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"Trying to give birth naturally was out of the question": Accounting for intervention in childbirth

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ABSTRACT

Problem: Studies of women's childbirth preferences repeatedly show that natural birth remains highly valued, yet the majority of births involve some form of medical intervention. Reasons for this lack of correspondence have typically been investigated through interviews and focus-groups with women. Relatively little research explores the ways in which women describe their experiences of childbirth outside of such research settings.
Background: Most maternity services promote woman-centred care, whereby women are encouraged to take active roles in deciding how to give birth. However, recent research indicates that women often report feeling disempowered during labour and birth in hospital settings.
Aim: We sought to examine how women account for use of medical intervention in hospitals by examining narratives posted on online discussion forums.
Method: A thematic analysis of 106 publically available birth stories, sourced using the Internet search terms 'birth story', and 'birth narrative', was undertaken.
Findings: Medical interventions in childbirth were routinely described as unwanted, yet as unavoidable, and two types of account were typically drawn on to explain their use: Protection of the baby/mother; and inflexible hospital policy/practice. We examine these two types of account, focusing on how their design oriented to the discordance between mothers' reported desires for a natural birth, and their experiences in hospital.
Conclusion: The experience of medical intervention in childbirth is routinely oriented to as a matter that requires explanation or account in online birth narratives. Women repeatedly referred to their preference to avoid intervention, but described being unable to do so in hospital.

Statement of significance

Problem of issue

Women are reported to prefer to avoid medical interventions in childbirth. However, such interventions are commonplace in hospital births. Little is known about how women explain or account for such medical intervention outside of interview or focus-group-based research settings.

What is already known

Despite recent changes toward woman-centered care in maternity services, research indicates that many women still report feelings of disempowerment during labour and birth.

What this paper adds

Analysis of naturally occurring data in the form of online birth narratives provides evidence that women routinely orient to medical intervention as an issue that requires explanation. A detailed examination of routine ways in which women account for the use of medical intervention is presented.

1. Introduction

A growing body of research is concerned with rising rates of medical intervention during labour and birth, in part due to the increased risk of morbidity associated with surgical birth compared to normal birth.[1] In the developed world, most births take place in hospitals, where pharmacological intervention and/or

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surgical procedures are commonplace.[2] A recent Australian study of around 700,000 low-risk first-time mothers, for example, found that only 15% of those giving birth in private hospitals, and 35% of those in public hospitals, did not experience some form of medical intervention (i.e., Induction, epidural, episiotomy, forceps, vacuum extractor/ventouse, caesarean section).[2] Concern about the negative consequences of increasing medical intervention has been noted in a range of disciplines associated with maternity care, including obstetrics, medicine, midwifery, sociology, and physiology.[2–6] Increasing reliance on medical intervention in childbirth is argued to stem from broad causes ranging from patriarchal social structures that function to control women and their bodies,[5,7–9] to a general shift toward a consumerist approach in medicine that results in increasing numbers of women actively requesting surgical birth.[4]

Despite high rates of medical intervention, 'natural childbirth' remains highly valued in Western culture.[7] Previous research on women's childbirth experiences has focussed attention on the inconsistency between women's reported preference to avoid medical intervention, and their lived experience of giving birth in hospital.[1,4,5,7,10] Cultural ideals of 'good mothering' have been argued to contribute to the valorisation of 'natural' birth, with researchers investigating the impact of a range of normative and moral orders around labour and birth.[10–12] It has also been argued that a sense of control for women is central to positive birth experiences, and also to a transition into satisfied mothering.[12–15]

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

1.1. Valorisation of natural birth

The ideology of 'natural birth' is underpinned by an understanding of women's bodies as physiologically designed to birth babies.[1,10,16] In recent times, the valorisation of natural birth has culminated in a 'natural birth movement' driven by women and health advocates, who argue that physiological birth is superior to other forms (e.g., the technocratic, medical model). Research has reported women's feelings of disappointment around not being able to achieve a natural birth.[10–12] Spinelli et al.,[12] for example, conducted interviews in the neonatal unit of an Italian hospital with thirty mothers of pre-term babies. These women described their experience of highly medicalised and controlled births as having a negative impact on their transition to motherhood. Similarly, an Australian interview study involving 25 women who had recently given birth to their first child reported that those who birthed vaginally (n = 16) described fewer difficulties transitioning to motherhood than did those who gave birth by caesarean section (n = 9).[11] Increasing reliance on medical technology during childbirth has also been reported as having other adverse impacts. In interviews with 40 mothers in Ireland and America, Smyth reported on how birth was characterised as an instinctual ability that was threatened by over-medicalisation.[10] It has been argued that the natural birth movement has set women up to fail by promoting an ideology of 'vaginal birth at all costs'.[16] However in general, research on women's experiences suggests that feelings of disempowerment and lack of control that occur during highly technological and medically controlled births can have detrimental ongoing effects.

