should she need to transfer from home to hospital. She described that there was no need to define a plan with her IM because in the time they had spent discussing this upcoming birth they had established rapport and trust, and she felt confidence in her IM's practice and their shared plan for contingencies. Attitudes, approaches and boundaries are established antenatally, so if they are raised intrapartum it is clear that there is a reason to do so. This dynamic is reflected in interviews, with *Midwife Ali* describing how established relational care makes formalised birth plans redundant.

'...(if there is a concern)...that is so clear cut as to need a change of plan then that's really easy to communicate to people, because just by talking about it, it will become clear that it's something that might be an impetus for change.'

Theme 4: Confidence over control. Knowing what to expect.

Key finding: Mothers want to have confidence in the care and support they can expect to access and receive intrapartum. They consider the opportunities and limitations offered by their care providers and birth supporters in order to develop a realistic plan which they can prepare appropriately for.

THE ORIGINS OF CHOICE AND CONTROL AS the presumed focus for improved maternity care have been discussed in earlier chapters. In interviews, however, mothers suggested the freedom to exert control and choice may be facilitators for the factor they value most highly – confidence – rather than a goal in themselves. Each of the interviewees described how writing the birth plan with their partners was an effective way to discuss the support they want and need. In this process they found reassurance

that their partners knew what might be needed from them, and were prepared and capable of providing it. Mothers were mindful that their ability to speak and communicate clearly may be compromised by labour, and that their awareness of time and events may be altered. It's notable that *Olivia* and her partner were preparing for their third birth together and had discussed plans for their previous two births. Nonetheless it remained important for them to set aside time to jointly discuss plans. It was evident in interview that *Olivia* felt it was an important part of her birth planning to ensure her partner was prepared, and that this was reassuring to her. *Olivia* described why it was important to her to be reassured that they shared expectations for how her experience of birth would be managed;

'So that if ... I wasn't in a state to talk about it, he, he knew, and he could advocate on my behalf.'

Olivia describes the value of knowing what you can expect from the people supporting you;

'...and because I've been accepted into the birth centre, I think I already know...I knew how they, they approach birth and that they're, they're very woman centred...'

While mothers may use different schema to their care providers, their plans are no less logical, situated and realistic. Mothers recounted addressing complex and multi-axial matters in their antenatal planning, delving into the granular detail of pragmatic plans. These included straightforward concerns like moving from home to birth location or making midwives comfortable (for *Lily's* home birth), as well as contingencies, such as caesarean birth. Mothers described mediating sensitive and emotional matters with their partners and negotiating careful routes through conflicting perspectives. These detailed investigations of matters both within and outside their control provided reassurance.

Three interviewees described circumstances in which they had compromised their personal preferences in preference for certainty. *Sophia* had intended to have a home birth after a first unsatisfactory birth in hospital. However, home birth services in her Trust were being intermittently suspended as a result of coronavirus measures. Despite her overall preference to have her baby at home, she took the decision to have her baby in hospital, saying;

'I don't want to have, have my hopes up for having a home birth... to be told actually, you know there's another lock down, or whatever and then have to go into hospital, and not have a plan and not be settled on it, so I...yeah...I ended up having hospital birth'

Both *Amelia* and *Lily* compromised their personal preferences to accommodate their partners preferences and concerns. *Lily* had wanted to plan a home birth with her first child, but her husband, as a result of lack of confidence and experience in birth, felt it was too great a responsibility for him to accept. As a result she opted to have her first baby in an on-site birth centre. *Alice*, after her first traumatic birth, considered a free birth for her second;

'...so I did all this reading and I thought to myself, you know, this is what I want to do, I want to do this on my own I think I can, and my husband said, I can't, I can't take this, right, I can't take this risk with you, you know...'

The pattern that I identify in this theme is that mothers actively consider the complete picture of care providers, birth partners, contexts and environments that might influence the path of their birth and their experience of it, and adapt their plans and expectations to accommodate them accordingly, even while this requires compromise to their choice. While this reflects the maternal freedom to exercise her choices and control there is nuance here. These mothers are demonstrating not dogmatic, ideological choices, but those which are fully cognisant of all the factors which have the potential to augment or limit her birth experience. In fact mothers are synthesizing a significant and broad complexity of factors, as their planning extends across a variety of

domains, including emotional, practical and contextual concerns and, in these interviews, the implications of a global pandemic. Mothers are prepared to trade their preferences for alternatives when to do so increases their confidence in the care and context they will birth in.

Maternal planning, then, requires the freedom to make choices and exert control over compromises and sacrifices as well as the freedom to consent or decline. This flexibility is also true of decisions made intrapartum and is a feature in trusting relationships with midwives and care providers. Mothers in this study suggest a similar attitude to the 'ambiguous reliance' described by Westergren (2016), in which mothers expect both equity in decision-making and simultaneously rely on the professional guidance and judgement of midwives. This dynamic is therefore a complex, nuanced, relational and situational one.

Olivia describes how her midwife inspired confidence in her during her third labour, in a relational and reciprocal dialogue which can be described as a 'shared decision making' (see Appendix x.);

'...but in the first 10 minutes I felt at ease with her really... by taking my notes and reading my birth plan... actively taking bits out of that to discuss with me, that showed me that she was interested in what I wanted to do. And then she applied that to her midwifery knowledge, you know, and then we discussed it, so I felt like we were a team, and that she was listening...'

Conceptualising mothers' intrapartum decisions as being 'shared' with partners, the needs of the wider family and care providers comes with potential risk in. Those who work intimately with mothers and families in the perinatal period must be watchful for indications of unhealthy dynamics of control and compromise, coercive control and domestic violence, which increases during pregnancy (Finnbogadóttir and Dykes, 2016). This points to the delicate and imprecise line between shared decision making (described in the Literature Review) and risk of coerced consent.

As a doula, the third party observer in the birth room, I can attest that it is not uncommon for maternal compliance to be anticipated and expected, and sometimes enforced by coercion. Interventions and procedures are, on occasion, undertaken without informed consent, and sometimes without consent at all. At interview *Lily* described her experience of unconsented cord traction after her first hospital birth;

'She started pulling the cord and pushing on my tummy. She didn't, she didn't ask, there was no sort of, this is what I'm going to do now... all of a sudden, she started doing it. It was the first time I'd ever felt like this kind of thing...'

While I suggest in this thesis that maternal antenatal planning and intrapartum decision-making is significantly influenced by both human actors and non-human agents, this should not be thought to diminish the standard that fully informed maternal consent is sought and provided. Coates et al (2019), Westergren (2019) and Darra (2018) present analysis describing the interrelated and wide-ranging conditions required for fully informed consent and the practical means to facilitate it. What participants in this study seem to suggest is that trust, rapport and confidence in mother/care-provider relationships is a critical factor in gaining informed consent because consent is not solely a rational process, but also a relational one, requiring mutual good-faith and trust. This subtlety is somewhat evident in *Olivia's* description of how her midwife reassured her about an intrapartum change to her plans;

'And so she sort of almost pre-emptively made me feel better about that small deviation from my birthing plan.'

What is notable is that in fragmentary care models, mothers are not able to seek confidence and reassurance in the care in antenatal discussion and planning with care providers, in the way they are able to with birth partners, doulas or IMs. The complex planning that mothers undertake, and the full extent of their milieu is not recorded in the written birth plan and therefore represents a significant loss of insight into the character, circumstances and attitudes of the mother. The mothers in my research were

mindful of this omission and the potential for lost nuance to compromise the relationship with their care provider. As *Lily* notes;

'...they don't necessarily have any sort of influence in it, or conversation around it, and I find that quite frustrating, it would be nice to have a conversation... about why you're making the choices that you're making.... Some sort of negotiation around that rather than 'I found these things on the internet, I think this works for me.'

What the mothers in my research relate can be better described as a quest for certainty. They are aligned with the insight that choice is situated in both place and time. To attain measures of certainty, mothers knit together their internal desires – values and preferences – and the pragmatic reality of what is limited and what is available to them. This requires them to adapt plans and, in some instances, make complex and emotionally challenging sacrifices to attain an 'overall better' outcome. Both the written birth plans and the interviews evidence that mothers are mindful that birth can be unpredictable, and that contingency plans are an important aspect of birth planning. 'Compromise + confidence' seems to be a more comfortable equation than 'control + uncertainty (caused by contextual variables. As *IM Ali* notes, *'...it's the uncertainty that's worse than, uhm... making it the best it can be.'*

Theme 5 : The Avoidance of Bureaucratic care

Key finding: Mothers are aware for the potential for decisions to be made about their care based on standardised guidelines. Maternal antenatal planning includes strategies to mitigate and avoid this

While none of the interviewees used the term 'bureaucratic care', it was evident that mothers were mindful of this as a potential factor they may need to negotiate intrapartum. Bureaucratic care can be described as a set of conditions in which maternal somatic experience is undermined in favour of rigid guidelines for practice. This draws attention to the clinical conflict between the embodied and human needs of the individual mother, and the operational needs of the institution.

Lily described how, during her first birth, access to delivery suite at the hospital had been declined, because on examination she had not reached the required stage of cervical dilation. She understood this decision to have been bureaucratic, based on guidelines rather than her particular situation, and that it had had an adverse effect on the path of her labour and her experience of it. In turn, this influenced her planning for her third birth at home;

'...(that) increased my anxiety....it was the, 'Oh you're only, you're only two centimetres dilated so we can't let you in', uhm, you know I'd been in labour for a little while and then it was, 'Oh well, you're only four centimetres now' and it's, it's that psychological impact that it has, so... writing my birth plan, I had a look online at what some other, other people had written and whether that resonated with me and my experience of my first birth as well..

Olivia described her sense that the birth centre midwives were not anxious about labour, and in doing so hinted at her sense that in some settings care providers were more keen to intervene;

'Whatever happens, they, they were coming from that, that place, you know that they weren't going to rush me up to the labour ward on any small thing, you know I was quite, I was quite confident in them.'

Sophie noted that her community midwife '*...was very like, supportive of like, advocating for yourself against...obstetricians really (laugh)*', which strongly reflects the analysis of tensions between mothers, midwives and doctors described by Kirkham and Lee, 2008

While each of the mothers in this study expressed a preference for physiological birth, it is important to note that they were not resistant to appropriate medical intervention when indicated. Contingency plans for intervention was mentioned in each of their plans, notably along with the phrase 'unless absolutely necessary' (referenced in Theme 1 in this chapter). While care providers might identify in this a challenge to their professional judgment, mothers use the phrase in an attempt to divert their care providers from standardised care. Rather than a critique of practice, I identify this as evidence that mothers are conscious of the potential that protocols and policies may be placed before assessments of their immediate individual situation, which can be described, as bureaucratic care (Kitzinger, 2005). As *Lily* neatly summarises;

'So when they say you're not progressing fast enough that's because they've got other places to be and other things to do'.

These mothers are making plans in order to avoid care 'being done to' rather than being done 'with' (Midwife Carla says; '*...I find that we've forgotten how to be 'With Woman' and it's more 'do to' women*'). IM *Shelia* notes the subtlety; '*it's all about.... where you felt control was. Was it with you or was it with someone else?*'.

Olivia, Sophia and *Lily* presumed that their birth plans would be read and recognised by their care providers, however, it is not always the case that birth plans are well received and recognised. *Midwife Bridget* recounted her exasperation, as a senior midwife, when she learned that midwives in her team had not asked labouring mothers to share their

birth plans. *Amelia* describes how her brother's recent experience of sharing a birth plan intrapartum correlated with her own first birth plan having been ignored;

'...they (recently) had their second baby, and he said, you know your birth plan it's like.... it's like a poem you've written, you know, they're like, 'Oh, that's nice', you know, 'anyway, back to what we were doing'.... I was really, again, I was blindsided that having been encouraged to create this birth plan, no one looked at it, no one referred to it...'

While bureaucratic care can be experienced as an unpleasant irritant, it has the potential to be pernicious. *Amelia's* account of her first birth experience is an example of how bureaucratic care can overwhelm the process and experience of birth and illustrates a number of factors described in the literature, therefore she features heavily in this section. In her account, *Amelia* describes the effect of a formulaic care pathway, limited within guidelines, and used 'at' mothers rather than in partnership with them (in contrast to *Olivia's* experience of shared decision making, described earlier in this chapter). *Amelia* described feeling as though she were *'...on a conveyor belt, once you got going, that was...was....was...so bad, and it didn't need to be that way'*. The metaphor of the conveyor belt is a common one, in my experience working with mothers who have experienced previous birth trauma. This describes a dynamic in care providers use of strategies to achieve maternal acquiescence to recommended pathways of care, such as repetition of the question, interventions from new and increasingly senior members of staff to reiterate risk and recommend the procedure and the application of notional time pressure. *Amelia* describes how it felt to be exposed to this increasing pressure;

'...why do you need to induce me? We need to induce you, we need to induce you. So I kept saying no no no no no, already feeling stressed and unsupported, no one gives a toss.'

Amelia depicts being caught in an illogical cycle. A risk factor indicates an induction, however, *Amelia* is reluctant to consent to this, as her understanding is that it may be long and painful and may anyway result in a caesarean birth. Her preference is to

discuss the potential to move to a 'maternal request' caesarean, which she recognises is major abdominal surgery, but which comes with the benefit of certainty and control. She identifies what she perceives to be an absurdity, as she is told a caesarean is not available to her because her baby is not in distress, yet the potential for foetal distress is the driver the intervention of induction. *Amelia* is trapped within the bureaucracy and has no option for movement.

