

When the Hospital Is No Longer an Option: A Multiple Case Study of Defining Moments for Women Choosing Home Birth in High-Risk Pregnancies in The Netherlands

Qualitative Health Research
2018, Vol. 28(12) 1883–1896
© The Author(s) 2018



Article reuse guidelines:
sagepub.com/journals-permissions
DOI: 10.1177/1049732318791535
journals.sagepub.com/home/ghr



Lianne Holten¹, Martine Hollander², and Esteriek de Miranda³

Abstract

Some women in a high-risk pregnancy go against medical advice and choose to birth at home with a “holistic” midwife. In this exploratory multiple case study, grounded theory and triangulation were employed to examine 10 cases. The women, their partners, and (regular and holistic) health care professionals were interviewed in an attempt to determine whether there was a pattern to their experiences. Two propositions emerged. The dominant one was a trajectory of trauma, self-education, concern about paternalism, and conflict leading to a negative choice for holistic care. The rival proposition was a path of trust and positive choice for holistic care without conflict. We discuss these two propositions and make suggestions for professionals for building a trusting relationship using continuity of care, true shared decision making, and an alternative risk discourse to achieve the goal of making women perceive the hospital as safe again.

Keywords

shared decision making; home birth; high risk; trauma; negotiation; multiple case study; qualitative; phenomenological; DESCARTE model; the Netherlands

Introduction

In the Netherlands, and other high-income countries, some women who are considered to have a high-risk pregnancy go against medical advice and choose to birth at home. Home birth with a community midwife is common in the Netherlands and is an integral part of the maternity care system. However, this option is limited to women with low-risk pregnancies. High-risk pregnancies are supervised by obstetricians, and these deliveries take place in the hospital. Lately, it has become apparent that not all Dutch women adhere to these recommendations. A small group of high-risk women opt for home birth with a community midwife in a “holistic” practice. This is usually a caseload midwife who accepts clients who choose to go against medical advice in their birth choices. The term “holistic” has been chosen to be consistent with the published literature on this subject. Another small group of women elect to forego any skilled attendance and attempt unassisted childbirth (UC; Hollander, de Miranda et al., 2017).

In a recent scoping review, Holten and de Miranda (2016) found 15 studies on the motivations of women

choosing to birth “outside the system,” that is, UC, home birth in countries where home birth is not well integrated into the maternity care system, or a midwife-attended high-risk home birth. The countries included Australia, Canada, Finland, Sweden, the United Kingdom and the United States. The key conclusion of this review was that “concerns over consent, intervention and loss of the birthing experience might be driving women away from formal health care and that there is a lack of fit between the health needs of some pregnant women and the current system of maternity care in several high-income countries. (p.60)” The authors argue that a dialogue on views regarding authoritative knowledge, risk, autonomy, and responsibility must take place between pregnant women and their health care providers.

¹Amsterdam UMC, location VUMC, Amsterdam, The Netherlands

²Radboud University Medical Center, Nijmegen, The Netherlands

³Amsterdam UMC, location AMC, Amsterdam, The Netherlands

Corresponding Author:

Lianne Holten, Midwifery Science, AVAG/APH/Amsterdam UMC, Vlaardingenvaan 1, 1059 GL Amsterdam, The Netherlands.
Email: lianne.holten@inholland.nl

Feeley and Thomson (2016) in a study on freebirth (or UC) in the United Kingdom found that women who chose UC faced opposition and conflict from maternity providers. The authors found that conflict appeared to be an important factor in the choice to birth outside the system.

Maternity care providers are increasingly faced with pregnant women who refuse some or all proposed interventions. These decisions may appear to be at odds with what medical professionals deem best for the fetus. Hollander et al. (2016) in their article on the legal possibilities and ethical intricacies of refusing recommended maternity care found, in contrast to the general perception, that the conflict was not between the mother and child, but between doctor and patient. Communication could be the key to solving this problem.

Jenkinson et al.'s (2017) article on refusal of recommended maternity care in a hospital setting in Australia found that when women's birth intentions were perceived by midwives and obstetricians to be across their "line in the sand," a range of responses were seen and escalated from manipulation, judgment, and badgering to outright abuse.

To examine the phenomenon of negotiation during a birth consultation, 10 cases of Dutch women who elected home birth in a high-risk pregnancy were examined and the results are presented here. In this multiple case study, interviews were conducted with the women, their partners, and their health care professionals (community midwives, holistic midwives, and obstetricians). The interview data were analyzed to determine whether a similar pattern of decision making occurred in these cases, which had led to the decision to birth outside the system. If a pattern emerged, it would be important for health care professionals to be aware of it so as to improve their care.

The purpose of this study was to explore how the wish to birth outside the system was negotiated in consultations/clinical encounters between pregnant women and their health care professionals. Special attention was given to the defining moment in the decision to leave the regular maternity care system. Understanding what happens in this decision-making process can generate implications for improving maternity care with a goal to increase women's options and reduce negative choices.

Method

Design

The Design of Case Study Research in Health Care (DESCARTE) model (Carolan, Forbat, & Smith, 2016) was used in the design of this exploratory multiple case study. This case study research used a cross-case analysis of 10 cases in which Dutch women with a high-risk pregnancy chose to birth at home against medical advice. The context of this study was the phenomenon of women

birthing outside the regular maternity care system in the Netherlands, and the focus was on the negotiation of care during conversations with health care professionals (midwives and obstetricians) wherein women with a high-risk pregnancy expressed their wishes.

Multiple case study design has been shown to be useful in exploring medical encounters (e.g., Barry, 2002; Ledderer, 2011). Whereas these studies combined interviews with (participant) observation, observation was not possible in this study as it was retrospective. Our interviews with the women who had chosen to birth outside the system took place months to years after their child's birth and their conversations with the health providers in question. Triangulation of the interviews with these women, their partners and their health care professionals were instrumental to understanding the issue under study. In this deductive approach, cases were selected not only for their own intrinsic value but also to provide insight into the phenomenon of deciding to have a home birth in a high-risk pregnancy (Rule & John, 2015). It was not the understanding of the particularities of each case (as in a naturalistic case study), but rather the identification of general patterns that was the goal of this study (Abma & Stake, 2014).

Theoretical Framework

Following Yin (2014), this multiple case (holistic) design used a theory-first approach with prior development of theoretical propositions to guide data collection and analysis. The following propositions based on a literature review were used as a theoretical framework. A discrepancy in the definition of authoritative knowledge complicates negotiations between women and health care professionals (Chadwick & Foster, 2014; Holten & de Miranda, 2016; Jordan, 1997; Tulloch & Lupton, 2003). Shared decision making (SDM) and true autonomy within consultations between clients and health care professionals are problematic (Barry & Edgman-Levitan, 2012; Elwyn et al., 2012; Holten & de Miranda, 2016; Stiggelbout et al., 2012). Conflict arises around the negotiation of a birth plan (Chervenak & McCullough, 2017; DeBaets, 2017; Feeley & Thomson, 2016; Hollander et al., 2016). Conflict in negotiation can also lead to a search for more tailored care (Hollander, de Miranda et al., 2017; Schoot, Proot, ter Meulen, & de Witte, 2005).

Defining moments in the decision to seek holistic (outside the system) care often lie in conflict or previous trauma (Feeley & Thomson, 2016; Hollander, de Miranda et al., 2017; Kotaska, 2017). As a rival proposition, the researchers explored whether the choice to birth outside the system was a positive first choice rather than the result of conflict or previous trauma, as this was one of the themes in Holten and de Miranda's (2016) scoping review.