1.2. Woman-centred maternity care

In Australia, the N*ational Guidance on Collaborative Maternity Care* defines woman-centred care as focusing on "the woman's individual, unique needs, expectations and aspirations, rather than the needs of institutions or maternity service professionals ... recognis[ing] the woman's right to self-determination in terms of choice, control and continuity of care"p.14.[17] The guidance was developed following a *National Review of Maternity Services*[18] that highlighted a range of improvements requested by women including: models of care that reflected their birthing choices; greater access to information about pregnancy and birth; respect for women's perceptions of risk; and greater recognition of birth as a natural process rather than as a medical procedure. Despite the creation of policies formulated to reflect women's preferences, a number of recent studies have reported women's continuing experience of disempowerment when birthing in the hospital system.[7,19–21] These studies, using interview and focus-group methods, have highlighted issues around power and decision-making in the birthing process as key. They describe women's difficulties in attempting to resist medical advice,[20,22] their inability to follow Birth Plans that they have made,[7,19] and to control the hospital-birth experience.[21]

Although interview and focus-group studies have provided important insights into women's experiences and their sense-making around childbirth, it has been argued that there are limitations associated with such methods.[23] It has been shown, for example, that interviewees' responses are impacted by the framing of interviewers' questions.[24–26] Another consideration involves the way that analysts typically treat participants' talk as a matter of factual reflection, rather than as a form of accounting that is designed to achieve particular functions in a local, research-oriented interaction (e.g., positive self-presentation; justification; assisting the research/researcher).[23,27] Goffman,[27] for example, discussed the ways in which descriptions involve impression management. Most often, people construct accounts in order to maintain a favourable identity, attending strategically to potentially problematic issues, actions and events for which they may be held responsible. In other words, they have stake or interest in the descriptions they provide.[23,26,28,29] Researchers have identified a range of interactional and linguistic practices that function to manage impression/stake or interest in descriptions, such as defensive detailing,[30] extreme-case formulation,[31] and prioritising membership to particular categories.[32] Goffman's work on presentation of the self has been applied to online forms of communication.[33,34] The present analysis considers the dataset from this general perspective. We take our lead from Potter and Hepburn[23] who pointed out that the study of naturally occurring (i.e., unsolicited) material can avoid many of the problems associated with the use of interview and focus-group data. In the present study, unsolicited narratives – in the form of online

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reports of hospital childbirth experiences – are used as a source of data with the aim of overcoming the limitations of interview and focus group methods. This is particularly important in respect of talk about childbirth, where normative moral orders – matters of responsibility, blame, and social evaluation – have been shown to be fundamental to sense-making and identity work.[10,35]

1.3. Childbirth research using online data

Online accounts of childbirth represent a relatively new form of information about women's experiences of pregnancy and labour. Online blogs in which mothers discussed choosing Vaginal Birth After Caesarean (VBAC), or repeat caesarean, were examined by Dahlen and Homer[36] who identified a dichotomy in the philosophical framework or perspective drawn on by women in their posts. A 'childbirth' form of accounting referenced sacrifice on the part of the mother for the good of the baby, in order to minimise risk (prioritising the baby). 'Motherbirth' accounts involved orientation to the idea that giving birth is important to women, and that happy, healthy mothers are necessary for happy healthy babies (both mother and baby prioritised). Online birth narratives written by women who had chosen to birth unassisted, at home, were analysed by Miller.[37] In these birth stories, women presented themselves as independent and self-determining, describing how they controlled what they did and when, as well as the environment in which they gave birth, and how they interacted with others. In particular, these birth stories routinely concluded with statements about the joy and sense of empowerment associated with unassisted birthing. Online support and information forums about breech presentations were the focus of analysis in another study[39] where a "clear difference in tone" was identified in posts by women who felt supported in their choice for vaginal breech birth (VBB) by their care provider, compared to those who did not. Women who had access to services that supported VBB were described as posting using "excited, joyous language", whereas those who lacked such support described feeling a lack of control, and disappointment about the lost opportunity to give birth vaginally.