Here, *Amelia* describes a defining feature of bureaucratic care, the increased potential for a 'cascade of intervention'. Dreger (2016) describes this as 'maximining', a paradox in which care providers maximise the number of interventions, each with their own risk profiles, in order to minimise the odds of the worst possible outcome. This phenomenon describes the use of protocols developed to minimise risk, which invite the potential for greater harm than expectant management, which legitimises the prioritisation of risk management over humanisation (Curtin et al, 2021; Scamell and Stewart, 2014). Dreger (2016) calls attention to the evidence, which reflects *Amelia's* instinct, that interventions designed to prevent the worst harm increase the net harm. In other words, some of the interventions recommended by care providers carry a high risk of iatrogenic harm to mothers, in order to confer the statistically less significant benefit of diminished risk to their baby.

Kitzinger (2005) identifies that than in order to practice bureaucratic care, care providers must understand mothers to be unreasonable, over-reacting or not connected with their bodies. *Amelia* discerns that she is being identified as both ignorant, and a potential risk to her child, saying first;

'...there was clearly a feeling of, you know, 'what do you know about this?'...'

And then, perceptively;

*'I'm not high risk. It's not **me** that's high risk.'*

This bureaucratic care is far from the relational, shared decision-making model identified as the standard for maternity care. *Amelia's* experience of her first birth illustrates the significant gulf between the promise of choice and control offered by the birth plan and the reality of pathways of care constrained by rigid adherence to guidelines. It is here that I identify that the personal desires of the individual mother outlined in the birth plan are overwhelmed by structural forces. *Midwife Carla* describes the conditions midwives tasked with providing compassionate care for mothers are working in;

'... part of that is due to the current crisis in midwifery where there is not enough, midwives, and there is not enough time within the appointments that the midwives have and that's just been compounded by COVID... I think staffing is a big issue across at the moment, so I think there is this sort of drive to just get women delivered and sorted and to the Ward and, and it is never ending... it truly is never ending, and it is very difficult...'

The impetus towards bureaucratic care is a force that creates negative effects for care providers as well as mothers. It is facilitated in a risk-averse, defensive environment where the weight of focus is turned towards mitigation of avoidable harms that might lead to litigation, rather than avoidable, iatrogenic harms which, in the circumstances, have been categorised as acceptable damage to mothers. The conditions required for midwives to support humanised and compassionate care is unavailable to midwives, as they work under pressure of time, inadequate resource and the drive towards record-keeping and risk escalation (Barrett, 2015; Scamell, 2011). Compassionate care, which takes time and whole-mother assessment, is in fact disincentivised in a hierarchical, bureaucratic culture (Elliott-Mainwaring, 2021). *Midwife Ali* reflects on the pressure midwives feel to comply with standardised pathways of care;

'... because you do get singled out if your clients within the NHS make unusual choices that you don't normally see.'

Midwife Carla notes how this pressure to conform constrains individual midwifery practice, and inhibits their freedom to centre mothers, rather than guidelines;

'...it makes people frightened and so they feel that they must conform to everything, and they don't look deeper....'

Mothers anticipate that antenatal planning and preparation, and the writing of a birth plan, will give them the insight and tools required to navigate maternity care, but in reality, the birth plan is unequal to the task. *Olivia* reflects on how this played out on in her first birth experience;

'... yeah I just felt the first time that, despite having done like that (antenatal education), and the hypnobirthing online courses and stuff like that I just wasn't really in a position to advocate for myself'

Amelia recounts,

'...I basically encountered an environment that just, you know, coerced me in the absolute opposite direction of everything I thought was important and knew was important.'

The mothers in my research provided a consistent picture of the way they planned for birth and wrote their birth plans, and the intentions that drove them. The primary intention for each of the birth plans in this study was to ease and expedite communication with a midwife they expected would be unknown to them. While it is evident that mothers develop their understanding and refine their expectations during the course of their childbirth career, the insight is that they apply their learnings in specific and pragmatic ways. They evolve plans which will protect aspects of birth they found enriching, and develop strategies to either avoid or cope with elements they found less palatable. In these interviews mothers described the complexities of

assessing and considering a wide range of concerns and potentials, including the perspectives and limitations of partners, the dynamics and hierarchies in maternity services and the practical realities of maternity care – and this last was particularly pertinent, given each of these mothers had their last baby while services were subject to restrictions during the Covid-19 pandemic. The mothers in this study recognised the potential for a mode of bureaucratic care, which has the capacity to place them on a ‘conveyor belt’ of standardised care, which in turn might expose them to the risk of cascades of intervention. In this sense the mothers in this research were neither as ignorant nor passive as they are presumed to be. They saw in the birth plan an opportunity to state their opposition to this formulaic care, however their experiences in practice illustrate that the birth plan, intended to facilitate mother-centred compassionate care, is unequal to the structural forces which exert pressure that drives individual midwifery practice towards the bureaucratic.

However, while the choices mothers express in their birth plans are representative of the general outcomes these mothers preferred, they did not tell the full story of maternal antenatal planning. The similarities in general format and content focus of birth plans reviewed in this study – despite the variances in length and content – indicate that this is understood to be the norm, and that mothers adopt this framework and approach because they understand it to be the ‘normal’ way for mothers to communicate with their care providers. However, it is also a limiting factor. Their ability to represent themselves as unique and multi-faceted whole humans, and to define the modality of care and support they did want is significantly limited by the modular consent/decline ‘binaries of choice’ (Dombroski, 2016) which make up the common format of the birth plan. The choices laid out in the birth plan are neither specific statements of desire nor definitive statements of inflexibility.

What mothers value more highly than choice or control (which, interestingly, none of the mothers in this study expressed a strong desire to exert), is certainty and relational care. Certainty about place of birth, modes of care and the levels of support they can expect to receive gives them the freedom to plan strategies for coping intrapartum and postnatally. Relational care reassures mothers that their unique concerns will be

recognised and that they will receive care appropriate to their situations, values and contexts. Professional midwifery expertise matters to mothers, and they rely on midwives to augment physiological birth and identify possible concerns. The birth plans represented here are emphatically not associated with the rejection of medical care when required.

From this mother-side, birth plans have greater meaning than the transactional choices which are stated overtly within them. They make sense as part of a relational framework in which the whole human mother exists. It's only when the fragmentary statements regarding procedures, pain relief and interventions are drawn together that the full picture of the mothers intentions can be recognised. In isolation, in the absence of relational care, the individual elements in the birth plan fail to coalesce to direct humanised, personalised modes of care.

Discussion

In asking what mothers seek to achieve when they write their birth plan, I intend to look beyond the status quo and question whether birth plans have the capacity to provide mothers with the factors they want and need to experience their births positively. I intend to centre maternal experience as a meaningful measure of maternity care.

My research findings identified that mothers seek certainty about the forms of care and support they will receive intrapartum. Mothers suggest that they value certainty and rapport more highly than choice and control. They value shared decision-making dynamics with partners and midwives in which control and power is not held by one party but is a dynamic dialogue. They prefer to receive this care in a trusting, relational care model. They accept that this is not accessible in the current fragmentary framework of NHS maternity care and utilize the birth plan to circumvent that lack, and to ease and expedite communication with care providers they do not expect to know.

Mothers undertake antenatal planning which encompasses a broad range of considerations. These include their preferences for the birth outcomes as well as pragmatic contingencies and the contextual conditions of older children, available support and previous birth experiences. Mothers essentialise this planning into the framework of the birth plan. The framework is not universal, and there are significant variances in style, content and format. The common factor shared by birth plans are the that they are sequentially chronological with the stages of birth, they are considered to be short form and contained within two A4 pages (although intriguingly the NHS template birth plan is a notable exception to this). This format is adopted by mothers even while they recognise that it does not adequately reflect the full context of their planning and considerations. Mothers chose this plan because it is the standard,

recognisable format, and is endorsed by credible perinatal ‘experts’, including the NHS, the NCT, antenatal education providers and numerous perinatal brands. The birth plan is somewhat effective at improving communication and engaging mothers in their intrapartum care. However, it is inconsistent in this regard as the conditions required to facilitate compassionate care are beyond the scope of the birth plan.

In this Discussion chapter I propose that birth plans are symptomatic of, and a response to, significant dissonances in maternity care which are correlated with the underlying factors of neoliberalism, dualism and the imaginaries described in the Framing. I will suggest that the challenges presented by the birth plan to both mothers and care providers cannot be significantly resolved without acknowledging these factors.

Birth plans function as bridges which, in the fragmentary model, connect antenatal maternal planning and contextual preferences with intrapartum decision-making. I suggest the birth plan form this bridging takes is evidential of the neo-liberalisation of cultural and political attitudes towards health and wellbeing services. This foregrounds choice and personal responsibility as essential factors in attaining the best possible maternity outcomes. Encouraging mothers to write birth plans suggests they have some measure of control over the process, however, the neo-liberal presumption of control over the body is not synonymous with either the process or institutions of birth.

In a manner grounded in Cartesian dualism, neo-liberalism connects and valorises the health and wellbeing of the body with astute and logical decision-making. In maternity care this suggests that the choices laid out in the birth plan move the mother, as an engaged and responsible consumer of healthcare services, inexorably towards a ‘better’ outcome. This formulation is problematic as it does not adequately reflect the dynamic complexities of birth. The format requires mothers to pre-determine their choices about location, analgesia, and comfort measures antenatally, yet labour is dynamic and can be unpredictable. The birth plan essentialises the complex and contemporaneous decisions which may need to be made during a labour to a series of superficial, modular and

transactional elements, comparable to LEGO™ parts which can be constructed and deconstructed in the 'correct' order to attain the 'correct' outcome from the 'correct' design. Thus, when a birth deviates from the plan – appropriately or otherwise – this deviation is framed as the outcome of careless, ignorant or reckless decision making by the mother (Hill, 2019; Dombroski, 2016, Kirkman and Lee, 2008).

The neo-liberalisation of decision-making in maternity care presents a further challenge to mothers. When mothers are held to account for the 'success' or 'failure' of their birth to mirror the plan and deliver optimal outcomes, attention is drawn away from the systemic and structural issues which influence both antenatal maternal choices and decision-making agency intrapartum, and those which underpin the provision of care within the institution (Alcade, 2013; Bumiller, 2008). The effect is to confuse and obfuscate the factors which *do* influence maternal satisfaction.

In her important 2014 work, Drapkin-Lyerly identified that mothers experience birth positively even when measurable outcomes do not meet the correlation between physiological birth and maternal satisfaction (for example, when birth happens after an obstetric emergency, or as an unplanned caesarean section). She secondly identifies six factors which are correlated for positive birth experience across all outcomes; control, agency, personal security, connectedness, respect and knowledge. There is clear dissonance here between the equivocal, subtle and human factors that mothers identify as forging positive birth experience (relational care and shared decision-making) and the definable and fixed elements that appear on birth plans (preferences for place of birth or analgesia). This is reflected in the difference between the content of maternal antenatal planning and the content of the birth plan discussed in the Findings. I suggest that this dissonance signals the conflation of maternal experience with birth outcomes.

In inaccurately conflating outcomes with maternal experience, a binary is established with physiological birth positioned as a target to be achieved and therefore rates of assisted birth to be decreased. However, this is at odds with the basis of national clinical guidelines, which position birth as a high-risk process requiring technological surveillance and management. This has led to a tendency to assume that maternal

attitudes to specific interventions and procedures is rigidly negative, and that the presence of these interventions and procedures will diminish maternal satisfaction. Both positions turn attention away from maternal experience and towards measurable, transactional outcomes, which, I argue, has influenced the development of the commonly recognised birth plan as a format which offers a check-list of modular and transactional elements of care. These specific, transactional options may be factors which are common to the physiological births that mothers have a general preference for (Hodnett (2002) and as evidenced by the four mothers in my research), but they are not the only factors which contribute to positive birth experience, nor are they foremost.

My research, and experience as a doula, suggests that this presumption is incorrect. Mothers are not avoidant of medical procedures when they understand that they are necessary. Instead, they are avoidant of iatrogenic harm caused by interventions and procedures which are undertaken to avoid the potential for an obstetric emergency, often in line with standardised guidelines, rather than individualised assessments of risk.

This inaccuracy, though, offers benefits to a neo-liberal institution. In this model, where the best outcomes are attainable via the exercise of personal responsibility for making the best choices, those choices must be standardised. Standardisation can only occur when practices can be defined, exacted and replicated, and this can only be the case where practices are consistent and tangible. The human relational factors which contribute to maternal satisfaction and positive birth experience are too nebulous, situated and dynamic to be bureaucratised and standardised. The options proffered by the birth plan, which seem to promise the freedom of choice and control, are in fact rationalised measures of medico-scientific presumptions regarding what makes birth 'good'.

It is evident that there is significant tension between the control over and governance of maternity care practice enforced by National Clinical Guidelines and the objectives of relational, mother-centred care defined and recommended in *Better Births*. The

adoption of maternal satisfaction as a measure of maternity care presents a significant challenge. Maternal experience is emotional, subjective and dynamic. In an attempt to rationalise and measure it, the practice and procedures which have been identified to somewhat correlate with maternal satisfaction have become ideological goals.

The result of this misinterpretation has significant unintended consequences for both maternal experience and research. *Amelia*, reflecting on her first traumatic birth, describes this powerfully and viscerally;

‘,, and so you have to lie on your back, like a battery chicken and try and go into labour, while a woman you've never met before six meters away from you staring at you and writing on a piece of paper, and that's going to be described as a natural birth.’

Defining outcomes as goals for maternity care, rather than maternal experience, runs the serious risk of developing pathways and practices of care which are based in ideology. As I write this chapter in late March 2022, the second report of the Independent Maternity Review of The Shrewsbury and Telford Hospital NHS Trust (Ockenden Maternity Report, 2022) is anticipated. Among many findings, the report is expected to identify that the drive to reduce caesarean section rates was responsible for practices which led to the deaths of up to 300 babies and 12 mothers.