Medical situation (high risk) in this and previous pregnancies
What did you want to do that was against medical advice?
Why?
What makes a good birth or a bad birth?
Relationship with maternity care provider (time, connection, needs)
Trust (in care provider, in yourself, in protocols, in evidence, in the system)
Preparation (people, sources)
Partner's position
Risk perception (yours, care provider's, how to weigh these)
Autonomy (informed consent, equality, control)
Fear (for what? Why?)
Needs (physical, emotional, social)
Defining moment (to deviate from protocol)
Search for alternative care(-r)

Figure 1. Topic list for the interviews with the women.

The researchers in this study used a feminist approach informed by Critical Theory, whereby the researchers had an idea of the root causes of the problem under investigation and sought to validate findings from previous research and ultimately to advocate for change based on the analysis of the findings (Kincheloe, McLaren, & Steinberg, 2011). A feminist approach was used to explain the focus on women's autonomy or lack thereof and the power differentials within the clinical encounter (Green & Thorogood, 2009).

Data Collection

Our sampling approach was deductive. In all 10 cases, the women had a high-risk pregnancy and opted for home birth. Their partners and at least two professionals (community midwives, holistic midwives, and/or obstetricians) involved in their care were also interviewed. Women were selected by several sampling methods: purposive (approaching certain nationally known advocates or famous "cases"), convenience (contacting potential participants who happened to be posting on an online maternity care users forum during the time of recruitment), and snowball (referral of some participants by other participants or their midwives, who were informed about the study by the researchers). Women's partners, if available, were also asked for an interview, as were all their known caregivers, provided the women gave permission for them to be contacted.

The interviews were semistructured and took place from August 2014 through February 2016. All participants gave verbal informed consent. A topic list based on themes known from the literature (Holten & de Miranda, 2016) was used to guide the interviews with the women (Figure 1). Partners were encouraged to tell the story of their child's birth in their own words. Community midwives and obstetricians were asked about their recollection of the specific case of the woman in whose care they

were involved and about their attitude about women making birth choices against medical advice. The holistic midwives were involved in several cases and were interviewed about their general opinion regarding this phenomenon and the particulars of the way they practiced, instead of focusing on individual cases.

All interviews were conducted by one of the three authors, who are all female and have a professional interest in women's motivation to give birth outside medical guidelines. All have a medical background in midwifery/obstetrics and experience with in-depth interviews. One (Lianne Holten) had extensive previous experience with qualitative research as a medical anthropologist.

None of the women or their partners who were interviewed were known to the interviewers, either personally or professionally, prior to the interviews. However, some of the professionals (midwives and obstetricians) were known to the interviewers through their professional networks. Prior to the interviews, there had been email contact with all participants, asking for their participation and explaining the reasons, goals, and methods of the study and the identity and background of the interviewer. For this study, permission was sought from and waived by the medical ethics committees of the Radboud University Medical Center Nijmegen and the Academic Medical Center in Amsterdam.

The interviews lasted between 30 and 120 min and were recorded by digital sound recorder. They were then transcribed verbatim either by a commercial company or by volunteer medical students. Quotes used in the text were translated from Dutch into English by the second author. All sound files and transcripts were stored anonymously in a secured password-protected university digital storage system. Data are available by request; however, all data are sound files or plain text in Dutch and contain sensitive information. Therefore, they are not publicly accessible.

Data Analysis

The researchers in this study used a case-based (rather than variable-based) analysis. Qualitative data analysis software MAXQDA (VERBI Software GmbH, 2017) was used in the thematic analysis of the cases. The within-case analysis was informed by Charmaz's (2007) grounded theory. The interviews with the participants were coded by all three authors and analyzed by the first two authors. The interview data generated themes that together with themes from the literature informed the theoretical propositions. The themes were then used as an analytical lens in the thematic analysis of the cases by the first author. The between-case analysis was modeled on Yin's (2014) pattern matching method. The researchers looked for replication and contradictions of all propositions. The purpose of this

cross-case synthesis was to determine whether the women followed a similar course, not to explain the particularities of negotiation within consultations between pregnant women and their health care providers. The researchers strove for rich narrative without risking confidentiality and therefore chose to only report on the cross-case analysis.

Trustworthiness/Rigor

In the within-case analysis, triangulation of interview data from multiple sources (women, their partners, and their health care professionals) on a single event served to increase the internal validity of this study (Morse, 2015). For the between-case analysis, pattern matching was used (Yin, 2014), whereby results were compared with an empirically predicted pattern (based on the literature) and rival propositions to strengthen internal validity. A member check was performed among holistic midwives in the form of a feedback focus group discussion. Analyzing multiple cases strengthens external validity. A case study protocol (propositions) was used as a standardized agenda for the researcher's line of inquiry, thereby heightening the between-case reliability.

Results

A total of 41 interviews with women ($n = 10$), their partners ($n = 10$, all males), community midwives ($n = 5$, all females), holistic midwives ($n = 8$, all females), and obstetricians ($n = 8$, 2 females, 6 males) were conducted. In all 10 cases, the women had had a high-risk pregnancy. Three had attempted a vaginal birth after cesarean (VBAC), three had had a breech birth, two had had twins, one had had a previous postpartum hemorrhage (PPH), and one had had a high body mass index (BMI) at the time of birth. All these women chose a home birth. In eight cases, they actually delivered at home, whereas in two cases, the women eventually agreed to be transferred to the hospital due to a failure to progress. There were no cases of perinatal morbidity or mortality. Table 1 illustrates the characteristics of the women who were interviewed. Characteristics of the individual cases are not provided due to privacy concerns. Several cases had media coverage due to the women's involvement in malpractice suits and might be publicly recognizable. For the same reason, case numbers were removed from all citations.

Nine of the 10 cases followed a similar pattern (Figure 2) outlined by the six themes resulting from the data analysis. These women had experienced an event in their past (e.g., a previous traumatic birth experience) that had caused an aversion to hospitals and medical staff. Following self-study, the women had acquired an alternative risk perception compared with the medical staff. They had begun to doubt the health care professionals' interpretation of the evidence for

Table 1. Characteristics of the Women.

Characteristics	N = 10
Women with high-risk pregnancy	
Risk factor	
VBAC	3
Breech (1 also post term)	3
Twins	2
Previous PPH	1
BMI > 35	1
Age at delivery (years)	
>25–30	1
>30–35	6
>35–40	3
Parity during relevant delivery	
1	3
2	3
3	3
4	1
Employed	
Yes	8
No	2
Highest education	
High school	1
Vocational training	2
College	2
University	5
Marital status at time of relevant delivery	
Married	6
Living together	4

Note. VBAC = vaginal birth after cesarean; PPH = postpartum hemorrhage; BMI = body mass index.

the proposed obstetric management. These women brought this aversion and differing risk perception into consultations with their health care professionals. In consultations with their community midwife or obstetrician, they often experienced a paternalistic decision-making model and a lack of autonomy. Inflexible use of a protocol by the health care professionals and/or the women's inflexibility made compromise impossible, and the hospital as a place of birth was no longer perceived as an option. These women then turned to holistic care, often as a last resort or second-best choice. In holistic care, they found true SDM within a trusting relationship. In Figure 3 is an illustration of a rival proposition of a positive first choice for a home birth in a high-risk pregnancy, as demonstrated by one case.