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

2. Method

2.1. Data collection

Publicly available birth narratives were sourced using the search terms "birth story" and "birth narrative" on Google. Four pregnancy and baby websites were identified that provided a broad range of childbirth experiences. We collected data from each of the identified sites in order to gain a cross-section of narratives. Australian-based sites were chosen to reflect experiences in a medical system that promotes a woman-centred care philosophy in maternity services. As the analytic focus of this study was on birth involving medical intervention, stories describing home or unassisted birth were excluded, as were websites dedicated to specific birth experiences (for example, www.freebirth.com.au). Stories involving planned caesarean-section births were also excluded, as were narratives where the author was not the mother. A total of 106 narratives (ranging in length from 200 to over 5000 words) were collected, describing a variety of medical interventions (pharmacological induction, pain relief, episiotomy, forceps, fetal heart-rate monitoring, fetal scalp monitoring, ventouse, and caesarean section).

2.2. Data analysis

Narratives were coded following Braun and Clarke's[38] guide to Thematic Analysis. Initial repeated reading was undertaken and codes were generated to identify aspects of the narratives that involved description of medical intervention during labour and birth. These codes were grouped together following discussion by the researchers, according to their perceived similarity, in order to produce a set of themes. These themes were subsequently refined and labelled in a process that involved repeated re-reading of the narratives and discussion by the researchers, with the aim of capturing the nature of the accounting practices involved.

2.3. Ethical considerations

There is ongoing discussion in the research literature regarding the use of data sourced online.[39,40] A particular ethical issue concerns consent and anonymity. Consent from participants is deemed to be relevant if they would not expect their online activity to be observed by others. Where there is any ambiguity, the consensus is that researchers should weigh up potentially damaging effects for participants with scientific value.[41] There is also agreement that particular care should be taken to ensure that any data from such sources that is used for research purposes remains confidential, and in the present study this is achieved through anonymisation. Pseudonyms are used throughout the paper in place of names, places and other information that might identify posters.

3. Analysis

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

3.1. Theme 1: medical intervention as necessary to avoid stress/distress

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

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account describing a highly medicalised birth (involving monitoring; gas and epidural for pain relief; a catheter; and a hormone drip) that resulted, ultimately, in a caesarean section. Here a doctor is described as 'concerned' about the size of the baby in relation to the size of the woman's pelvis (line 6). The extract comes just over half way through a 2500-word narrative. The extract begins after the woman has described the posterior presentation of the baby as threatening her preferred method of vaginal birth. As in all extracts, pseudonyms are used.

Extract (1), F1-2

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

Here, the doctor's 'concern' about physiology (line 5) is used to frame the introduction of the 'possibility' of a caesarean birth. The mother's preference for avoiding this form of medical intervention is made explicit a few lines later in her description of the outcome of the doctor's subsequent examination of her: 'I was so overcome with joy as I really did not want to have a c section' (lines 8–9). An orientation to the normative or moral order around natural childbirth can be seen in the design of this description that uses the extreme-case formulations, 'so overcome', 'really did not want', to present her preference. Extreme-case formulations are practices that invoke the maximal or minimal properties of events or objects (e.g., 'always', 'never', 'completely'). They have been shown to be used interactionally to defend against, or counter, potential challenges to justifications, and to portray the circumstances that precipitate actions as external to, or independent of, the speaker.[31,42] Here, the description works to defend against potential undermining of the claim that the author wanted to avoid a caesarean-section birth. The narrative then moves to a description of the doctor's final check-up prior to birth where the previously introduced 'concern' about physiology is presented as fact ("The baby was stuck. My pelvis was too small for the size of its head and it could not get any further down", lines 12–14). As a result, giving birth naturally is described using another extreme-case formulation as "out of the question" (line 15), that is, as unavoidable, rather than as an active choice on the part of the mother. It is at this point that a reference to "stress" occurs. Trying to give birth "naturally" is described in terms of the non-specific negative outcome of causing "too much stress" (line 15) – in this case, for both the baby and the woman. An idiomatic expression "it was just not worth it" (line 16) rounds off the description of this aspect of the birth story. The vagueness of such idiomatic expressions has been argued to make them difficult to challenge or contradict.[43] This feature contributes to their routine use at points in interaction where there is potential for questioning a participant's stake or interest in the descriptions they are producing.[43] In this example, then, reporting of a health professional's 'concern', together with use of the descriptive category 'stress', provide warrants for an account of a medical intervention that was unwanted, but unavoidable.

Extract (2) provides another example of a 'concern' construction, again framed in terms of a baby's size. Here, the category descriptor, "distress" is used to account for an unwanted caesarean-section birth. The extract comes near the end of a 2000-word narrative about a pharmacologically induced birth.

Extract (2) F4-12

"He (doctor) was concerned about the baby gaining more weight and then having complications due to its size, and then not engaging well enough and placing both myself and the baby in distress.