What are the factors which have contributed to the failure of maternity services to respond to the academic and public health research which has consistently identified that humanized relational care is what mothers seek from their birth experiences? In this analysis I suggest that beliefs and biases founded in dualism and Irigaray's description of the male imaginary play a part in hampering the development of maternity services in line with research findings.

Dualism, which I identified in the Framing as a conceptual foundation to medico-scientific approaches to maternity care, advances bias and prejudice against female bodies as unruly and bestial in contrast to the invaluable presumed rationality of the mind. Female bodies are regarded as a flawed deviation from the male standard (Gribble et al, 2022; Jones, 2014). Female reproductive bodies carry additional taboos arising from the messy corporeality of menstruation and birth and their theoretical threat to male imaginary avowal of bodily autonomy and sovereignty (Jones, 2022; Dammary, 2105; Green 2012).

This suspicion of the unreliability and risk inherent in the female reproductive body places the safety in maternity care directly and intrinsically under the auspices of healthcare, to such an extent that the consideration of alternative methods of measuring the benefits and effectiveness of maternity care becomes impossible. This is evident in the use of what Hill (2019) calls the 'dead baby card'. This tactic is used to shutdown consideration of alternative framing for maternity care in both the personal and institutional spheres. *Amelia* precisely described this narrative in her first birth experience; she recounted that in her attempt to negotiate an alternative pathway to the induction which was being recommended, her care provider suggested that were she to deviate from his recommended pathway, the life of her baby would be at risk. This strawman logical fallacy over-simplifies the risks of immediate and long-term harm to mother and child of medical intervention and perpetuates the narrative of mothers as ignorant of risk, unable to parse information and rigidly ideological in their avoidance of medical care.

I propose that this example from my research provides evidence for hierarchical, oppositional discourses which maintain authoritative knowledge mechanisms and simultaneously deprivilege other perspectives, in this case, the potential for tacit, intuitive, humanised and individual care. The pandemic exposed the tenets on which maternity services have been built, including the fundamental centring of risk management, which has been evident in the draconian adaptations to NHS maternity care services in response to the Covid-19 pandemic. Antenatal appointments were reduced and conducted via telephone rather than in-person, home birth services were

suspended, birth centres closed and restrictions were placed on the number of birth partners and their access to their partners intrapartum and immediately post-partum (Jardine et al, 2021). When services were reduced to their essence, it became evident that the power to make choices is merely granted to mothers, and easily revoked. The medical management of risk is judged to be a crucial precondition for birth while women's values and preferences are disposable and not easily won back. Twenty four months after the first lock-down, while all legal restrictions in England have been lifted, maternity services continue to be limited by COVID measure in many Trusts.

I propose that this is evidence that at some level, it has come to be accepted that mothers will tolerate high levels of indignity and suffering in order to mitigate low levels of potential harm to their infants. I argue, in alignment with Kirkman and Lee (2008), that this disregard for the experience of mothers is possible only when female bodies are understood to be not only failing, but also insensate and of less value, which I propose is only possible from within the male imaginary.

Further to Jordanova (2017) and Jones (2022), I suggest that dualism in the male imaginary offers hierarchical, oppositional '*either/or*' binaries. Birth in the female imaginary, however, presents the opportunity for co-existing, pluralistic '*also/and*' binaries, for example, birth is a solo-endeavour and a communal effort; it makes female bodies simultaneously vulnerable and powerful; birth presents unpredictable risks and is also the pinnacle of physiological evolution.

The inability of the male imaginary to conceptualise and accommodate this is the basis for several issues in maternity care. Practically, it presents an institutional estate which has not been able to conceive of physical or logistical ways to provide care which is primarily embodied and which is also supported by compassionate and humanised encoded medical care if it is required, despite stated commitments to the contrary. The result is an institutional framework which prioritises cure over prevention, placing risk and the potential for intervention centrally and marginalising strategies designed to augment physiological birth and protect mothers physical, emotional and mental well-being. It is worth noting that compassionate, tacit maternity care has not disappeared

(Clancy, 2020), rather it has been segregated from what has come to be understood as mainstream care. This is arguably the historic pattern in which women's knowledge is driven underground. This presents a problem for mothers on three counts; firstly, this standard of care is not consistently accessible; secondly, the benefits (and risks) of this form of care are hidden from view; thirdly, marginalised midwifery practice of this form is at risk of being irrecoverably lost (Martin, 1998)).

I propose this theoretical notion has a further real term effect. The female imaginary accommodation of *'also/and'* offers an account of the existential realities and risks of reproduction which the male imaginary is fundamentally resistant to (Jones, 2016). In the dualist, patriarchal attempt to exert control over aspects of the natural world, we may excise risk but we also jeopardise the uniqueness of the human experience in the process. Here I follow Jones in the view that 'The game of generation and becoming, the game of life, is also, necessarily the game of death' (Jones, 2016, p165). Only the rebalancing of paternalistic ownership of authoritative knowledge in which care providers define which risks are appropriate, will mothers be able to access choices and control over their own assessments of risk in order to gain full access to the fully embodied experience.

Mothers enter maternity care with the neo-liberal expectation of bodily autonomy and freedom to exercise choice. On arrival they are faced with a medical culture which perceives their bodies as a risk, and themselves as unequal to the task of making reasoned judgements, and thus anticipating they will act as passive recipients of care. Mothers are risk averse and do want to protect their infants, and they are also alert to other forms of harm which may happen to them.

So the neo-liberalism which underpins contemporary maternity services and foregrounds maternal choice is fundamentally incongruent with birth. It's a particular form of patriarchy which is based in a grounding belief that humans are invulnerable and able to exercise complete control through rational choice. It has its basis in the

economic domain and valorises individuality and disembodiment. Birth, in contrast, is communal, embodied and exists in close proximity to life, death and risk. The birth plan exhorts mothers to make unmediated choices and retain autonomous control. Which is impossible.

The birth plan is not able to overcome these systemic issues, which are obfuscated by the powerful neo-liberal inclination towards personal responsibility. The result is significant layers of dissonance in a system which valorises choice, control and personal responsibility yet frames that in a system which is constrained by risk aversion and governance.

I argue that the birth plan is not only flawed in its objective to provide maternal freedom of choice and control, it might also be considered harmful to mothers. Birth plans are not reflective of the interconnected breadth and complexity of maternal antenatal and intrapartum decision-making. Despite the promise of choice and control, in reality birth plans are powerless to effect changes in attitude and practice in the face of systemic and structural factors which construct maternal bodies as failing sites of risk. Birth plans are complicit in the privileging of outcomes over maternal experience which obscures mothers' real needs and aspirations for their birth experience. In contradiction to its intended benefit as an aid to access free, informed and unmediated choice, the birth plan restricts and misdirects.

This places individual mothers, who are charged as the authors of their own birth destinies, in an invidious double bind. If they choose not to write a birth plan and make claims about their choices and preferences, they reject active engagement in their care. If they do, they take notional responsibility for a process they have limited control over. Any divergence from this birth plan can be utilised a mechanism to confirm their ignorance. In an institution which see birth as fundamentally risky and women as fundamentally ignorant, this places the birth plan at a significant disadvantage. For mothers writing their birth plans this presents a significant challenge between what *should* be and what *is*.

So we might ask what birth plans would look like if mothers did not feel constrained by the common birth plan format, and felt they had free reign to communicate their attitudes to and intentions for birth? My colleague, an experienced birth- and post-natal doula, wrote a birth plan in this manner for her second birth in October 2020, a planned home birth after a caesarean (H-VBAC). Rather than a birth plan in the common format, she wrote a direct and personal letter intended for the midwives in attendance. In this letter she recognised both her objective and the potential discomfort of her midwives at attending an ‘out of guidelines’ birth and explained her carefully considered contingency plans (see Appendix xi., ‘Susie’s birth plan’). This birth plan (written in October 2020, as I was just embarking on this research, and only remembered and included in this thesis in early 2022) mirrors a number of the themes I identified in interview data; the urge towards confidence in the conditions around birth, rather than a desire to control the process; the application of expertise gained in previous births; the desire to create a relational connection with midwives. While this form of birth plan – or communication with midwives – cannot overcome the systemic and structural issues I have identified as restricting the provision of humanised midwifery care in the NHS, I wonder how dynamics and discourses between mothers, midwives and doctors would be impacted were birth plans to follow this model.

Conclusion

The motivation behind this research question was my observation, as a practicing doula, that birth plans carry considerable meaning for mothers and are held to offer potential. Yet they are not correlated with improved outcomes or increased maternal satisfaction. Indeed, in many instances the birth plan that a mother has invested time and effort in plays little or no part at all in her birth. Further, while birth plans offer mothers the promise of choice and control they are derided as indicative of both hubris and naivety. This qualitative study comprising semi-structured interviews with four multiparous mothers and three midwives provides insights into the motivation of mothers who write birth plans, despite this backdrop

I framed my research findings by proposing that no comprehensive analysis of birth plans can take place without account of the powerful cultural and political conditions they exist within. Here I contend that foundational dualist theories which privilege the presumed rationality of the mind over the corporeality of the body remain influential in maternity care services, and that this account inclines beliefs and biases against the female reproductive bodies as pathological and destined to fail. Alongside this contention I suggest there is a dissonance between the neo-liberal logic of active, foresighted and unmediated choice as primary method by which individual mothers can access the best quality maternity care, and therefore the best outcomes and maternal satisfaction, and the complex and multi-axial material realities of the birth room.

Within the literature review I drew attention to the history of the slow transfer of authoritative knowledge of and power over birth from the female realm to the male realm, and the correlation of this to liberatory activist movements campaigning to regain mothers lost knowledge of and engagement with birth. I presented analysis of the power mechanisms of hegemonic authoritative knowledge which facilitated these

shifts and presented analysis of how these mechanisms justify and perpetuate beliefs and biases which influence the practice of individual care providers and the focus of risk-averse policies and guidelines. I presented an analysis of the foundations of concepts of maternal intrapartum choice and control under the aegis of the birth plan, approaches to decision-making and the specific challenges against birth plans in action.

Building on the extant literature, this research study determines that the options and choices recorded in birth plans is not fully representative of the breadth and scope of planning that mothers undertake antenatally. Further, this research suggests that mothers are, at some level, aware that birth plans do not adequately convey what they wish to communicate to their care providers, but that they continue to use the common form of the birth plan because of the absence of any other modelled alternative.

However, the choices and preferences the birth plan contains is coded. Notably, this research provided a description of the conditions mothers seek to avoid. A theme which ran throughout interviews, and was coded into birth plans, was the avoidance of bureaucratic care based in risk averse practices and the commoditisation and industrialisation of women's reproductive labour. Mothers are aware of the potential for dehumanising care, and disembodiment during a process which – whether it happens at home, in a birth centre, a hospital labour ward or a theatre, whether it is spontaneous or assisted – they view as emotionally vital and personally transformational.

Strikingly, mothers demonstrated a willingness to compromise their preferences in order to attain certainty about the care and support they can expect to receive intrapartum. This finding directly challenges care provider concerns identified in the literature that mothers are unyielded and rigidly attached to ideological and unrealistic outcomes. Mothers are realistic about the required intrapartum role of flexibility and the unpredictable nature of birth. Mothers make complex antenatal choices and intrapartum decisions which are closely related to contemporaneous opportunities and limitations.

Findings in this study would be augmented by further research with mothers who do not write birth plans, to identify their attitudes to choice and control in birth, their expectations for their relationship with care providers and the influences that foreground their beliefs about birth and their maternal bodies. I propose that it would be particularly valuable to correlate the findings from this research with the expectations and experiences of mothers from marginalised groups.

Findings from this small-scale research would be augmented by the perspective of obstetricians and obstetric anaesthetists, who engage with intrapartum mothers in significantly different ways to the midwives interviewed in this study.

Finally, more rigorous and comprehensive analysis of theories of sexual difference and the male and female imaginaries would enhance contextual analysis of the findings in this research.

At the conclusion of this research I propose that the question we should ask of birth plans is not 'how can they be improved', but rather what would a system that is structured to respect the needs, values and desires of all mothers and their reproductive labour look like? If we seek only to measure the influence of birth plans on mothers and care providers we presume the birth plan is the appropriate format, the natural manner of communication, However, the influence of the birth plan is so inconsistent, and subject to the complex dynamics of numerous conditions, modalities and motivations, it seems more apt to take a more removed perspective, and ask what mothers are seeking to achieve when they undertake the time and effort required to write one.

While mothers have consistently expressed their general preference for relational models of individualised and compassionate care, contemporary maternity care in the

UK remains overwhelmingly fragmented. I propose that attention be turned not to whether continuity of care is the solution, but to how it can be implemented in a way which recognises the deep cultural negativity about birth.

These findings are not an intention to propose alternative but equally homogenous frameworks of midwifery care. It is evident that there is no universal, one-size fits all, resolution, that can or should be centred in midwifery care. The only universality is that all mothers and all pregnancies are different and therefore maternity services, in catering for a diversity of mothers, must centre the individual and prioritise connection. In this I propose consideration of Pickering's Mangle (Hekman, 2012), in which interactivity between materiality and society may inform dynamic and pluralistic services. I propose that the intention should not be to aspire to move inexorably towards a perfect model of maternity services provision, but to embrace a self-reflective model which challenges presumptions and biases and strives to break new ground, in considering the needs and values of mothers as well as the mitigation of risk.

Findings from my research correlate with Kirkman and Lee's (2008) assertion that female bodies continue to be sites of political and ideological struggle. I suggest that the dissonance between the stated intentions of maternity care and the reality of maternal experience in the birth room reflects a cultural willingness to tolerate women's poor experiences of birth. If health care is representative of a society's attitude towards women, as suggested by Jordan (1997), what does this tell us about contemporary British attitudes to women and the female body?