Primary Proposition: A Negative Choice

Previous traumatic experience. In all nine cases, the women felt that they were safer giving birth at home than in the hospital, and most had a strong aversion to birthing in a hospital. In two cases, the women had experienced previous hospital admissions as extremely stressful:

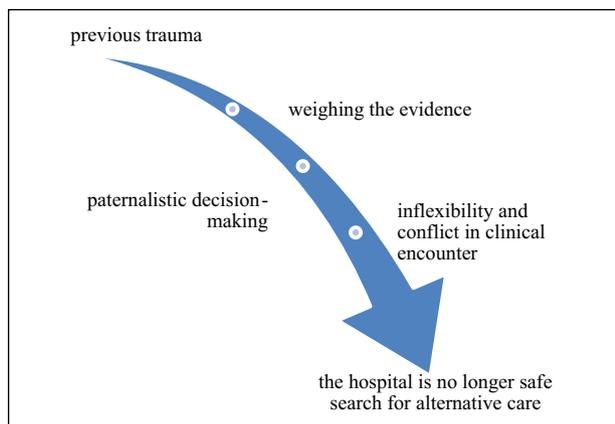


Figure 2. Proposed mechanism of traumatic experience, conflict, and negative choice.

... in a hospital I am very nervous, tense, uncomfortable, my blood pressure goes up, all things that I thought [I could prevent] with the undisturbed birth that I could have at home, which would therefore also prevent the postpartum hemorrhage and the shoulder dystocia, those are all things that I [feel that I] would seek out if you would make me go to a hospital. I so dreaded that. (Woman, high BMI, home birth)

In six cases, the women had had a negative experience during a previous birth. These were not related to a poor obstetrical outcome (there were no cases of previous perinatal deaths or major maternal or neonatal morbidity). The women explained that they had experienced a lack of autonomy during medical interventions during birth (e.g., an induction of labor, instrumental delivery, or cesarean section) as traumatic:

He says: "I am not here for my own amusement; I am here to help you." And he rams that vacuum pump in, literally. Like that! ... It has left me with vaginism. I never had that problem before. (Woman, home VBAC)

In four cases, an experience during the current pregnancy was also perceived as traumatic. These situations involved a lack of autonomy as well:

But before I knew it they were prodding my stomach to see if they could do an external cephalic version. That really made me close down. I felt so, ... like my sense of self-worth was compromised. That I thought: somebody is messing with my baby, without asking for permission, without any explanation. I thought: what is this? ... I would rather just go for a breech birth than have to go through this again ... It really was a traumatic experience. (Woman, home breech birth)

Some health care professionals we interviewed were aware of the fact that many women who birth outside the hospital have had a previous traumatic experience in the hospital. They believed that this made caring for these

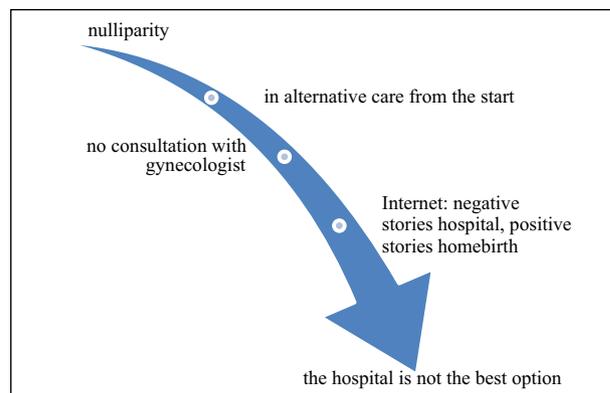


Figure 3. Rival proposition of positive choice.

women difficult because of the extra time needed to ameliorate previous trauma, and that they were placed at a disadvantage by a pre-existing lack of trust:

... many people who have been traumatized during a delivery ... well, that's where something went wrong in the past. And wrong enough that when I am confronted with someone like that, I don't have the time or the space to repair the damage, to make them feel differently about the impending delivery. And that is a shame. (OB/GYN, male, home VBAC)

Community midwives and obstetricians often understand that previous trauma can influence a woman's choices, but this does not necessarily mean that they want to attend a high-risk home birth:

When I see some women come home traumatized after a hospital delivery, I completely understand that you don't want to go back the next time. But I do believe that talking it through could help solve matters. If it doesn't, then everyone has their own responsibility to give birth in another way. Just not with me present. (Community midwife, female, home VBAC)

Weighing the evidence. After having had a negative experience in regular care, and vowing not to lose their autonomy again, the women started gathering information. They used websites, Internet fora, and medical journals to increase their knowledge of obstetrics and heighten their trust and confidence in their ability to birth naturally:

You can go on PubMed ... There are all sorts of social media where you can discuss things with lots of different people. So, I do think that women standing up for themselves more is increasing. What they actually want is to discuss things on a different level. [Women] expect communication to be based on solid scientific information. And I also think that there are more women who say: you know, I will just trust in myself and trust that this will go the way it is meant to go and I will just stay home. (Woman, twin home birth)

Some health care professionals have noticed a shift to a more empowered clientele. They feel that there is a growing awareness among women that they have the right to refuse medical advice:

She read a lot then, too. She was busy with all kinds of dissertations trying to weigh the risk for herself. She had also given me a lot of information, and for her, the decision was that she said: "That is a risk I am willing to take, that I will experience a uterine rupture at home." (Community midwife, female, home VBAC)

With their newly gained knowledge, these women critically appraised the relevant protocols and guidelines, and the statistics they were based on. Often, they decided that the risks did not apply to them or that they were willing to take their individual risk:

The downside of evidence-based medicine is that you only know what you know. There has never been a study comparing breech birth at home versus at the hospital. So, the risks associated with a breech birth compared to a normal cephalic birth [in the hospital] can't be extrapolated to the fact that I gave birth at home. Of course, that is exactly what is being done. They are group statistics. You can't apply those to one individual. That bothers me. So, I think that the risk of complications [at home] is smaller than the literature shows. That is why I completely focused on: all will be well. (Woman, home breech birth)

Several health care professionals were also critical of the evidence many protocols and guidelines they were expected to adhere to were based on:

But, if you look at which part of the guidelines is actually really evidence-based, of course, that is only one page. So, we are all saying things like . . . expert opinions and I don't know what else, and so that changes over time. So, I find that somewhat difficult, if you go around spouting that as the truth. And our proposition at our national meeting was, let's start by being clear about what is really evidence-based, where the gaps in our knowledge are, and then we can investigate those and supplement our knowledge. I could work much better like that. So, those are my thoughts about our guidelines. I am not so . . . not such a fan of the guidelines. (OB/GYN, female, high BMI, home birth)

After weighing their risks, women decided that the interventions they feared would take place in the hospital posed more of a risk to them and their baby than a home birth did:

I felt that those risks were because of the interventions. At some point I had the notion that if I made sure I had a good, physiological process, I would not run that risk at all. That I was actually keeping that risk at bay. (Woman, previous PPH, home birth)

Some women also felt that the risks they took having a home birth in a high-risk pregnancy were outweighed by the possible negative effects of (routine) interventions. As one OB/GYN concurred,

Of course, it is quite difficult to . . . many of the things we do routinely, to indicate which of those are actually useful . . . And then, some people say: "Well that is such a small risk." That doesn't justify the intervention, for me. (OB/GYN, male, home breech birth and home VBAC)

The women stepped into the consultation with their health care professional with this (alternative) risk perception and aversion to the hospital.