(12 lines on decision-making process omitted)

I agreed to have the c-section. And then promptly burst into tears, partly for not being able to deliver my own baby vaginally and partly because I was tired, and I think partly because I was going to meet my baby so soon."

Here, the woman's preference for avoiding medical intervention (a caesarean) is evidenced by her reported emotional reaction "burst into tears, partly for not being able to deliver my own baby vaginally" (lines 6–7). Similar to the construction illustrated in Extract (1), a description is presented in which the mother's preference for a natural birth is contrasted against the unavoidability of medical intervention. The non-specific term 'distress' (line 4) is used here, again in relation to both the woman and the baby, to provide further warrant for the need for medical intervention.

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

Extract (3), F1-15

"I wanted to avoid an epidural or pethidine as much as possible, and felt able to continue as I was, although I was worried about how long it was going to take . . . (53 words deleted). When the midwife came in a while later, I just mentioned my pad and asked her to have a look. Immediately there was concern as it was meconium (the substance in baby's first bowel movements, which can indicate that a baby is in distress). After much difficulty getting in and out of the shower because of the intensity of the contractions, the monitors were put on so the baby's heart could be listened to. Much to our concern, each time I had a contraction his heart rate was going down considerably. The doctors were alerted and after another internal examination (revealing that I was only six centimetres) they decided that an emergency caesarean was the only option."

Here, the midwife's concern about the presence of meconium (line 6) builds to a description of shared concern on the part of the mother (line 10). The descriptive category 'distress' (line 7) is used here in relation to the baby, and the birth outcome of an emergency caesarean is presented as a decision made by "the doctors" (lines 11–12) using the extreme-case formulation, "the only option" (line 14).

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

3.2. Theme 2: medical intervention as hospital policy/practice

In this broad pattern of accounting, women routinely positioned themselves as having little agency in the birth process as a

result of hospital policy and/or practice. Typically, they referred to their belief in their physiological ability to birth without intervention, but described being impeded or overridden by hospital policy/practice. In some cases, general institutional policy was mentioned, in others, practices of individual doctors were described as limiting birth options. As in accounts that referenced the 'concern' of medical professionals, references to physiology were also often made in accounts that described hospital policy/practice as the reason women did not birth in the way they claimed to prefer. However, unlike descriptions of intervention as unavoidable that were framed in terms of medical 'concern' and invoked 'stress' as a warrant, descriptions of intervention that invoked compliance with hospital policy/practice typically constructed medical intervention as *unnecessary*. Typically, in this second pattern of accounting, as well as claiming not to want the intervention, women claimed not to need it. Extract (4) below provides an example of this pattern. Here, a woman claims that she could have birthed her baby without a caesarean section, but was unable to do so because the hospital did not support breech vaginal birth. The extract comes from a 2600-word narrative about the birth of the woman's third child.

Extract (4), F2-40

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

Here the doctors' insistence on a caesarean (line 3), and their lack of confidence around breech presentations (line 4), are cited as reasons for the caesarean-section birth that the woman "never wanted" (line 2). The description concludes with a statement of her belief that she could have birthed the baby vaginally: "I still regret . . . as I knew I would have done it" (lines 8–9).

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

Extract (5), F3-44

"I spent 30 minutes in the shower and thought if the midwives and doctor left me alone I could most certainly birth my baby in the shower but another midwife came in to stop my shower as I was connected to a machine and said I wasn't allowed in the shower because of it, I cried."

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

Not all narratives describing 'unnecessary' medical intervention involved caesarean-section births. Extract (6) describes a birth involving an artificial hormone drip to strengthen contractions, an epidural for pain relief, and the use of a ventouse to assist with the birth. The woman describes the medical interventions as physiologically unnecessary, but as unavoidable, due to hospital policies/practices. Similar to Extracts (4) and (5), she describes not feeling, physically, in need of medical intervention in her labour (*"I didn't feel exhausted. I felt I had a lot more to give"*, lines 5–6). In Extract (6), however, the labour's progress is described as having violated hospital policy (line 4), resulting in intervention. The extract comes around half way through a 2250-word narrative.

Extract (6), F3-73

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

Here, the woman positions herself as having little agency in the birthing process, as was typical in narratives citing hospital policy/practices to account for medical intervention. Similar to the pattern observed in Theme one, a 'worry' construction on the part of the midwife is drawn on (line 3). However, here, the woman undermines this construction, reporting her own feelings that she and the baby were 'fine', and specifically stating that she did not 'feel exhausted' (line 6), adding that she had "a lot more to give" (line 6). She attributes the requirement for intervention to hospital policy (lines 4–5). As was the case in Extract (4), an orientation to medical authority can be seen here. The agency and control of the midwife and consultant is referenced by repeated use of the pronoun 'they' in her description of the third stage of labour: '*they thought it would be a good idea to set up a Syntocinon drip*' (line 11), '*they'd try a Ventouse extraction*' (lines 12–13), and '*They thought I should have an epidural so I'd be ready, whatever they needed to do*' (line 13–14). The medical intervention is positioned as part of an institutional imperative to adhere to hospital policy (line 4) thus avoiding the attribution of blame to specific individuals or professions.