'Birth carries more meaning in society and has greater meaning in women's lives than the traditional medical model comprehends.'

(Kirkman and Lee, 2008)

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What are mothers seeking to achieve when they write their birth plan

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Appendices

- i. Ethics approval, University of York, Centre for Women's Studies Ethics Committee (dated 4th June 2021). Includes participant information and consent forms
- ii. Interview Schedule
- iii. NHS birth plan template.
Downloaded from <https://www.nhs.uk/pregnancy/labour-and-birth/preparing-for-the-birth/how-to-make-a-birth-plan/>
Last accessed Tuesday 8th February 2022
- iv. BabyCentre UK birth plan notes
Downloaded from <https://www.babycentre.co.uk/ims/pdf/uk/birth-plan-notes-UK-20200324.pdf>
Last accessed Tuesday 8th February 2022
- v. National Childbirth Trust (NCT) 'Template birth plan for hospital birth'
Downloaded from <https://www.nct.org.uk/sites/default/files/BirthPlan-HospitalBirth.pdf>
Last accessed Tuesday 8th February 2022
- vi. Interviewee *Olivia's* birth plan
- vii. Interviewee *Sophia's* birth plan
- viii. Interviewee *Lily's* birth plan
- ix. Interviewee *Amelia's* birth plan for her second birth
- x. Interviewee *Amelia's* birth plan for her first, ultimately traumatic birth

What are mothers seeking to achieve when they write their birth plan

- xi. The Positive Birth Movement Facebook post, drawing attention to a Twitter thread discussing the correlation between birth plans and caesarean birth, November 2017
- xii. Diagram describing shared decision making
- xiii. *Susie's* birth plan
- xiv. Hierarchies of scientific knowledge. © 2006 Trustees of Dartmouth College and Yale University

Appendix i. Ethics approval, University of York, Centre for Women's Studies Ethics Committee (dated 4th June 2021). Includes participant information and consent forms

Centre for Women's Studies

Ethics Policy

The Centre for Women's Studies has introduced an ethics policy in line with University policy, the ESRC's Research Ethics Framework and the necessity for all students to be reflexive about the ethical implications of their work. This policy applies to all research students and to the dissertation stage of MA programmes.

During supervision and prior to any fieldwork/work on primary sources, the student will be guided to the ethical guidelines of the professional association or research council most relevant to their field of study.

MA students will be required to complete the Centre's Ethics Form on which they are asked to register any ethical issues raised by their research. They are expected to discuss this with their supervisors. Such issues are related to responsibilities towards participants in their research (e.g. issues of consent, confidentiality and anonymity), risk and personal safety as well as their responsibilities towards the Centre, University and wider academic community. This form will be completed in preparation for an early supervision for MA dissertation students and passed on the CWS Ethics Committee

If it is decided that the research falls into the 'minimal risk' category as defined by the ESRC framework, or if the CWS Ethics Committee deems that all relevant risks have been identified and dealt with appropriately, ethical approval will be granted. If the CWS Ethics Committee is not satisfied with the documentation it may return it to the student and supervisor for further discussion and revision.

MPhil/PhD students whose research involves human subjects must seek ethical approval from the Economics, Law, Management, Politics and Sociology Ethics Committee (ELMPS) before fieldwork. Details and forms are available from the ELMPS website:

<http://www.york.ac.uk/about/organisation/governance/sub-committees/ethics/elmps/>

There are two forms. Most will fill in the 'lite' form but if your research involves children or vulnerable adults or is otherwise sensitive, you will need to complete the full form. See the ELMPS website for further information. You should discuss with your supervisor, which is the appropriate form for you. Once you have completed a draft of the form, your supervisor will discuss it with you prior to submission to ELMPS. Note that ELMPS meets only four times a year – you need to keep an eye on the website for details of deadlines.

In some cases, though this is rare in CWS, further ethical clearance may be necessary – e.g. from the NHS where research entails the recruitment of patients or staff.

Those PhD students whose work does not involve 'live' human subjects do not need to apply to ELMPS but should instead complete the form used by MA students (see below) and submit it to the CWS ethics committee for approval.

**Centre for Women's Studies
Research Ethics form
(For use by MA students and those MPhil/PhD students whose work does not involve
living human subjects)**

Section 1, for completion by the student

Name: Charlotte Edun

Supervisor: Dr. Rachel Alsop

Degree for which registered:

Masters by research

Provisional title of dissertation/thesis:

What changes in maternity care are multiparous²⁵ women in the UK seeking to effect when they write their birth plan?

Give 300 word description of your research project in the space below, covering aims, scope and methodology:

Rationale The individualised, woman-centred care identified by the WHO²⁶ as a key factor in determining positive birth experience, is manifested in the UK as the definition of personal choices and preferences, most commonly in the form of a birth plan. However, birth plans fail on 3 fronts. Firstly, they are not effective at determining the path or outcomes of birth. Secondly, they are dissonant with the physiological realities of birth and the practicality of NHS maternity care, and therefore can be criticised as setting unrealistic expectations for women. Thirdly, I propose, their focus on active choice and control is a distraction from the model of care women really seek; compassion.

My hypothesis is that the intended purpose of the birth plans of multiparous women is to define & clarify the interpersonal dynamic they wish to experience during late pregnancy and birth, and to gain the compassionate engagement of medics. While the form and content of

²⁵ The term commonly used in obstetric medicine to describe women who have given birth more than once.

²⁶ Simelela, N. (2018) *A "good birth" goes beyond having a healthy baby*". Available at : <https://www.who.int/mediacentre/commentaries/2018/having-a-healthy-baby/en/> (Accessed : Monday 24th May 2021)

the birth plan suggests an intent to control, in fact this common framework is utilised by women because there is no alternative schema to communicate their objective.

Aims The purpose of this research is to gain a more thorough understanding of whether choice and control are the most appropriate pivots from which positive birth experiences can be facilitated.

These insights will offer women a broader, more appropriate lexicon and framework to define and express the intrapartum care they wish to receive. Further, this research has the potential to resolve conflict between mothers and medics elicited by birth plans. Finally, this research has the potential to appropriately inform the adaptation, development and funding of woman-centred maternity services.

Methodology I will undertake qualitative interviews because I seek to describe and explore women's subjective experiences of preparing & utilising birth plans. Multiparous women represent a rich opportunity, as their previous engagement with maternity care gives the content and intent of their birth plan a basis in first-hand experience. I intend interviewees be no more than 6 months post-partum, as this time frame offers time to reflect on the birth experience while the memories remain keen.

Interviews will take place, preferably in-person (if COVID restrictions allow) and via Zoom if we are unable to meet, in July 2021. Interview locations will preferably be in a meeting room at the interviewees local library. Details of each meeting will be shared confidentially with my doula colleague Laura Scarlett as a safe-guarding precaution.

Interviewees will be recruited via my existing doula network covering the Kent and South East London region. I will write a proforma letter inviting women to take part in the project to be distributed by birth worker colleagues to women they have supported with in the preceding 4 months. This letter will request women contact me directly if they would like to take part in this research.

I will assure all interviewees anonymity, with identifying information removed from the transcripts (apart from those details of the birth which are relevant to the research).

Reflecting on birth experiences offers the potential to trigger uncomfortable memories or birth trauma. The interview may also offer a safe environment for women to disclose post-natal anxiety or depression, or other perinatal distress. If I identify that an interview is causing distress, or the interviewee requests it, I will stop the interview and proceed again only if/when the interviewee is ready to do so. I will invite them to make contact with an agency which can offer support, and sign-post them to their Health Visitor, their GP, the Birth Trauma Association and/or PANDAs. This will form part of my research findings. Interviewees will be able to withdraw from the research up to four weeks after their interview takes place.

All interviews will be recorded on my Apple iPhone, which is password protected. Immediately after interview, on return to my office, the interview will be uploaded to and stored on the University of York cloud server. All interviewee data will be stored and managed in accordance with the Data Protection Act 2018.

Interviewees **Three multiparous women**, one each who birthed their baby at home (attended by community midwives), at a birth centre and at a consultant-led hospital unit. I intend to use the birth plan of each woman as stimulus to reflect on;

- How they knew to write a birth plan in preparation for their birth
- What influenced the content of their birth plan
- How effective their birth plan was in practice
- What outcome they wanted for their birth
- Identifying events and interactions that were meaningful to their birth story, both positive and negative.

Three midwives, one each working in the community, at a birth centre and at a consultant-led hospital unit. I intend to use an anonymised birth plan submitted by a multiparous women in my local positive birth Facebook group as stimulus for these conversations, to reflect on;

- Where birth plans can be beneficial to women and medics
- Identifying flaws in birth plans, and the factors that contribute to these.
- What do they perceive to be the factors that improve birth experiences for women. How do they define this?

Head of Midwifery, from an NHS Trust. This interview will focus on how policy and practice support or limit the use of birth plans and opportunities for truly individualised compassionate care.

Ethics Checklist 1.	YES	NO
1. Does the study involve human subjects	x	
2. Does the study involve participants who are particularly vulnerable or unable to give informed consent (e.g. children, people with learning difficulties, people particularly vulnerable to official surveillance)?		x
3. Will the study require the co-operation of a gatekeeper for initial access to the groups or individuals to be recruited (e.g. school students, members of support group, residents of a home or closed community)?		x
4. Will the study involve the use of private archives/collections for which permission needs to be sought?		x
5. If undertaking textual work, are you dealing with living authors or authors with living descendants?		x
6. Will any covert methods be necessary (e.g. observing/interacting with people without their knowledge that they are subjects of research or without their knowledge of the nature of the research)?		x
7. Will the study involve discussion of sensitive issues (e.g. sexual practices, drug use)?	x	
8. Will financial inducements (other than reasonable expenses and compensation for time) be offered to participants?		x
9. Will the study require additional ethics approval (e.g. if it involves the recruitment of patients or staff through the NHS) or criminal records checks (e.g. if working with children)?		x
10. Does the study entail meeting unknown respondents off university premises?	x	

11. Is the study likely to require copyright clearance for the use of images, text or tables?		x
12. Are there any other ethical issues you consider important?	x	

If you have answered ‘yes’ to any of the above questions, please insert an account of how you intend to deal with the relevant ethical issues: (See methodology, above)

Ethics Checklist 2.

I confirm that I have considered the following:	Yes	N/A
1. Responsibilities to participants	x	
2. Responsibilities to gatekeepers		x
3. Responsibilities to the academic community	x	
4. Intellectual property rights	x	
5. Protection of data	x	
6. My own personal safety	x	

Charlotte Edum

Signed:

Date: 25th May 2021

Please send the completed form and attached statement, if any, to the CWS administrator cws@york.ac.uk who will pass it on to your supervisor/TAP members

Section 2: To be completed by the supervisor

I confirm that the ethical issues entailed in this project have been discussed with the student and (in the case of MPhil/PhD students) with TAP members and that:

- The student has read and understood the Centre's policy on ethics and the ethical guidelines of the relevant professional bodies (ESRC, BSA, Royal Historical Society etc.)
- That having taken ethical concerns into consideration the project is viable
- The student has the skills to carry out the research
- Where relevant, procedures for recruitment and obtaining access and consent are appropriate
- Participant information sheets and consent forms, where needed, are appropriate
- Procedures for obtaining any necessary copyright permissions have been considered

Brief Comments: I am confident that Charlotte has given full consideration to the ethical dimensions of her research. We have discussed in supervisions and she has also audited the Feminist Research Methodologies module. As per the comment above I'll discuss with Charlotte the issue of retaining anonymity of participants when using a buddy system if doing in person interviews. I'll also check consent and information sheets before they are sent out.

**Signed: Rachel Alsop
2021**

Date: 3 June

Name: Rachel Alsop

Section 3, to be completed by the CWS Ethics Committee

I confirm that this form and supporting documentation has been scrutinised by the Centre for Women's Studies Ethics Committee. The following has been agreed (highlight as necessary):

The project has been approved x

The project has been referred back to the student and supervisor for further consideration

The project has been referred to the Social Science Ethics Committee

The project requires specialist ethical clearance (e.g. NHS)
(tick as appropriate)

If further ethical scrutiny is deemed necessary, please explain why (attach separate sheet if necessary)

Signed on behalf of the CWS Ethics Committee:

Prof V Robinson

Date: 4 6 21

Document	Participant Interview Information Sheet (Multiparous women)
Author	Charlotte Edun
Department	Centre for Women's Studies, University of York
Research project	What changes in their maternity care are multiparous women in the UK seeking to effect when they write their birth plan?

My name is Charlotte Edun. I am writing an MA at the Centre for Women's Studies, the University of York.

You are being invited to take part in a research study looking at the purpose and use of birth plans by mothers in their second and subsequent pregnancies in the UK. Before you decide whether to take part, it is important for you to understand why the research is being conducted and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish. Ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of the study?

The purpose of the study is to gain a deeper understanding of why pregnant women write birth plans, and how they wish them to be used during late pregnancy, labour and birth. This insight can improve training for midwives and obstetricians, and guidance for pregnant women. These improvements have the potential to improve birth outcomes for individual women and maintain and protect the health of new mothers and their children more generally.

Why is the study being done?

The writing of birth plans is encouraged in the UK, with the intention of facilitating informed choice and engaging women in shared decision making. However mothers, midwives and medics commonly recognise that the birth experience may not resemble the preferences outlined in the birth plan.

This study aims to understand what expectations women have from their maternity care, to define the factors which they value in their maternity care and to clarify how they hope their birth plan will influence their care.

Why have I been chosen?

You have been chosen because you recently given birth to your second or subsequent child. You wrote a birth plan, and you gave birth in your preferred location, either at home, in a midwifery-led birth centre, or in a consultant-led hospital unit.