Paternalistic decision making and a perceived lack of autonomy (again). Most health care professionals were of the opinion that the style of counseling pregnant women has changed over time and that this is a good development:

What I am realizing more and more, is that we are slowly moving from "informed-consent" to "shared decision" to "informed choice." In which the patient makes an informed choice, and that you . . . that I find myself respecting that more and more. (OB/GYN, male, home breech birth and home VBAC)

However, in eight out of 10 cases, the women felt that there had been no SDM during health care provider consultations in which they discussed their wishes for giving birth. They experienced a paternalistic style of counseling and a lack of autonomy:

I was just not heard at all . . . there has actually never been anyone who asked me: why don't you want to give birth in the hospital? (Woman, high BMI, home birth)

The women felt there was no room for their wishes and that they had limited choice, as one woman's partner articulated:

I do expect [of the midwife], that if you are told "no," that you will be offered something else, or . . . some alternative or in any case something to discuss, let there at least be some form of discussion, we have had a few instances where no discussion was possible and I found that very, uhm, what shall I say . . . disappointing. (Partner, male, high BMI, home birth)

Yet most health care professionals were convinced that they had counseled the woman adequately and did not understand where it had all gone wrong, as the following quote by an obstetrician counseling in the case of a breech presentation illustrates:

She was referred for a breech position, after which we discussed her wishes: what she would want and what she didn't want. I explained the possibilities at length and told her that as far as I was concerned, we could accept her for a vaginal breech delivery Then I explained [to her] how this works, where, in case of an intent to deliver vaginally, there are conditions, in terms of [the following]: is there enough progress during dilation, is the estimated fetal weight not too high. And the progress during the second stage also needs to be sufficient, and therefore, there can always come a time during the delivery that we say: "well, now there is a reason to make a different choice." Well, that in itself was ok. It was a normal conversation. I don't remember anything unusual about it. It was just accepted . . . as it is usually accepted by most people. I made a follow-up appointment and never saw her again. (OB/GYN, male, home breech birth)

In this case, the obstetrician was convinced that the consultation had gone well. The woman however experienced a complete lack of autonomy, which led her to abandon plans for a hospital birth in favor of a home birth. This is how the woman experienced the same encounter:

He [OB/GYN] said: "Ok, a vaginal breech birth. There are a number of conditions" . . . he ended that story with: "But anyway, I have the final say during the delivery." And then I thought: wait a minute, am I not the one giving birth? I was given no further explanations. So, we just went home. It was such an unsatisfactory feeling . . . I have never felt like I was a . . . not so much equal partner but as a serious participant in this conversation. While I am the one carrying this child. (Woman, home breech birth)

There were two cases in which women were satisfied with how they had been counseled in the hospital. In one case, the woman who was pregnant with twins and desired a home birth had a consultation in a clinic that specializes in consultations with women who want to birth outside the system. The other case was a woman who wanted a VBAC at home. She was counseled by an obstetrician who also involved the community midwife in SDM.

Inflexibility: Conflict in negotiation. In all cases but one, there had been some form of conflict during negotiation of the women's birth plan. Women encountered inflexibility from community midwives and obstetricians with regard to deviating from guidelines or protocol. In three cases, health care professionals threatened to call child protective services, and two actually did. In two other cases, the obstetricians lodged a formal complaint against holistic midwives for attending high-risk births at home. All this caused a great deal of stress for the women involved:

. . . at first I sent my birth plan and then we talked again, and that was when he let me know that they were not willing to make any concessions and that continuous [fetal] monitoring was an absolute requirement Then we said: ok, well then, we will do things differently. And that is when the telephone conversation became distinctly unpleasant. That he said: "Yes, well, that is not allowed, and a midwife who does this is acting against the law. Your child has rights too." That was unpleasant. . . . One and a half hours later he phoned and said: "I am going to report you to child protective services, because you want to have a home birth." . . . As far as we were concerned, that definitely closed the door to the hospital. It was quite intense too, because I was thirty-nine weeks at the time. I found that very threatening. (Woman, home VBAC)

In some instances, the women had been in contact with more than one obstetrician from the same clinic and had encountered two very distinct viewpoints. This did not increase their confidence that the clinic would respect their wishes during their labor. In one case, an obstetrician expressed his negative views on women who chose home birth in a high-risk pregnancy in a telephone conversation with a community midwife, as she explained,

[the obstetrician said] "Someone who opted for a home birth was just a borderliner If that lady really didn't want that [the hospital], then something was not right. Then she should be reported to child protective services." . . . That was the actual advice from the hospital No, we did not report her I do not feel that she made a decision based on not wanting to care for her child properly. (Community midwife, female, home VBAC)

However, another obstetrician from the same department, who saw the woman later on, had other ideas and was very set against involving child protection services:

And in this situation, I am dealing with two, in my mind, very realistic people with an obvious trauma which has not been dealt with. I do not labor under the illusion that child protective services deals in trauma therapy. I also estimate chances are good that running to child protective services will double the trauma, so for me that was not a realistic option. (OB/GYN, male, home VBAC)

In consultations, health care professionals often felt that they had done their best to reach a compromise but that the women themselves were too inflexible in their wishes:

I was really amazed that she thought we were being too "medical," while actually, all other things besides a home birth, that we should have done, according to regional protocols, we didn't do. We decided not to do those. We thought: oh well, if she doesn't want those, that's fine. (Community midwife, female, previous PPH, home birth)

At the same time, this community midwife's client had experienced their negotiation of her birth plan as inflexible:

They said, yes, you have to give birth in the hospital, you can't have a home birth any more. And well, I had just been working on taking charge of my autonomy, so the sentence "you can't have a home birth any more," that was, that was just very unpleasant for me. I felt that was an unpleasant conversation. And also, for instance, that they said, like, "yes, because you lost so much blood we want to put in an IV and you will get oxytocin right away." . . . It wasn't that I didn't want that, but I didn't want it to happen just because they said so. (Woman, previous PPH, home birth)

In this particular case, the community midwife was aware of her client's opinion about the consultation. However, often women avoided conflict by leaving regular care without giving their health care professionals an explanation.

The partners' role in the negotiation of the birth plan seems limited. In all cases, partners left it up to the woman to inform them of her choices, and they respected her choice:

I just supported her all the way. I let her do the research because I felt that she, it had to be right for her, and, well, I could see that after a while it calmed her down, and it is . . . we did talk about it a lot, you know, she kept me informed the whole time of what she had found this time. . . . It was her that convinced me. (Partner, male, previous PPH, home birth)

In one case, the partner was not aware that his wife was considered to have a high risk pregnancy (twins):

I also wonder if this is actually a high-risk pregnancy. Is this always automatically high-risk? . . . Ok. I did not experience it as such . . . Also, haven't really given it much thought. I did consider it as higher risk than a singleton pregnancy, but . . . didn't really give it much thought. (Partner, male, twin home birth)

In nine out of 10 cases, conflict during the negotiation of a birth plan was a reason for the women to search for care outside the system.