You are one of 3 new mothers being asked to take part in this study. Other interviewees include midwives working in the community (i.e, attending home births), at a birth-centre, at a hospital unit. and a Head of Midwifery working in an NHS Trust.

Do I have to take part?

It is up to you to decide whether or not to take part. If you decide to take part you are still free to withdraw up to one month after your interview and without giving a reason. You do not

have to take part but your participation in the study is greatly appreciated. The interview will last no more than 90 minutes.

You do not have to answer any questions that you do not want to. The interview will be audio recorded, fully transcribed, and kept confidentially as a password-protected and encrypted computer file accessible only to the researcher. You are welcome to have a copy of your file once the interview has been transcribed. I, Charlotte Edun, am responsible for the security and confidentiality of the interview data. You will receive an electronic copy of this information sheet and the signed consent form to keep.

Reflecting on and discussing your birth experience can sometimes raise powerful and uncomfortable memories and emotions. If you feel upset or anxious in our interview we will pause. If and when you are comfortable to speak again the interview will continue. If you decide you do not wish to continue, we will end our interview. At our interview I will give you a leaflet containing information about services, charities and groups you can contact if you experience strong, uncomfortable or upsetting memories about your birth either during our interview or at any time afterwards.

Will the information the researcher collects be kept confidential?

All information collected about you during the course of the research will be kept strictly confidential, and pseudonyms will be used instead of real names or any details that could identify you. An anonymised transcript of your audio recording will be kept as a secure computer file for up to 4 years after the end of the study. Anonymised data from this study may also be used in conjunction with research data from other studies for academic purposes. While written extracts (verbatim quotations) may be used within publications relating to the study, individuals will not be identified from the details presented. All data will be treated in accordance with the Data Protection Act 1998. This study has received approval from the University of York research ethics committee.

The researcher has a duty of care to inform the relevant agencies of any illegal activity or safeguarding issue disclosed to her.

What if I change my mind after the interview?

If you change your mind about being part of the study, up to one month after your interview, your data will be left out of the study and all related information about you erased.

What will happen to the results of the study?

The results of the study will be reported in the MA dissertation.

Who can I talk to for more information or advice about the study?

If you have any queries about this research please do not hesitate to contact Charlotte Edun at:

CWS, Grimstone House, University of York, Heslington, York, YO10 5DD.

Email: cle530@york.ac.uk

Research Project Supervisors: Dr. Rachel Alsop and Prof. Vicki Robinson.

Chair of ELMPS Ethics Committee: Professor Tony Royle, email: elmps-ethics-group@york.ac.uk

What do I do now?

If you would like to hear more about the study or think you might like to take part, just approach the researcher by emailing the address above.

Thank you for your time.

Document	Participant Interview Information Sheet (Midwives)
Author	Charlotte Edun
Department	Centre for Women's Studies, University of York
Research project	What changes in their maternity care are multiparous women in the UK seeking to effect when they write their birth plan?

My name is Charlotte Edun. I am writing an MA at the Centre for Women's Studies, the University of York.

You are being invited to take part in a research study looking at the purpose and use of birth plans by mothers in their second and subsequent pregnancies in the UK. Before you decide whether to take part, it is important for you to understand why the research is being conducted and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish. Ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of the study?

The purpose of the study is to gain a deeper understanding of why pregnant women write birth plans, and how they wish them to be used during late pregnancy, labour and birth. This insight can improve training for midwives and obstetricians, and guidance for pregnant women. These improvements have the potential to improve birth outcomes for individual women and maintain and protect the health of new mothers and their children more generally.

Why is the study being done?

The writing of birth plans is encouraged in the UK, with the intention of facilitating informed choice and engaging women in shared decision making. However mothers, midwives and medics commonly recognise that the birth experience may not resemble the preferences outlined in the birth plan.

This study aims to understand what expectations women have from their maternity care, to define the factors which they value in their maternity care and to clarify how they hope their birth plan will influence their care.

Why have I been chosen?

You have been chosen because you are an experienced midwife in either the community (e.g., attending home births), at a midwife-led birth centre or at a consultant-led hospital unit.

You are one of three midwives being asked to take part in this study. Other interviewees include three recently multiparous women who gave birth at home, at a birth-centre or in a hospital unit and a Head of Midwifery working in an NHS Trust.

Do I have to take part?

It is up to you to decide whether or not to take part. If you decide to take part you are still free to withdraw up to one month after your interview and without giving a reason. You do not

have to take part but your participation in the study is greatly appreciated. The interview will last no more than 90 minutes.

You do not have to answer any questions that you do not want to. The interview will be audio recorded, fully transcribed, and kept confidentially as a password-protected and encrypted computer file accessible only to the researcher. You are welcome to have a copy of your file once the interview has been transcribed. I, Charlotte Edun, am responsible for the security and confidentiality of the interview data. You will receive an electronic copy of this information sheet and the signed consent form to keep.

Reflecting on and discussing your experiences as a midwife may sometimes raise powerful and uncomfortable memories and emotions. If you feel upset or anxious in our interview we will pause. If and when you are comfortable to speak again the interview will continue. If you decide you do not wish to continue, we will end our interview. At our interview I will give you a leaflet containing information about how to contact your Professional Midwifery Advocate and the Laura Hyde Foundation, but of which can offer you resources and support if you feel you need it.

Will the information the researcher collects be kept confidential?

All information collected about you during the course of the research will be kept strictly confidential, and pseudonyms will be used instead of real names or any details that could identify you. An anonymised transcript of your audio recording will be kept as a secure computer file for up to 4 years after the end of the study. Anonymised data from this study may also be used in conjunction with research data from other studies for academic purposes. While written extracts (verbatim quotations) may be used within publications relating to the study, individuals will not be identified from the details presented. All data will be treated in accordance with the Data Protection Act 1998. This study has received approval from the University of York research ethics committee.

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Email: cle530@york.ac.uk

Research Project Supervisors: Dr. Rachel Alsop and Prof. Vicki Robinson.

Chair of ELMPS Ethics Committee: Professor Tony Royle, email: elmps-ethics-group@york.ac.uk

What do I do now?

If you would like to hear more about the study or think you might like to take part, just approach the researcher by emailing the address above.

Thank you for your time.

Document **Consent Form for Participants**
Author **Charlotte Edun**
Department **Centre for Women’s Studies, University of York**
Research project **What changes in their maternity care are multiparous women in the UK seeking to effect when they write their birth plan?**

Have you read, or has someone read to you, the ‘Information Sheet’ about the project?

Yes No

Do you understand what the project is about and what taking part involves?

Yes No

Do you understand that if you take part in the research that your words will be used but you will not be identifiable in any way. A pseudonym will be used and no other identifying data – other than the information you discuss in your interview - will be included?

Yes No

Do you understand that the information you provide may be used anonymously in future research?

Yes No

Do you know that if you decide to take part and later change your mind, you can leave the project up to one month after your interview without giving a reason?

Yes No

Would you like to take part in the project ‘*What changes in maternity care are multiparous women in the UK seeking to effect when they write their birth plan?*’

Yes No

If yes, is it okay to record your interviews on an audio recording device?

Yes No

Please write your name here, in block capital letters	
Please sign your name here	
Interviewer name	
Date	

Appendix ii. Research interview schedule

Date	Time	Interviewee	Location
8 th July 2022	10.30am	Olivia	Via Zoom
13 th July 2022	9.30am	MW Bridget	Via Zoom
15 th July 2022	10.00am	Sophia	Via Zoom
16 th July 2022	11.00am	MW Ali	Via Zoom
20 th July 2022	11.15am	Lily	Via Zoom
21 st July 2022	9.30am	MW Carla	Via Zoom
2 nd August 2022	10.00am	Amelia	Via Zoom

Appendix iii. NHS birth plan template



My name:

Due date:

Where to give birth

You will have a choice about where to have your baby. Your midwife or doctor will be able to tell you what services are available locally and advise you on any issues to do with your health or pregnancy that may affect your choice.

- I would like to give birth at home
- I would like to give birth in a midwifery unit
- I would like to give birth in a maternity team unit in hospital
- I am not sure yet where I would like to give birth

My comments on where I would like to give birth and why:

Companions

Having a companion you can 'lean on' and who can support you during your labour can be helpful. It has been shown to reduce the need for pain relief.

- I would like my partner or companion(s) to be with me during labour
- I would not like my partner or companion(s) to be with me during labour
- I am not sure yet whether I would like my partner or companion(s) to be with me

My birth partner or companion is:

Companions during a forceps or vacuum delivery

A forceps delivery is where forceps are placed around the baby's head to pull him or her gently from the birth canal. Vacuum delivery, sometimes called ventouse, is when the baby is guided out using a cap fitted to its head by suction.

- I would like my partner or companion(s) to be with me if I have a forceps or vacuum delivery
- I would not like my partner or companion(s) to be with me if I have a forceps or vacuum delivery
- I do not mind if my partner or companion(s) is with me if I have a forceps or vacuum delivery
- I am not sure yet whether I would like my partner or companion(s) to be with me if I have a forceps or vacuum delivery

Appendix iii. NHS birth plan template



Companions during a caesarean section

A caesarean section is when the baby is delivered by cutting through the abdomen and into the womb. This will only be performed when it is necessary, but there are situations where this is the safest option for either you or your baby. If your caesarean section is carried out under local anaesthetic and you are awake, your partner or companion may sit with you.

- I would like my partner or companion to be with me if I have a caesarean section
- I would not like my partner or companion to be with me if I have a caesarean section
- I do not mind if my partner or companion is with me if I have a caesarean section
- I am not sure yet if I would like my partner or companion to be with me if I have a caesarean section

Birthing equipment

You may find that items such as wall bars, mats or beanbags help you to change position and remain comfortable during labour. If you're giving birth in a maternity unit, your midwife will be able to tell you if specific items are normally available. However, you may need or prefer to provide some equipment yourself.

- I plan to use equipment such as mats or beanbags during labour
- I do not plan to use equipment such as mats or beanbags during labour
- I am not sure yet whether I would like to use equipment such as mats or beanbags during labour

My comments on birthing equipment and whether I will provide it:

Special facilities

Some units may offer you special facilities such as a birthing pool. Some have special rooms called LDRP rooms (labour, delivery, recovery, postnatal rooms) where you stay in the same room until you leave the hospital, although availability is limited. Your midwife will be able to tell you what's available.

- I would like to use a special LDRP room, if available
- I would like to use a birthing pool, if available
- I would like to use other special facilities
- I am not sure yet whether I would like to use special facilities, such as a special LDRP room or birthing pool, if available

My comments on any special facilities I would like to use:

Appendix iii. NHS birth plan template



Any other comments or preferences on birth location, facilities or companions:

Monitoring during labour

Every baby is monitored throughout labour to make sure that it is not in distress. There are different ways of monitoring the baby's heartbeat.

- I have discussed with my midwife how I would like my baby's heart to be monitored if everything is straightforward
- I have not discussed with my midwife how I would like my baby's heart to be monitored if everything is straightforward

My comments on monitoring my baby during labour:

Keeping active during labour

Keep active for as long as you feel comfortable. This helps the progress of the birth. Keeping active doesn't mean doing anything strenuous, just moving around normally.

- I would like to move around during labour
- I would not like to move around during labour
- I do not mind whether or not I move around during labour
- I am not sure yet whether I would like to move around during labour

Appendix iii. NHS birth plan template



My comments on moving around during labour:

Positions for labour and birth

Find the positions you prefer and which will make labour easier for you. Try out various positions at antenatal class or at home to find out which are the most comfortable for you. You can choose as many positions as you want and vary them throughout your labour.

- I would like to be in bed with my back propped up by pillows
- I would like to be standing
- I would like to be sitting
- I would like to be kneeling
- I would like to be kneeling on all fours
- I would like to be squatting
- I would like to be lying on my side
- I am not sure yet which positions I would like to be in during labour

Skin-to-skin contact with your baby

After the birth you can have your baby lifted straight onto you before the cord is cut so that you can be close to each other immediately. If you prefer, you can ask the midwife to wipe your baby and wrap him or her in a blanket first.

- I would like my baby delivered straight onto my tummy
- I would like my baby cleaned first before being given to me
- I do not mind if my baby is cleaned before being given to me
- I am not sure yet whether I would like my baby delivered straight onto my tummy

My comments on anything special I would like to happen immediately after the birth:

Midwives, nurses and doctors in training

Midwives, nurses and doctors need to observe women in labour as part of their training. They will always be supervised by a senior health professional.

- I have discussed with my midwife my thoughts about having midwives, nurses or doctors in training with me during labour
- I have not discussed with my midwife my thoughts about having midwives, nurses or doctors in training with me during labour

Appendix iii. NHS birth plan template



Other comments or preferences about my labour and birth:

Pain relief options

There are many different pain relief options. Some women use a combination of methods. You may find that you want more pain relief than you had planned, or that more effective pain relief may be advised to assist with delivery. You can use a number of different methods at different times.

- I would like to try breathing and relaxation
- I would like to try being in water during labour and/or birth
- I would like to try massage
- I would like to try acupuncture
- I would like to try TENS (transcutaneous electrical nerve stimulation)
- I would like to try gas and air (entonox)
- I would like to try pain-relieving injections
- I would like to try an epidural
- I would like to try other methods of pain relief
- I would like to try to manage without pain relief

My preferences for pain relief:

Having an episiotomy

An episiotomy is a cut in the perineum (the area between the vagina and anus). This may be necessary if the perineum won't stretch enough and may tear, or if the baby is short of oxygen and needs to be delivered quickly.

- I have discussed with my midwife or doctor why an episiotomy might be necessary
- I have not discussed with my midwife or doctor why an episiotomy might be necessary



My feelings about the possible need for an episiotomy:

Delivering the placenta after the birth

After your baby is born your midwife will offer you an injection in your thigh. This contains the drug syntometrine or syntocinon which helps the womb contract and can prevent the heavy bleeding that some women may experience without it.

- I have discussed with my midwife what happens after labour when the placenta is delivered
- I have not discussed with my midwife what happens after labour when the placenta is delivered

My preferences about delivering the placenta:

Feeding your baby

Breast milk is the best form of nutrition for babies as it provides all the nutrients a baby needs and has lasting benefits for the health of your child. Infant formula milk can be used as an alternative to breast milk.

- I would like to breastfeed my baby
- I would like to bottle feed my baby
- I would like to try a mixture of breastfeeding and bottle feeding
- I am not sure yet how I would like to feed my baby

My comments about feeding my baby:

Vitamin K for your baby

Vitamin K is needed to make the blood clot properly. Some newborn babies have too little vitamin K so it may be suggested that your baby be given vitamin K either by injection or by mouth.

- I have given my midwife my consent to give my baby vitamin K
- I have not given my midwife my consent to give my baby vitamin K

Appendix iii. NHS birth plan template



Any other comments or preferences about me and my baby immediately after the birth:

Special requirements

Please tick any that apply to you. You can fill in more details in the box below.

- English is not my first language, and I need someone present who speaks my first language
- I need a sign language interpreter
- I have special dietary requirements
- I and/or my partner have special needs
- I would like certain religious customs to be observed

More information about my special requirements:



Appendix iii. NHS birth plan template

General comments:

A large empty rectangular box with a black border, intended for writing general comments.

Appendix iv. Babycentre birth plan template



Planning your birth | Thinking ahead

Birth plan: what to think about

A birth plan is a way of communicating with the midwives and doctors who care for you in labour. It tells them about the kind of labour you would like to have, what you want to happen and what you definitely want to avoid. Be flexible – the best birth plans recognise that things don't always go to plan.

Birth partner:

- Do you want your partner with you at all times?
- Are there stages when you'd prefer your partner to leave the room?
- Do you want to talk to your partner in private about interventions that may be suggested?

Positions for labour and birth:

- Do you want to stay upright and mobile for as long as possible or would you prefer to be in bed?
- Do you want to give birth lying on the bed?
- Do you want to be kneeling, standing, squatting?
- Do you want to keep your options open?

Checking your baby's heart rate:

- While your midwife is checking your baby's heart rate electronically with a hand-held Sonicaid, do you want to stay upright and mobile?
- Do you have objections to having your baby's heart rate monitored continuously?

What if you're told you need help to give birth:

- Do you want to avoid an episiotomy? Do you want to try other positions for giving birth first?
- Do you have a preference for forceps or ventouse, or are you happy to see what is recommended when the time comes?

Unexpected situations:

- What if your baby needs special care while you need stitches or to recover from a caesarean? Do you want your birth partner to stay with you or go with your baby?
- Is there someone else who can help?

Birth pool:

- Do you want to use a pool at hospital or midwife-led unit or are you hiring one to use at home?
- Do you want to use it just for pain relief or for giving birth too?
- Do you want to use it to deliver the placenta?

Pain relief:

- What sort of pain relief would you prefer?
- In which order would you like to try different medical methods? For example, gas and air before an epidural.
- Which, if any, methods do you want to avoid?

Speeding up labour:

- If your labour slows down, do you want your midwife to use interventions to speed it up again?
- Would you prefer to wait and see what happens naturally?

Third stage (delivery of the placenta):

- Do you want to have a managed third stage?
- Do you want to have a natural third stage?
- Who do you want to cut your baby's umbilical cord?

Special needs:

- Have you had a past experience that may affect your labour or birth?
- If you have a disability, what will help you?
- Do you need a special diet after the birth?
- If you have religious needs, be sure to add them.

Find out more about writing a birth plan at www.babycentre.co.uk

Appendix v. National Childbirth Trust (NCT) 'Template birth plan for hospital birth'

Template Birth Plan for Hospital Birth

This template birth plan includes a wide range of preferences for the birth of your baby. Some may not be relevant to your circumstances e.g. presence of students in a non teaching hospital, and there may be other areas which you don't wish to include, there will probably be some aspects not covered which you wish to add.

It is important to create your personal birth plan. So use this document for ideas, make as many changes as you wish, and share it with the people who will be present when you give birth.

You may find it helpful to discuss it with your birth partner if you plan to have one, so they can support you in achieving the birth you want.

Some of the terminology may be unfamiliar. Do ask your Midwife, other health professional or antenatal teacher to provide you with more information.

Before our baby's birth

If there is any research you would like me to participate in please provide details as far as possible in advance of the birth / I prefer not to be involved in research.

I am planning a vaginal hospital birth without intervention / caesarean section, but, should circumstances dictate, I am willing to consider other options so long as I am fully informed of the advantages and disadvantages.

During our baby's birth

1st Stage

I would like to remain at home for as long as I feel comfortable. I would like to be attended by the community midwife at home. / I would like to attend the hospital as early as possible.

In Hospital

I would like my husband / partner / doula / friend / children to be present

Appendix v. National Childbirth Trust (NCT) 'Template birth plan for hospital birth'

I would like my privacy and dignity to be respected at all times

I would like to remain as active as possible, finding the best positions for myself and changing these as I wish.

I would like to try and rest between contractions where possible.

I would like monitoring of the baby to be kept to a minimum unless there is cause for concern.

I would like any proposed intervention e.g. breaking waters, acceleration, ventouse, to be explained and discussed first, and ideally to be kept to a minimum.

I would like information about any proposed medication before receiving it, including the purpose, potential side effects on me / the baby and options on timing e.g. before or after the baby is born.

Pain Relief

I would like to cope without pain relief / I would like to use entonox / TENS machine / homeopathic pain relief / pethidine

I would like to use massage / move around / bathe / be given lots of support to help with this.

I would like to use water birth pool I wish to use for 1st / 2nd stage

I plan to use an 'all fours' / squatting / other / position to help with pain relief.

Advice will be welcome, and I am open to considering other pain relief options if necessary.

Transition

I wish to be very centered on myself at this stage and to have no intrusion.

Gentle support and firm guidance will be appreciated.

Information on progress and caring support will be helpful.

I will probably be in an all fours / upright / semi reclining position

Appendix v. National Childbirth Trust (NCT) 'Template birth plan for hospital birth'

2nd Stage

I would like to find my own comfortable position for pushing. This is likely to be an all fours / upright / semi reclining / position especially if things are progressing quickly.

I wish to know when the head is crowning

I wish to feel the baby's head / see it in a mirror

I will appreciate firm advice and guidance at this time to guard against too quick a delivery giving the perineum time to fan out thus (hopefully) preventing a tear.

We plan to take photographs / video the birth

I do not wish to have an episiotomy unless vital and I or my partner agree / I prefer an episiotomy to a tear.

I wish the baby to be delivered onto my tummy / I wish to hold my baby straight away / I wish for the baby to be washed and then given to me.

We would like to discover the sex of our baby ourselves

I wish the cord to remain attached until it stops pulsating

My partner would like to cut the cord

I wish the baby to suckle to encourage 3rd Stage.

3rd Stage

I wish to have an actively managed 3rd stage / I wish to deliver the placenta physiologically

I only wish cord traction to be used if syntometrine has been administered.

If there are signs of haemorrhage then I will have IV ergometrine as necessary.

We would like to hold our baby immediately / we would like the baby to be washed first

We would like our baby to stay with one of us at all times

Appendix v. National Childbirth Trust (NCT) 'Template birth plan for hospital birth'

We would like to be left alone with our baby

We would like to see the placenta and have it explained to us

We would like to be consulted if our baby needs to go to special care

Multiple birth – We would like both/all of the babies to be taken to special care together / If one baby needs special care and the other(s) don't we would like the well baby(ies) to stay with us until we go

I wish to breast feed as soon as is appropriate

We do / do not consent to Vitamin K injection

Tears

I hope to avoid this and will appreciate support to adopt positions to minimise tears. If one occurs I would prefer not to be stitched unless it is essential to healing / I prefer to be stitched

If stitching is necessary I do want a local anaesthetic to be well administered prior to stitching.

Emergencies

I or my husband / partner will discuss all eventualities as they arise. Please share any concerns with us as soon as they arise. It will help us to know the answers to these questions:

1. What is wrong?
2. What do you suggest and why?
3. What would be the possible outcomes with and without this intervention?
4. How much time do we have to make a decision?
5. Are there any other courses of action open to us.

We will be guided by balanced, informative advice. We want a healthy baby and mother and will take all necessary steps to achieve this.

In the event that assisted delivery is necessary I prefer ventouse to forceps.

In the event that a caesarean section is necessary I would like to have a spinal / general anaesthetic.

Appendix v. National Childbirth Trust (NCT) 'Template birth plan for hospital birth'

Note to writer: It may be useful to read the 'template birth plan - planned caesarean' for other points to add in here. Approximately one in five hospital births are caesarean at the time of writing so you may wish to consider what you would like to happen should one be recommended for you.

In the post-natal ward

We do not want our baby to be given any artificial milk

I intend to bottle feed on demand / I intend to breastfeed on demand

I would like our baby with me at all times unless I request otherwise

I would like to be present when our baby has a nappy change or bath

We would like our other children to visit as soon as possible after the birth

I would like to be consulted as to when I should be discharged from hospital

Any Other Comments:

This is a sample birth plan and should be adjusted to meet the needs of each individual couple.

Some people may also wish to prepare contingency plans for a baby needing special care. (This may also include a list in the rare event of a baby dying.)

Appendix vi. Olivia's birth plan

[Redacted] - Birth Plan [Redacted]

Location/Environment	
Who to partner Where	My husband, [Redacted] Larkhan Birth Centre - calm, dark, quiet, only essential monitoring
Pain relief	No pain relief offer unless I request.
Delivery preferences	Achieve birthing positions/no coached pushing Know girl. Prefer placenta delivery naturally dependant on iron levels/blood loss - injection if necessary. Deferred cord clamping and straight to breast - golden hour.
After birth	Vitamin K ✓ Breast feeding
Interventions	only when absolutely necessary Preference against episiotomy/ventouse/forceps
Any issues previously	focal incontinence after 2 nd baby due to long active labour phase/pushing phase + coached pushing. Both previous births were back to back.

Appendix vii. *Sophia's* birth plan



My birth plan

My name:

Due date:

Where to give birth

You will have a choice about where to have your baby. Your midwife or doctor will be able to tell you what services are available locally and advise you on any issues to do with your health or pregnancy that may affect your choice.

- I would like to give birth at home
- I would like to give birth in a midwifery unit
- I would like to give birth in a maternity team unit in hospital
- I am not sure yet where I would like to give birth

My comments on where I would like to give birth and why:

Companions

Having a companion you can 'lean on' and who can support you during your labour can be helpful. It has been shown to reduce the need for pain relief.

- I would like my partner or companion(s) to be with me during labour
- I would not like my partner or companion(s) to be with me during labour
- I am not sure yet whether I would like my partner or companion(s) to be with me

Appendix vii. *Sophia's* birth plan



My birth plan

My birth partner or companion is:

My husband. [REDACTED]

Companions during a forceps or vacuum delivery

A forceps delivery is where forceps are placed around the baby's head to pull him or her gently from the birth canal. Vacuum delivery, sometimes called ~~ventouse~~, is when the baby is guided out using a cap fitted to its head by suction.

- I would like my partner or companion(s) to be with me if I have a forceps or vacuum delivery
- I would not like my partner or companion(s) to be with me if I have a forceps or vacuum delivery
- I do not mind if my partner or companion(s) is with me if I have a forceps or vacuum delivery
- I am not sure yet whether I would like my partner or companion(s) to be with me if I have a forceps or vacuum delivery

Companions during a caesarean section

A caesarean section is when the baby is delivered by cutting through the abdomen and into the womb. This will only be performed when it is necessary, but there are situations where this is the safest option for either you or your baby. If your caesarean section is carried out under local anaesthetic and you are awake, your partner or companion may sit with you.

- I would like my partner or companion to be with me if I have a caesarean section
- I would not like my partner or companion to be with me if I have a caesarean section
- I do not mind if my partner or companion is with me if I have a caesarean section
- I am not sure yet if I would like my partner or companion to be with me if I have a caesarean section

Appendix vii. *Sophia's* birth plan



My birth plan

Birthing equipment

You may find that items such as wall bars, mats or beanbags help you to change position and remain comfortable during labour. If you're giving birth in a maternity unit, your midwife will be able to tell you if specific items are normally available. However, you may need or prefer to provide some equipment yourself.

- I plan to use equipment such as mats or beanbags during labour
- I do not plan to use equipment such as mats or beanbags during labour
- I am not sure yet whether I would like to use equipment such as mats or beanbags during labour

My comments on birthing equipment and whether I will provide it:

[I would like to use the birthing equipment available.](#)

Special facilities

Some units may offer you special facilities such as a birthing pool. Some have special rooms called LDRP rooms (labour, delivery, recovery, postnatal rooms) where you stay in the same room until you leave the hospital, although availability is limited. Your midwife will be able to tell you what's available.

- I would like to use a special LDRP room, if available
- I would like to use a birthing pool, if available
- I would like to use other special facilities
- I am not sure yet whether I would like to use special facilities, such as a special LDRP room or birthing pool, if available

My comments on any special facilities I would like to use: [I would like to use a birthing pool and to remain in the same room.](#)

Appendix vii. *Sophia's* birth plan



My birth plan

Any other comments or preferences on birth location, facilities or companions:

I would like my birthing environment to be quiet, dark and with minimal people in attendance. I would like minimal conversation and to be left alone to labour as far as possible. I would like to use a pool if available. My birthing partner will be fully aware of my wishes and will ensure this environment is maintained.