Holistic care: A last resort/second best choice. In all 10 cases, the women started care with a midwife and decided during their pregnancy to go against medical advice and protocol by choosing a home delivery. The women found that the wishes they had for their birth could only be met by a holistic midwife as the community midwives and/or obstetricians were unable or unwilling to help them. Holistic midwives were more accommodating to the

women's wishes. These midwives had other criteria for agreeing to attend a home birth compared with hospital guidelines or protocols:

Yes. I go along with every wish. If I feel like people are actually taking responsibility for it themselves. I have to feel like they have thought it through sufficiently. That they are coming from a position of strength and not from fear. For instance, not from fear of ending up in a hospital, but from a conviction or a trust in something in themselves, or whatever. I have to feel like they can carry themselves. If not, I won't do it. (Holistic midwife, female, home VBAC)

Some community midwives and obstetricians actually worked together with holistic midwives and realize that they address a need for personalized care:

I also feel that we are learning a lot from this. I think that . . . patients are having trouble recognizing themselves in hospital care as it is sometimes offered. Too impersonal, not involved enough. That they really miss that [the personal involvement] and opt for a caseload midwife to monitor their pregnancy and . . . I actually feel that you can make tremendous use of that model and still have a good basic outcome for these women. (OB/GYN, male, home breech birth and home VBAC)

In most cases, the women found their holistic midwives through the Facebook community *De Geboortebeweging* ("the Birth Movement") on the Internet. In two cases, women actually started their pregnancy in holistic care, but in most cases, the women had switched to holistic care late in their pregnancy (sometimes just before the due date) when all other options had been exhausted.

In one case, the woman wanted a VBAC at the hospital with her own midwife. The consultation at the hospital ended in conflict and the hospital refused to admit her. The adjoining primary care birthing center also refused her because they were afraid of a bad outcome:

Then I thought: "Well, then we will go do it at home, to make a statement. If she is not welcome in the hospital nor in the [birthing center], then she will have to stay home. And we can't let her down." (Community midwife, female, home VBAC)

As not all of this community midwife's colleagues agreed to assist during a home VBAC, eventually this woman had to find a holistic midwife.

In another case, a woman, pregnant with twins wanted to birth in the hospital with her holistic midwife. The hospital refused. The conflict between the woman and the obstetrician escalated so that she decided to birth at home without telling the obstetrician. The birth stagnated, yet the woman waited more than 24 h before she went to the hospital:

Well . . . see . . . in hindsight, I have been thinking that it shouldn't have come to this. Where your relationship [with the hospital] is so disturbed that even when the delivery is not going at all as it should, you still don't want to go to the hospital. (Partner, male, twin home birth)

In six out of 10 cases, it was not the woman's first choice to birth at home. In four of these cases, the women were prepared to deliver in the hospital with an obstetrician if some of her requests had been honored. In the other two cases, the women wanted to deliver in the hospital with their holistic midwife, but this was not allowed. Thus, for these women, delivering in the hospital was no longer an option, and they saw home birth as their last and only choice.

Defining moment: *The hospital is no longer an option.* In nine cases, the defining moment in the choice to birth outside the system lay in the fact that for these women the hospital felt like it was no longer an option. After a conflict with their obstetrician, some women and their partners felt that the risks of delivering in the hospital were greater than the risks of a home birth:

We felt like (my wife) would be on the operating table in no time at all for a cesarean section . . . That is how we interpreted the conversation with [obstetrician]. He literally said: "I prefer to do only cesareans, because then I can plan them so I don't have to get out of bed at night." We just didn't feel safe in the hospital, so that is why we delivered at home . . . If all [the consultation] had gone well, then I think we would have just delivered in the hospital. And then we would have probably been just as happy. (Partner, male, home breech birth)

For some women, the defining moment was when they felt they had no autonomous choice in the hospital:

Then [we had] the desire to not immediately implement that active management of the placenta. When it was actually being said that there is no question, that that is possible. Then I thought, well yes, but then this is not the right place for me. Then, I do not feel heard . . . I know exactly at which appointment that happened, and I said that evening that this is not going to work out this way. (Woman, twin home birth)

Women and their partners felt that they could not choose which interventions would or would not be done, such as active management of labor or continuous fetal monitoring. Nor could they choose their mode of birth, for example, a breech on all fours or a VBAC in a birthing pool:

Especially certain wishes that she [pregnant woman] had that could not be met by the hospital. From her third [delivery] she knew that she liked giving birth in the bath. And that was impossible. But, what also factored in, was that she did not have a good feeling at all . . . about the hospital.

Because they just dictated to her what she would do: "You will do this and that and that and now we will do this and that." Yes . . . that is also a strange way of caring for a pregnancy. (Partner, male, twin home birth)

At a certain moment, often after a conflict with an obstetrician, the women felt that the hospital had become unsafe or even dangerous and/or that the hospital was a place where true autonomy was not possible.

Rival Proposition: Positive Choice

Negative case. One case followed an alternative pattern (Figure 3). This case involved a nulliparous woman with a breech presentation who had not had a previous traumatic experience and did not have any conflict in the negotiation of her birth plan. She had started prenatal care with a holistic midwife, apparently by coincidence, and did not consult an obstetrician during her pregnancy. She did not have an aversion to the hospital:

There is actually nothing wrong at all with a protocol and with giving birth in a hospital or under medical supervision, except my truth is . . . that it has to feel good and right, from within myself. Because I personally just believe that every person, but also a baby, being a soul, makes certain choices, and that is a factor for me, and I really believe that a baby can actually make a conscious decision to be born in a hospital or not . . . If I had felt that a planned cesarean section was meant to be, then I would certainly have been open to that. (Woman, home breech birth)

This woman's membership in an Internet community and her trust in birth as a physiological process played a defining role in her choice to deliver at home with her holistic midwife:

It is always a feeling of course, but indeed, also stories that I [saw] on the internet. YouTube is full of home breech birth movies. (Woman, home breech birth)

Some community midwives and obstetricians believe that certain Internet fora actually create distrust and fear of the regular system and put women on the path of home birth in a high-risk pregnancy:

What I find difficult about that, is that there are actually certain movements, for instance the "Birth Movement" in the Netherlands, which, to my mind, create some sort of bias . . . Who create a certain situation of distrust, which is not right either. So, I find that to be a shame . . . where it is stated beforehand, that the doctors won't listen. That there will be too many medical interventions and that unnecessary things will be done, and that opinion makes people afraid. So, in part it [birthing outside the system] is based on trauma and part it is based on information which I feel is not always accurate. (OB/GYN, male, twin home birth)

A holistic midwife explained that, according to her, there are two groups of women who choose to birth outside the system—those that have fear and those that trust:

There is a part, I think 75 percent, who come out of fear. They come [to me] because they are afraid of the hospital, that someone will think something of them, and will want them to do something they don't want to do. To be taken over. There is a lot of fear there. Often, there is sexual abuse behind it. And then there is a smaller percentage, that is I think 25 percent, of people who come because it is just a better fit. They have no fear of hospitals, they don't fear . . . decisions that may need to be made. And they just have confidence in things being right. So, there is a small group of trust and a larger group of fear. (Holistic midwife, female, high BMI, home birth)

In this negative case, there was no conflict in the negotiation of the birth plan because there was no consultation with a regular community midwife or obstetrician. Even though there was no aversion to the hospital, the Internet had an important part in the representation of the hospital as being not the best option for a breech birth.

Discussion

The results of this multiple case study demonstrate that there is a discrepancy in the definition of authoritative knowledge that often makes negotiation difficult. Women may feel that their true autonomy during consultations with health care professionals is threatened and conflicts arising during the negotiation of a birth plan may lead them to search for more tailored care.

Whereas one woman's story followed an alternative pattern that supported the rival proposition of a positive choice, the other nine women followed the primary proposition of a negative mechanism. This confirmed the theory of a traumatic experience and conflict resulting in a negative motivation to choose a holistic birth.

What this multiple case study adds to existing knowledge:

1. The defining moments in the decision to seek holistic (outside the system) care usually lie in conflict during consultations. These conflicts are often triggered by a birth plan based on a previous traumatic experience. Behind motivations to birth at home with a high-risk pregnancy lie a negative experience with the regular maternity care system. This includes negative stories about the system on the Internet.
2. There is often a discrepancy in how health care professionals and women perceive their clinical encounters.

Traumatic Experiences and Conflict

In all cases, the women's negative experiences or trauma involved a perceived lack of autonomy, during either a previous birth or their current pregnancy. This finding is similar to Byrne, Egan, Mac Neela, and Sarma (2017), who described health care professionals ignoring and discounting a woman's identity and individuality, and a "loss of self" throughout the process of childbirth that led to the perception of birth as traumatic. Similarly, Henriksen, Grimsrud, Schei, and Lukasse (2017) found that "not being seen or heard" and an "experience of pain and loss of control" led to the perception of birth as traumatic. In a recent Dutch study of 2,192 women, Hollander, van Hastenberg, et al. (2017) found that women attribute their traumatic childbirth experience primarily to a lack and/or loss of control, issues of communication, and the lack of practical and/or emotional support. These women believed that in many cases, their trauma could have been reduced or prevented by better communication and support by their caregiver.

Based on the results of this multiple case study, it seems likely that previous trauma may make it very difficult for women and professionals to have a consultation without conflict because women no longer experience trust in the health care professional. They are so afraid to lose their autonomy again that they (and therefore their birth plans) become inflexible. Health care professionals, however, find it difficult that these women question their biomedical risk definitions by wanting to deviate from guidelines. They believe that women are putting the safety of their child at risk to have a better birth experience. Such a consultation seems doomed to be difficult. DeBaets (2017) has also reported that birth plans can often lead to frustration and antagonism between patient and providers.

In the matter of conflict over a proposed birth plan, Chervenak and McCullough (2017) state that an "unlimited-rights model of obstetric ethics is an unacceptable over-reaction to physician paternalism and therefore a threat to professionalism in obstetrics" (p. 1144). They posit that SDM (and an emphasis on client autonomy) is not possible or even desirable in many clinical circumstances. Chervenak and McCullough advocate that what they call the unlimited-rights model should be replaced with a "professional responsibility model," wherein there is room for evidence-based, directive SDM (p. 1146). Some health care professionals suggest that attending a woman who chooses to accept more risk than they deem necessary is enabling her choice. They believe that by refusing to assist women who insist on birthing outside the system, they will force the women to change their minds. However, Kotaska (2017) posits that in actuality, many (if not most) women may choose

to forego professional assistance instead. Thus, both the women and their babies end up in a higher risk situation than they initially set out to be. This was also a finding in this multiple case study.

Negotiating the Birth Plan and the Role of the Professional

Although community midwives and obstetricians are often of the opinion that they counsel women adequately, the women in this study felt otherwise. The women interviewed in this study experienced a lack of autonomy and subsequently believed they had no true SDM. This finding is similar to Jenkinson, Kruske, & Kildea (2017), who demonstrated that clinicians claimed to respect women's autonomy, but still invoked a "line in the sand" which they were unwilling to cross. The professionals believed that this gave reasonable women enough room for their own input for the birth plan. Although caregivers in Jenkinson et al.'s study tended to deny or minimize the frequency of coercion, they simultaneously described coercive practices, which can also be seen in the current multiple case study.

Shared Decision-Making

Many health care professionals feel they use SDM in most, if not all, of their consultations. This is also true for the health care professionals in this study. Yet, researchers have identified a perception–reality gap. Despite obvious benefits, SDM is still not routine in clinical practice. Stiggelbout et al. (2012) posit that the use of guidelines may make the implementation of SDM difficult, especially, if patient preferences are at odds with guideline recommendations and/or with health care professional preferences. When professionals are using guidelines, client preferences are generally not elicited or are overruled and options are not given. It appears clinicians find it very difficult to discuss options they do not personally support, or if they have a very clear (guideline-inspired) preferences. Several community midwives and obstetricians in Stiggelbout et al.'s study went immediately to risk talk and explaining the harm and benefit of the situation, thereby giving women no option but to follow protocol.

According to Elwyn et al. (2012), there are three important steps in SDM: choice talk, option talk, and decision talk. The health care professional should support deliberation throughout the process. Choice talk refers to the step of making sure that patients know that reasonable options are available. Option talk refers to providing more detailed information about options, and decision talk refers to supporting the work of considering preferences and deciding what is best (Elwyn et al., 2012, p. 1363).

Health care professionals could improve their SDM skills using choice talk, option talk, and decision talk as

an alternative to risk talk. However, the results of this multiple case study show that better SDM skills by themselves are not enough. Women with high-risk pregnancies who choose home birth are often using a discourse very different from the clinicians' biomedical risk definitions, which makes the clinicians uncomfortable. It appears that pure SDM, as described by Elwyn et al., only works optimally when all available options are acceptable to the professional, at least to some extent.

Discussing Risk

Although in general, risk is assumed to be negative and risk avoidance is regarded as normal, Tulloch and Lupton (2003) have shown that lay people can see risk knowledge as "situated rationalities," and these compete with expert risk knowledge (p. 9). For example, women with high-risk pregnancies who opted for home birth in this study rejected the biomedical definition of their birthing bodies as inherently risky and instead perceived the process of giving birth in medicalized settings as risky. Thereby, the women provided an alternative construct of the birthing body as a site of knowledge and an active capacity. This articulation of birthing bodies as "knowing bodies" threatens biomedical conceptualization of the birthing body solely as a source of risk and potential dysfunction.

Similar to findings in Chadwick and Foster's (2014) study on women who gave birth at home in South Africa, the women in this multiple case study were classified by biomedical discourse as bodies at risk for complications. The women, however, perceived themselves as vulnerable bodies at risk of being objectified, losing autonomy, and experiencing trauma. For the women in this study, their choice for a home birth in a high-risk pregnancy functioned as a strategy for reducing potential vulnerabilities and risk in their birth process. This may help to explain the importance of "situated rationalities" or lay risk knowledge (such as intuition) over expert knowledge in everyday lived experiences and why this alternative discourse is uncomfortable for health care professionals. Given the above, it is no wonder that discussions about risk during a consultation between clients and professionals can be fraught with misunderstanding. Edwards, Elwyn, and Mulley (2002) speak of suboptimal risk communication and advocate that communicating risks should be a two-way process, in which both professionals and patients exchange information and discuss how they feel about those risks. This requires professionals to understand the various risk concepts that patients may have. Edwards et al. (2002) state that care providers need to assist patients in making choices by providing statistical data as absolute rather than relative risks to avoid manipulative "framing" of data with the goal of coaxing the patient toward the "desired" choice.