Monitoring during labour

Every baby is monitored throughout labour to make sure that it is not in distress. There are different ways of monitoring the baby's heartbeat.

I have discussed with my midwife how I would like my baby's heart to be monitored if everything is straightforward

I have not discussed with my midwife how I would like my baby's heart to be monitored if everything is straightforward

My comments on monitoring my baby during labour:

I would like for minimal monitoring throughout labour. Please do not ask to use continuous monitoring, scalp monitors or fetal blood samples unless you believe there is danger to the wellbeing of myself or the baby should these checks not take place.

I am happy for intermittent monitoring to be done through a Doppler.

Appendix vii. *Sophia's* birth plan



My birth plan

Keeping active during labour

Keep active for as long as you feel comfortable. This helps the progress of the birth. Keeping active doesn't mean doing anything strenuous, just moving around normally.

- I would like to move around during labour
- I would not like to move around during labour
- I do not mind whether or not I move around during labour
- I am not sure yet whether I would like to move around during labour

My comments on moving around during labour:

I would like to remain active, upright and moving throughout labour. I do not wish to be laying down.

Positions for labour and birth

Find the positions you prefer and which will make labour easier for you. Try out various positions at antenatal class or at home to find out which are the most comfortable for you. You can choose as many positions as you want and vary them throughout your labour.

- I would like to be in bed with my back propped up by pillows
- I would like to be standing
- I would like to be sitting
- I would like to be kneeling
- I would like to be kneeling on all fours
- I would like to be squatting
- I would like to be lying on my side

Appendix vii. *Sophia's* birth plan



My birth plan

- I am not sure yet which positions I would like to be in during labour

I do not want to be on a bed, on my back, with my legs in stirrups whilst delivering my baby. I wish to deliver on all fours/in birthing pool or otherwise upright.

Skin-to-skin contact with your baby

After the birth you can have your baby lifted straight onto you before the cord is cut so that you can be close to each other immediately. If you prefer, you can ask the midwife to wipe your baby and wrap him or her in a blanket first.

- I would like my baby delivered straight onto my tummy
- I would like my baby cleaned first before being given to me
- I do not mind if my baby is cleaned before being given to me
- I am not sure yet whether I would like my baby delivered straight onto my tummy

My comments on anything special I would like to happen immediately after the birth: Unless in immediate danger and in need of medical intervention, please deliver baby straight to my tummy for undisturbed skin-to-skin and wait until the umbilical cord goes white before cutting.

Midwives, nurses and doctors in training

Midwives, nurses and doctors need to observe women in labour as part of their training. They will always be supervised by a senior health professional.

- I have discussed with my midwife my thoughts about having midwives, nurses or doctors in training with me during labour
- I have not discussed with my midwife my thoughts about having midwives, nurses or doctors in training with me during labour

Appendix vii. *Sophia's* birth plan



My birth plan

Other comments or preferences about my labour and birth:

I would prefer as little people as possible in the room.

Pain relief options

There are many different pain relief options. Some women use a combination of methods. You may find that you want more pain relief than you had planned, or that more effective pain relief may be advised to assist with delivery. You can use a number of different methods at different times.

- I would like to try breathing and relaxation
- I would like to try being in water during labour and/or birth
- I would like to try massage
- I would like to try acupuncture
- I would like to try TENS (transcutaneous electrical nerve stimulation)
- I would like to try gas and air (entonox)
- I would like to try pain-relieving injections
- I would like to try an epidural
- I would like to try other methods of pain relief
- I would like to try to manage without pain relief

Appendix vii. *Sophia's* birth plan



My birth plan

My preferences for pain relief:

I would prefer non-medical methods of pain relief. Please do not offer pain relief other than what I have selected unless I ask for it.

Having an episiotomy

An episiotomy is a cut in the perineum (the area between the vagina and anus). This may be necessary if the perineum won't stretch enough and may tear, or if the baby is short of oxygen and needs to be delivered quickly.

I have discussed with my midwife or doctor why an episiotomy might be necessary

I have not discussed with my midwife or doctor why an episiotomy might be necessary

My feelings about the possible need for an episiotomy:

I would prefer not to have an episiotomy unless absolutely necessary. Please discuss with me before carrying out this procedure.

Delivering the placenta after the birth

Appendix vii. *Sophia's* birth plan



My birth plan

After your baby is born your midwife will offer you an injection in your thigh. This contains the drug ~~syntometrine~~ or ~~syntocinon~~ which helps the womb contract and can prevent the heavy bleeding that some women may experience without it.

I have discussed with my midwife what happens after labour when the placenta is delivered

I have not discussed with my midwife what happens after labour when the placenta is delivered

My preferences about delivering the placenta:

I would prefer to wait 30 minutes before consenting to an actively managed third stage. If after 30 minutes, or if I ask before, the placenta has not been birthed then I consent to an injection in my leg. If I am bleeding a lot immediately following delivery then I consent to a super active third stage but please do not administer any drugs as a preventative measure.

Feeding your baby

Breast milk is the best form of nutrition for babies as it provides all the nutrients a baby needs and has lasting benefits for the health of your child. Infant formula milk can be used as an alternative to breast milk.

I would like to breastfeed my baby

I would like to bottle feed my baby

I would like to try a mixture of breastfeeding and bottle feeding

I am not sure yet how I would like to feed my baby

My comments about feeding my baby:

Vitamin K for your baby

Appendix vii. *Sophia's* birth plan



My birth plan

Vitamin K is needed to make the blood clot properly. Some newborn babies have too little vitamin K so it may be suggested that your baby be given vitamin K either by injection or by mouth.

I have given my midwife my consent to give my baby vitamin K

I have not given my midwife my consent to give my baby vitamin K

Any other comments or preferences about me and my baby immediately after the birth:

[Any baby checks can be carried out after golden hour/first feed and initial bonding.](#)

[Please do not remove baby from me at any time without my explicit consent.](#)

[Please support me to breastfeed.](#)

[Please take a photo of us and allow my partner to take photos ☺](#)

More information about my special requirements:

[In the event of a c-section, please attempt to make the birthing environment as quiet, calm and relaxing as possible. Please allow for lowered drapes and delayed cord clamping followed by immediate skin to skin. Please place any monitors away from my chest to allow for undisturbed skin to skin. Please do not remove baby from me at any time without my explicit consent and knowledge.](#)

[Please take a photo of us and allow my partner to take photos ☺](#)

~~Deleted: Special requirements~~

Please tick any that apply to you. You can fill in more details in the box below.

- English is not my first language, and I need someone present who speaks my first language
- I need a sign language interpreter
- I have special dietary requirements
- I and/or my partner have special needs
- I would like certain religious customs to be observed

Appendix vii. *Sophia's* birth plan



My birth plan

General comments:

Vaginal exams: I would prefer not to have any routine vaginal exams.

Breaking waters: I would prefer not to have my membranes ruptured artificially.

MY BIRTH PREFERENCES

Appendix viii.
Lily's birth plan

ABOUT ME

Name: [REDACTED]

Contact number: [REDACTED]

Estimated due date: [REDACTED]

Birth place choice: Home

I wish to have a calm, quiet, water birth at home with minimal intervention.

We are using hypnobirthing techniques and therefore language is very important to us. I would appreciate it if you could avoid using the words 'pain' or 'contractions', and instead talk about 'comfort' and 'surges'.

This is my second baby (third pregnancy) and I hope to have a similar empowering birth experience.

MEDICAL CONDITIONS

Temporal Lobe Epilepsy

I have not had a seizure in over 10 yrs and I have been discharged to midwife led care.

I am keen that my medical history should not have any impact on my birth choices.

In the unlikely event that I do have a seizure, I am usually aware prior to it happening and remain conscious and communicative during.

BIRTH PARTNER

Name: [REDACTED]

Relationship: Husband

Contact number: [REDACTED]

My husband understands my birth choices and I trust him to communicate on my behalf and help me make difficult decisions.

In case of an emergency, I would like my husband to stay with me.

MONITORING

Intermittent monitoring

I would like to remain as upright and active as possible during labour.

I am happy for intermittent monitoring- you do not need to ask, if you feel it is necessary, as I would prefer as little questions and interruptions as possible please.

I would like internal examinations and physical interventions to be kept to a minimum unless you think they are necessary for the safety of me or my baby.

PAIN RELIEF

Hypnobirthing and Entonox

I will use breathing techniques for pain relief. Please remind me about my breathing, positive affirmations and to make low, deep sounds.

I will ask for Entonox if I need it. Please don't offer pain relief unless I ask.

I would prefer to avoid other forms of medicated pain relief or assisted delivery unless absolutely necessary.

SECOND STAGE

Waterbirth

I intend to use a birthing pool and would like to birth my baby in the water.

Please give me space to listen to my body and birth my baby instinctively.

I would find it encouraging to know when my baby is crowning, but please let me push instinctively (without coaching, except to avoid a perineal tear).

When my baby is born, I would like him placed on my chest for immediate skin to skin.

BIRTH PREFERENCES: AT A GLANCE

IN AN EMERGENCY

Avoid hospital transfer if possible

I would like to avoid a transfer to hospital, but I understand why this may be necessary.

I do not want to stay in hospital overnight.

I would like to avoid an assisted delivery or c-section, but I will discuss whatever options are recommended, in the best interests of our baby.

Me and my birth partner:

- Estimate due date [REDACTED] nt to Vit K injection for baby.
- Birthpartner- [REDACTED]
- Second baby (third pregnancy)
- Husband can/will advocate preferences.
- Please don't let medical history impact on birth or birth choices.

In an emergency:

- Avoid hospital transfer if possible.
- Avoid staying in hospital overnight unless absolutely necessary.
- Avoid assisted delivery or c-section unless absolutely necessary for baby's safety.
- Baby should remain with me or my birth partner wherever possible.

Monitoring:

- Intermittent monitoring.
- Minimal internal examinations and physical interventions.

Pain relief:

- Hypnobirthing and breathing techniques.
- Entonox (only when requested)
- Please avoid other medicated pain relief.

Second stage:

- Waterbirth- ideally like to deliver baby in water.

THIRD STAGE

Physiological. Optimal cord clamping.

I would like to delay clamping the cord until it stops pulsating.

My husband would like to cut the cord if possible.

I intent to breastfeed asap after birth to stimulate physiological 3rd stage, but I am happy to receive the Syntometrine injection to deliver the placenta once the cord has been cut.

Please delay newborn checks, if appropriate, to allow us time to bond.

Appendix viii. *Lily's* birth plan

- Please avoid coached pushing.
- Let me know when baby is crowning.
- I would like help to avoid a perineal tear.

Third Stage:

- Immediate skin to skin.
- Optimal cord clamping.
- Husband to cut cord if possible.
- Golden hour- delayed washing and new-born checks.
- Physiological 3rd stage.
- Consent to Syntometrine injection after cord is cut.
- Consent to stitches if required.

Our baby:

- Consent to recommended tests and medicines, including the vitamin K injection.
- Intend to exclusively breastfeed- no bottles or formula milk unless explicitly agreed with us first please.

Appendix ix. *Amelia's* birth plan

Birth Plan for

- My preference is to have a natural delivery.
- I had a very traumatic first birth and postnatal period with my last child and do not want to repeat this experience - hence I have made an alternative choice this time to have my baby at home. If it is necessary for me to transfer into hospital I will want to replicate the home environment as much as possible, including maintaining my privacy and control over who is with me.
- I do not want any vaginal examination unless there is a very good reason that has been fully explained to me.
- I do not want induction or augmentation of labour including Artificial Rupture of Membranes or a sweep.
- I do not want to be engaged in conversation during my labour.
- I do not want to be constantly observed during my labour - I would like my midwife, along with any other medical staff, to remain outside the room unless I ask them to come in.
- I absolutely do not consent to medical students being present at any stage during any time in hospital.
- I have researched the topic of the third stage of labour and do not want to go into hospital in the event of the placenta not being delivered after 2 hours after delivery.

Appendix x. *Amelia's* first birth plan

Birth Plan for [REDACTED]

General

1. I would like my husband [REDACTED] and our doula [REDACTED] to be with me during labour and birth.
2. Our focus is on a calm and natural birth. We would very much appreciate your support in this by helping us to create a calm, quiet and low-lit environment.
3. We would be grateful for maximum privacy at all times and for this reason would prefer not to have students attend – be they midwives, paediatricians or obstetricians.
4. We would also like anyone entering the room to knock first and await a response before entering.
5. I request not to be induced before 42 weeks unless there is a clear medical need.
6. I have a phobia of needles which, given my history of low blood pressure, has in the past frequently caused me to faint when injected. Please bear this in mind when proposing or administering injections.
7. I particularly request not to be placed on my back through any stage of the labour and birthing process.

Labour (General & 1st Stage)

8. My preference is for a natural spontaneous birth with no interventions other than essential routine checks.
9. I would like to be informed as soon as possible if the baby's presentation is slowing labour down (e.g. back to back).
10. I would like to be informed of any procedures throughout labour and to be involved in decision-making in a manner in which allows me time to process information (e.g. not being given information during a contraction) and consider my options.
 - a. Please inform me of the potential benefits, potential risks, potential alternatives, and pros and cons of doing nothing in the case of each proposed intervention.
11. I would prefer to avoid having my waters broken. I would also prefer to avoid using a drip to speed up and intensify labour. If this becomes necessary, I would prefer it to be used gradually. I may like to consider an epidural in this eventuality.