The Professional as Coach/Partner

Unfortunately, SDM skills and an understanding of lay risk knowledge are not enough. According to Barry and Edgman-Levitan (2012), to engage patients in decision making, health care professionals need to let go of their role as the single authority and train to become more effective coaches or partners. They must learn how to ask, “What matters to you?” as well as “What is the matter?” Porter, Crozier, Sinclair, and Kernohan (2007) posit that some health care professionals may be uncomfortable with the new rebalancing of power relationships between professionals and their lay clients. Schoot et al. (2005) in their study on interactions between patients and their caregivers aimed at tailoring care to the client demand found that recognition of client values underlying their demand (such as uniqueness and autonomy) and recognition of values underlying the care relationship (such as equality and partnership) were the basis for tailored care. Klaver, van Elst, and Baart (2014) state that the process of care starts with the recognition of a need, which cannot be done without attentiveness to the client’s perspective. It then follows that good care is about recognition—women want to be seen. This means that attentiveness and care are indelibly connected as good care cannot exist without attentiveness. As demonstrated in this multiple case study, many obstetricians and community midwives take a somewhat opposing view of their professional role.

A Trusting Relationship

Jenkinson et al. (2017) state that relationships are key in all consultations between professionals and clients. In their study on pregnant women, clinicians emphasized the importance of building trusting relationships with women but, at the same time, acknowledged that this was challenging in a busy public hospital. This finding was confirmed by O’Brien, Butler, and Casey (2017), who stated that women’s understandings revealed that informed choice was not only defined by but also dependent on the quality of women’s relationships with their caregivers and the caregivers’ ability to engage in SDM with their clients. In that study, informed choice was experienced as a relational construct. The authors found that the support provided by maternity care professionals to women in contemporary maternity care must reflect this. Dahlberg and Aune (2013) and Todd, Ampt, and Roberts (2017), in their respective studies, also defined relational continuity as a key concept in the context of a positive birth experience. The current multiple case study also demonstrates that whereas a good relationship (for instance, with a holistic midwife) can prevent trauma, distrust of the professional due to a previous traumatic experience can make the relationship difficult. As Reed,

Sharman, and Inglis (2017) posit, it is necessary to address interpersonal aspects of birth trauma. Women who experience a lack of continuity in their care find it difficult to establish a trusting relationship with their caregivers, which makes negotiating a birth plan increasingly troublesome.

Implications for Practice

Prevention of conflict and negative choices starts with the original traumatic experience. To prevent a negative birth experience, based on perceived loss of autonomy and lack of support, professionals should invest in the continuity of care and a respectful relationship with their clients based on equality, partnership, and true SDM. This requires introspection and awareness on the part of the professional regarding their own concepts and perception of risk. Once there is trauma and distrust, any consultation or negotiation between client and professional will almost automatically be difficult and lead to conflict. This may well result in the hospital no longer being perceived as a birthing option and lead women to turn to holistic midwives and a home birth in a high-risk pregnancy. If we as professionals want fewer women to make this negative choice, then hospitals must be perceived as safe again. This can only be accomplished by establishing a reputation of respect, trustworthiness, and equality between women and professionals. In cases of continuing disagreement about a birth plan, second-best care must be explored to prevent choices for even higher risk options.

Further study is needed to understand why some women with high-risk pregnancies, who may have suffered an equivalent trauma in the past, have chosen to stay in the hospital system. It is important to determine which health care professional approaches have led to trust being regained. This knowledge could provide health care professionals with the tools they need to prevent the trajectory of events described in this study.

Strengths and Limitations

A strength of the theory-first approach using propositions is that it generated a strong research design and clear focus for data analysis. However, a limitation of this approach is that some unanticipated findings across the cases may have gone unnoticed. The instrumentality of the cases in testing the theoretical propositions does not allow for a study of the intrinsic interest of the individual cases (Rule & John, 2015).

Another strength of this study lies in the fact that 41 interviews with women, partners, and caregivers provided a wealth of thick description and highlighted multiple viewpoints relating to 10 cases of women with a high-risk pregnancy who elected to have a home birth. This allowed for triangulation between the experiences of

all parties present at the same event and demonstrated how several people had very distinct recollections of the same conversation. The fact that there were 10 separate cases to analyze made it possible to reliably establish a pattern in the trajectory of the vast majority of these cases. This enabled us to make several pertinent recommendations for health care professionals and help guide their future negotiations with women in this situation. Hopefully, this will prevent more women from resorting to negative choices that entail more medical risk than they initially set out to take.

A limitation of this study is recall bias. Some obstetricians could not initially remember the specific case they were questioned about. In those instances, they made use of their notes in the electronic patient file, which usually triggered their memory and helped them recall the case in more vivid detail.

As a member check, a focus group discussion was held with six holistic midwives in which the results of this multiple case study were shared. The participants recognized and agreed with the patterns described above, which heightened the validity of this study. However, the midwives remarked that the majority of our sample were extreme (high-risk) cases and that the more extreme the case, the more likely that the woman's choice was based on a negative experience with the current system of maternity care. The midwives found our emphasis on trauma was a bit heavy handed. They believed it was possible that we could have found more women with a high-risk pregnancy making a positive choice for a home birth had we interviewed more women with relatively minor increases in risk. However, the fact that we had so many extreme cases in our sample can also be considered as a strength because in these cases, caregivers are most worried about the outcome for mother and child, and so, these cases are the most important to understand.

Conclusion

In this multiple case study, we examined the negotiations between health care professionals, women, and their partners in 10 cases of women with a high-risk pregnancy who had gone outside guidelines/protocol and had a home birth. The vast majority (nine) of these cases followed a similar trajectory, wherein a previous traumatic experience and a paternalistic decision making by the health care professional led the woman to weigh the evidence for themselves and decide on an alternative birth plan. Negotiating this birth plan with their health care provider led to conflict as both parties experienced a lack of flexibility from the other side. This in turn resulted in a defining moment when the women decided that the hospital was no longer an option.

One case followed another pattern, in which trauma did not play a role and there was no conflict. This woman

with a high-risk pregnancy decided on a home birth as a positive choice based on trust and confidence.

It appears that the original proposition is the most common one. Therefore, we recommend that health care professionals invest in preventing the original trauma, become more aware of their own concepts of risk perception, practice true SDM, and strive for continuity of care in an equal, respectful, and trusting relationship, and thereby limit the risk of women making negative choices.

Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The authors disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: Travel costs and costs for transcriptions were paid by the department heads.

References

- Abma, T., & Stake, R. (2014). Science of the particular: An advocacy of naturalistic case study in health research. *Qualitative Health Research, 24*, 1150–1161. doi:10.1177/1049732314543196
- Barry, C. (2002). Multiple realities in a study of medical consultations. *Qualitative Health Research, 12*, 1093–1111. doi:10.1177/104973202236577
- Barry, M., & Edgman-Levitan, S. (2012). Shared decision making—The pinnacle of patient-centered care. *New England Journal of Medicine, 366*, 780–781. doi:10.1056/NEJMp1109283
- Byrne, V., Egan, J., Mac Neela, P., & Sarma, K. (2017). What about me? The loss of self through the experience of traumatic childbirth. *Midwifery, 51*, 1–11. doi:10.1016/j.midw.2017.04.017
- Carolan, C., Forbat, L., & Smith, A. (2016). Developing the DESCARTE model: The design of case study research in health care. *Qualitative Health Research, 26*, 626–639. doi:10.1177/1049732315602488
- Chadwick, R., & Foster, D. (2014). Negotiating risky bodies: Childbirth and constructions of risk. *Health, Risk & Society, 16*, 68–83.
- Charmaz, K. (2007). *Constructing grounded theory: A practical guide through qualitative analysis* (2nd ed.). London: Sage.
- Chervenak, F., & McCullough, L. (2017). The unlimited-rights model of obstetric ethics threatens professionalism. *British Journal of Obstetrics and Gynecology, 124*, 1144–1147. doi:10.1111/1471-0528.14495
- Dahlberg, U., & Aune, I. (2013). The woman's birth experience—The effect of interpersonal relationships and continuity of care. *Midwifery, 29*, 407–415. doi:10.1016/j.midw.2012.09.006
- DeBaets, A. (2017). From birth plan to birth partnership: Enhancing communication in childbirth. *American Journal of Obstetrics and Gynecology, 216*(1), 31.e1–31.e4. doi:10.1016/j.ajog.2016.09.087