12. I would like to remain mobile during labour, using a mixture of the below as pain relief according to my preference:

Breathing	Massage	Different Upright Positions
TENS	Birth Ball	Bean Bag
Birthing Pool	Shower	Entonox

13. In particular, **I would like to use a birthing pool for pain relief, and plan to stay in the pool for the second stage and birth.**
14. I would prefer not to use an epidural as pain relief except in case of a medically necessary induction/acceleration of labour.
15. Please monitor the baby's heart by a hand-held monitor so that I am able to remain mobile.
16. I prefer minimal vaginal examinations and no artificial rupturing of membranes or manual stretching of the cervix, unless agreed beforehand.

Labour (2nd Stage)

17. I wish to push with my natural urges without external direction or 'pushing' prompts, unless I am struggling, in which case I would appreciate gentle support and suggestion.
18. I would like everyone to be 'hands off' during this stage, unless essential.
19. I do not consent to an episiotomy unless there is a very clear medical need for my baby to be born quickly. In case of a minor rupture, I would prefer the cut to heal without being sewn.
20. I would like to be told when the worst contractions are likely to be happening.
21. If the baby is not moving satisfactorily, I would like the reasons for this to be examined by ultrasound scan prior to a potential intervention.

Birth

22. At birth, I would like to breathe my baby out gently after crowning, along with my natural urges.
23. My husband and I would like to maintain a private, darkened, quiet, hormone-enhancing environment at birth.
24. Please do not cut the cord until it has stopped pulsating. We would like to let the cord stop pulsating by itself. If there are medical reasons which prevent this, we would like to have the cord remain attached for at least 1-3 minutes before cutting.
25. Please give the baby to me as soon as possible for skin to skin contact. I would appreciate support in maintaining skin to skin contact from the moment of birth, for as long as I feel is appropriate.
26. Please check whether the baby is tongue-tied and let me or my husband know when this check has been completed.

Labour (3rd Stage)

27. I would prefer to birth the placenta naturally, without syntometrine or being pulled out.

Postnatal

28. I will be breastfeeding my baby and am not intending to give my baby formula milk.
29. I would like to breast feed when the baby is ready, and allow the baby to latch on independently. If I require assistance with positioning and attachment, I request it from a breastfeeding-trained midwife or breastfeeding counsellor, or from my doula.

In case of Emergency / 'Plan B'

30. I would like my husband and L [redacted] to stay with me at all times. If only one person is allowed to accompany me (e.g. in the operating theatre), I would prefer my husband to accompany me.
31. I would like to be shown the baby as soon as she/he is born, and for the baby to be returned to me as soon as possible after initial checks for skin to skin contact.
32. Should the baby need to go to special care, I would like to see and touch the baby first. If kangaroo care is viable, I would like this option. I would also like the baby to be accompanied by its father or by [redacted].

THANK YOU VERY MUCH FOR YOUR SUPPORT AND UNDERSTANDING

Appendix xi. The Positive Birth Movement Facebook post, drawing attention to a Twitter thread discussing the correlation between birth plans and caesarean birth, November 2017

The Positive Birth Movement
@positivebirthmovement · ★ 4.8 (32 reviews) · Community

Home Shop Reviews Photos More ▾

Liked Message 🔍 ⋮






The Positive Birth Movement
14 November 2017 · 🌐

Recently on twitter a group of doctors discussed a piece of research into the effectiveness of birth plans. These doctors openly mocked the women they are supposed to care for, one joking that the bigger the plan, the bigger the caesarean cut would be, another saying that laminated birth plans are helpful only in the case of massive haemorrhage. 😞 Sadly this is not the first time I've heard jokes like this, which summarise the misogynistic power imbalance in birth that the Positive Birth Movement and so many others are working daily to challenge.

On the same Twitter thread (now many tweets deleted) appeared the age old chestnuts, a healthy baby is what's important here, and questions about why women are so obsessed with the 'experience' of birth instead of focusing on the outcome.

I'm pretty sure that women had this same message a couple of hundred years ago when they were told to 'lie back and think of England'? After all, any kind of sex can make a 'healthy baby' can't it? Why does it matter if you don't enjoy it? Silly selfish girls...

What are mothers seeking to achieve when they write their birth plan

 The Positive Birth Movement [View Shop](#)  Liked  Message  

Dear followers, let me tell you that making a birth plan is precisely the most vital action you can take, not in spite of these disgraceful attitudes, but because of them.






If we all had continuity of care from a midwife we knew and trusted, then a plan might be less necessary. We might have time to have meaningful discussions with them about the kind of birth we wanted. We might trust them.

But most women are not getting this kind of personalised care. And even if they were, making a birth plan is not about the plan itself as much as the process which is helpful to ALL women in ALL circumstances - the process of getting informed, learning about your options and rights in every eventuality, and being clear about what you want.

In short, it's about being INFORMED, and being AUTONOMOUS. And this, I'm afraid to say, is why it's discouraged. This is why we're told it's pointless. This is why we're told it's selfish, and this is why, in extreme circumstances, you might find jokes about the women who make such plans being cut or covered in blood. 😞

Recently we've seen women coming together under the hashtag #MeToo, and using the collective voice to say, respect our bodies, respect our boundaries, respect our autonomy, listen to our voices, we've had enough. And it's been super powerful, a true tipping point. Maybe we need something similar for birth? Maybe we need to start sharing these stories of disrespect or downright violation? Maybe we need #metoointhebirthroom?

Certainly we need to continue to support each other and encourage women to believe that they deserve to be treated with kindness, dignity and respect in birth and that it is ok to care about the experience of birth as well as the outcome. Indeed, better experiences improve safety and long term physical, mental and


 The Positive Birth Movement [View Shop](#)  Liked  Message  

experiences improve safety and long term physical, mental and emotional health of families. It's not silly. It's not selfish. It is not to be cruelly mocked.

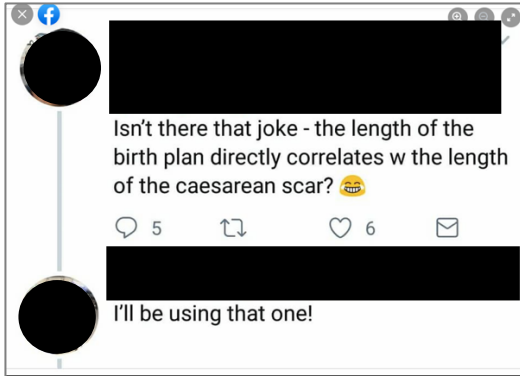
You may also wish to complain to the doctors professional bodies about their unacceptable attitudes. If they are prepared to speak this way in a public forum then they need reeducating, and fast. Birth matters. Women matter. It's not a joke.

Milli -PBM Founder

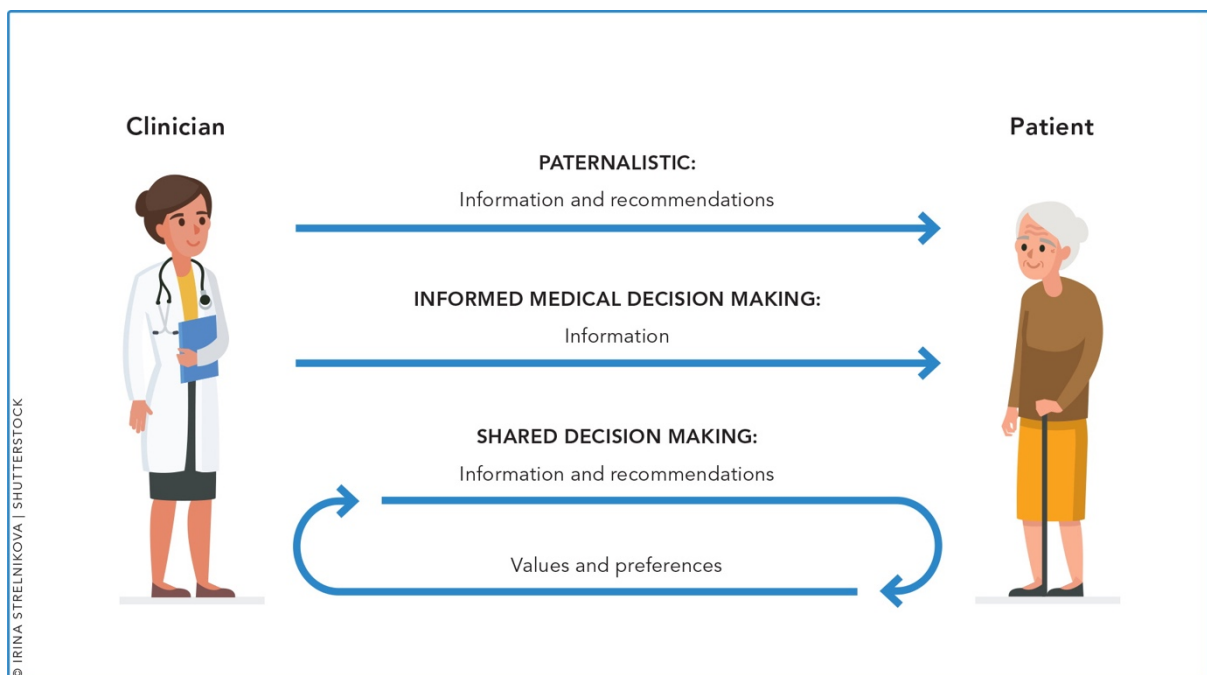
Edited to add info for those wishing to make a complaint.



What are mothers seeking to achieve when they write their birth plan



Appendix xii. Shared decision making model. © Irina Strelnikova / Shutterstock



Appendix xiii. Susie's birth plan

Welcome Letter to our Midwives + Our Preferences

Thank you for being here with us, we feel really lucky to have the opportunity to labour and birth at home.

Following a previous traumatic birth, we have thought long and hard about how to give ourselves the best chance of avoiding that this time. That means that a lot of our preferences are outside of trust guidelines and this could put you outside of your comfort zone.

We appreciate your huge clinical responsibility, with all the additional challenges that this year has brought, and we really want to avoid adding to your stress with our strange hippy demands, so we wanted to offer the only two pieces of reassurance that we feel we can in this situation; 1. Our word that we are making these choices based on heavily researched and careful decisions that suit our family, and 2. No one cares more about mine and our baby's lives than us. That said, if you feel uncomfortable with our choices we totally respect that your feelings and experiences around risk as well as your professional responsibility might mean that you want to leave or swap with someone else (if possible for you) and we give you our full support to do that. And apologies for causing you hassle.

Our main hope for this birth (aside from us all being alive at the end of it) is that we can make each decision that comes up by combining your clinical assessment with our values and preferences. We do not have a fixed idea of what birth will look like; if the decisions lead us to a theatre forceps birth then we will know that is the right call and feel happy that we got to take part in the path to that outcome.

Our hospital bags are ready to go, childcare and back up childcare arranged, and we have open minds in case of need to transfer. We have labelled or laid out what we could think of for you to eat and drink, please help yourselves, or have a rummage if there isn't anything you like and you need sustenance!

*Grateful for your support and expertise,
Xxxx and Xxxx*

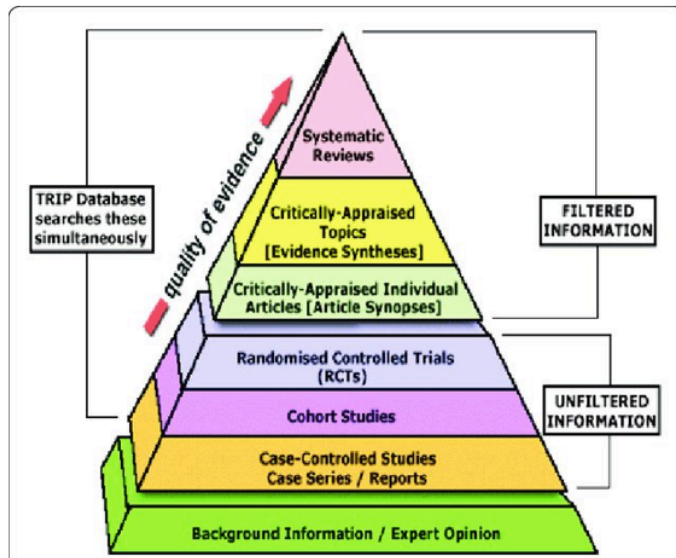
Our Preferences:

- To birth at home; calmly and privately
- To avoid any VEs. From experience I find them painful and triggering
- To have reduced intermittent auscultation without another medical indication e.g. meconium
- For me or my husband to be the first to touch our baby
- To wait for a physiological 3rd stage, with cord intact until either the placenta is born, or I get fed up
- To birth my placenta in the same environment that I birthed my baby; calm and private
- To birth my placenta out of water onto a clean inco pad/ bowl so it can be encapsulated (into yellow bag and plastic box with cold packs in freezer into blue cold pack)
- To use a cord tie (instructions in pack if needed: wrap tie around cord 360° + surgical knot + simple knot)

Appendix xiii. *Susie's* birth plan

- To transfer to hospital for medical support
 - CS scar pain
 - Contractions stop
 - Fever
 - Persistent fetal bradycardia
 - Reduced fetal movements
 - Haemorrhage
 - Thick mec + early baby (if baby is late and birth is imminent it makes sense to me to continue unless combined with decels)
 - My exhaustion, dehydration, need for more pain relief
 - Cord prolapse
 - Poor APGAR
 - Vaginal tearing that can't be managed at home

Appendix xiv. Hierarchies of scientific knowledge. © 2006 Trustees of Dartmouth College and Yale University



Figure

Caption

Figure 1. The traditional hierarchy of evidence-based medicine. The higher you come in the evidence-based hierarchy, the better will the inferential powers of your study become. EBM Pyramid and EBM Page Generator, © 2006 Trustees of Dartmouth College and Yale University. All rights reserved. Produced by Jan Glover, David Izzo, Karen Odatto and Lei Wang.

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