- Edwards, A., Elwyn, G., & Mulley, A. (2002). Explaining risks: Turning numerical data into meaningful pictures. *British Medical Journal*, *324*, 827–830.
- Elwyn, G., Frosch, D., Thomson, R., Joseph-Williams, N., Lloyd, A., Kinnersley, P., . . . Barry, M. (2012). Shared decision making: A model for clinical practice. *Journal of General Internal Medicine*, *27*, 1361–1367. doi:10.1007/s11606-012-2077-6
- Feeley, C., & Thomson, G. (2016). Tensions and conflicts in “choice”: Womens’ experiences of freebirthing in the UK. *Midwifery*, *41*, 16–21. doi:10.1016/j.midw.2016.07.014
- Green, J., & Thorogood, N. (2009). *Qualitative methods for health research*. London: Sage.
- Henriksen, L., Grimsrud, E., Schei, B., & Lukasse, M. (2017). Factors related to a negative birth experience—A mixed methods study. *Midwifery*, *51*, 33–39. doi:10.1016/j.midw.2017.05.004
- Hollander, M., de Miranda, E., van Dillen, J., de Graaf, I., Vandenbussche, F., & Holten, L. (2017). Women’s motivations for choosing a high risk birth setting against medical advice in the Netherlands: A qualitative analysis. *BMC Pregnancy and Childbirth*, *17*, Article 423. doi:10.1186/s12884-017-1621-0
- Hollander, M., van Dillen, J., Lagro-Janssen, T., van Leeuwen, E., Duijst, W., & Vandenbussche, F. (2016). Women refusing standard obstetric care: Maternal fetal conflict or doctor patient conflict? *Journal of Pregnancy and Child Health*, *3*, 251.
- Hollander, M., van Hastenberg, E., van Dillen, J., van Pampus, M., de Miranda, E., & Stramrood, C. (2017). Preventing traumatic childbirth experiences: 2192 women’s perceptions and views. *Archive of Women’s Mental Health*, *20*, 515–523.
- Holten, L., & de Miranda, E. (2016). Women’s motivations for having unassisted childbirth or high-risk home birth: An exploration of the literature on “birthing outside the system”. *Midwifery*, *38*, 55–62.
- Jenkinson, B., Kruske, S., & Kildea, S. (2017). The experiences of women, midwives and obstetricians when women decline recommended maternity care: A feminist thematic analysis. *Midwifery*, *52*, 1–10. doi:10.1016/j.midw.2017.05.006
- Jordan, B. (1997). Authoritative knowledge and its construction. In R. E. Davis-Floyd & C. F. Sargent (Eds.), *Childbirth and authoritative knowledge: Cross-cultural perspectives* (pp. 55–79). Berkeley: University of California Press.
- Kincheloe, J., McLaren, P., & Steinberg, S. (2011). Critical pedagogy and qualitative research: Moving to the Bricolage. In N. Denzin & Y. Lincoln (Eds.), *The Sage handbook of qualitative research* (pp. 163–173). London: Sage.
- Klaver, K., van Elst, E., & Baart, A. (2014). Demarcation of the ethics of care as a discipline: Discussion article. *Nursing Ethics*, *21*, 755–765. doi:10.1177/0969733013500162
- Kotaska, A. (2017). Informed consent and refusal in obstetrics: A practical ethical guide. *Birth*, *44*, 195–199. doi:10.1111/birt.12281
- Ledderer, L. (2011). Understanding change in medical practice: The role of shared meaning in preventive treatment. *Qualitative Health Research*, *21*, 27–40. doi:10.1177/1049732310377451
- Morse, J. (2015). Critical analysis of strategies for determining rigor in qualitative inquiry. *Qualitative Health Research*, *25*, 1212–1222. doi:10.1177/1049732315588501
- O’Brien, D., Butler, M., & Casey, M. (2017). A participatory action research study exploring women’s understandings of the concept of informed choice during pregnancy and childbirth in Ireland. *Midwifery*, *46*, 1–7. doi:10.1016/j.midw.2017.01.002
- Porter, S., Crozier, K., Sinclair, M., & Kernohan, W. (2007). New midwifery? A qualitative analysis of midwives’ decision-making strategies. *Journal of Advanced Nursing*, *60*, 525–534. doi:10.1111/j.1365-2648.2007.04449.x
- Reed, R., Sharman, R., & Inglis, C. (2017). Women’s descriptions of childbirth trauma relating to care provider actions and interactions. *BMC Pregnancy Childbirth*, *17*(1), Article 21. doi:10.1186/s12884-016-1197-0
- Rule, P., & John, V. (2015). A necessary dialogue: Theory in case study research. *International Journal of Qualitative Methods*, *14*(4), 1–11. doi:10.1177/1609406915611575
- Schoot, T., Proot, I., ter Meulen, R., & de Witte, L. (2005). Recognition of client values as a basis for tailored care: The view of Dutch expert patients and family caregivers. *Scandinavian Journal of Caring Science*, *19*, 169–176. doi:10.1111/j.1471-6712.2005.00327.x
- Stiggelbout, A., Van der Weijden, T., De Wit, M., Frosch, D., Legare, F., Montori, V., . . . Elwyn, G. (2012). Shared decision making: Really putting patients at the centre of healthcare. *British Medical Journal*, *344*, Article e256. doi:10.1136/bmj.e256
- Todd, A., Ampt, A., & Roberts, C. (2017). “Very Good” ratings in a survey of maternity care: Kindness and understanding matter to Australian women. *Birth*, *44*, 48–57. doi:10.1111/birt.12264
- Tulloch, J., & Lupton, D. (2003). *Risk and everyday life*. London: Sage.
- VERBI Software GmbH. (2017). *MAXQDA software for qualitative data analysis*. Berlin: VERBI software
- Yin, K. (2014). *Case study research: Design and methods*. London: Sage.

Author Biographies

Lianne Holten is a former community midwife with a PhD in anthropology, and one of the researchers of the WONDER study (Why women want Other or No DELivery caRe). She is currently affiliated with the Amsterdam Midwifery Academy and the Department of midwifery Science of the Free University of Amsterdam.

Martine Hollander is a former community midwife who is now working as an obstetrician with a subspecialty in maternal-fetal medicine. She is currently finishing her PhD on the subject of women who choose to give birth in settings that are against medical advice (the WONDER study).

Esteriek de Miranda is a former community- and clinical midwife now working as a researcher. She holds a PhD in midwifery, is the coordinator of the Midwifery Research Network Netherlands (MRNN), and is project leader of the WONDER study.