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

Extract (7), F1-52

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

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

This narrative describes the woman's justification for agreeing to have her membranes ruptured, despite her claim to have "no

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intention of agreeing to induction" (lines 5–6) which was described as routine hospital practice for a twin birth (lines 2–4). The woman constructs her decision as reasonable (lines 12–5) given the rostering of her preferred ("good") consultant (line 12). Had she chosen not to be induced, the implication is that she would have been assigned "some random doctor" (line 15) with whom there would have been little possibility of managing the birth in line with her wishes. In agreeing to have her labour artificially induced (a decision that was constructed as giving her a higher chance of vaginal birth), the woman accounts for intervention (rupturing of the membranes) by referencing the constraints of institutional practice.

3.3. Summary

This analysis of descriptive patterns, and broad themes, in online birth narratives illustrates ways in which accountability was managed: women reported that they wanted to avoid medical intervention but described how such intervention was nonetheless involved in their births. Unwanted medical interventions were described as being unavoidable in accounts that were warranted with descriptions of professional 'concern' for the baby and/or the woman if intervention did not occur (Theme 1). Unwanted medical interventions were described as unnecessary in accounts that referenced hospital policy/practice (Theme 2) as the reason for their use. Descriptions drawing on the non-specific category, 'stress/distress', that would result for both mother and baby if intervention did not occur was a common pattern throughout the narratives.

4. Discussion

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

Findings reported here are in line with evidence from previous research indicating that that natural birth continues to be valourised in contemporary society.[1,7,44] The overarching theme identified in our analysis of online birth narratives involved the positioning of medical intervention as unwanted. As such, narratives routinely displayed attention to issues of accountability for the medical intervention that women had experienced during birth. In our dataset, a construction of medical professionals' 'concern' around some physiological aspect of the birth was repeatedly used to warrant the use of medical interventions that women described as having wanted to avoid. Malacrida and Boulton[7] demonstrated a similar pattern in their analysis of women's talk about their use of Birth Plans. The Canadian women they interviewed did not blame medical staff for the use of medical interventions that altered their plan/preference for maximizing the potential for natural birth, but instead described their own body's failings, internalising or individualising responsibility for the unwanted interventions. Malacrida and Boulton referenced Lupton's[45] discussion of the 'proliferation of risk discourse' in Western countries that has resulted in the framing of pregnancy as a 'perilous journey' (p. 66) in which women are held accountable for avoiding risks and protecting the wellbeing of the baby. In the present study, a recurring pattern involved women describing unwanted medical intervention as warranted in order to protect the baby/themselves from 'stress'/'distress', a general, non-specific, negative descriptive category. Fisher, Hauck and Fenwick have described how biomedical hegemony can be maintained in maternity services through the promotion of fear of childbirth amongst women, and undermining of their confidence to give birth without medical monitoring.[46] The findings presented in this article support the assertion that a lack of opportunity to resist medical interventions in hospital births exists.

A second pattern of accounting for unwanted intervention in birth – that positioned intervention as unnecessary – was also identified in the online narratives we examined. In this pattern, women drew on descriptions of hospital practice and/or policy to account for the use of intervention. A large body of feminist research has criticised the medicalised management of birth as a form of control over women's bodies[46–48] that benefits standardised medical systems and their scheduling.[8] These claims are reflected in the pattern of accounting seen here, in which women described undergoing treatment and practices they felt they did not require. Our analysis thus supports claims that the power of biomedical discourse continues to contribute to women's experience of decision-making during childbirth,[22] even in the context of woman-centered care. The descriptions of birth examined here were consistent with previous work that shows women position themselves as responsible patients, comply with medical advice, and submit to medical scrutiny and intervention in order to avoid risks to their own, and their baby's health. The evidence from our analysis of online narratives describing unplanned medical intervention reinforces reports in respect of a number of atypical forms of birth. Dahlen and Homer's[36] examination of women's decisions to pursue vaginal birth after previous caesarean section (VBAC), for example, highlighted the difficulties women encountered when resisting medical advice (in this case to undergo repeat caesareans). Similarly, women in Petrovska et al.'s study[49] reported pressure from medical professionals to opt for medical management when planning for a breech birth. Findings from the present study thus provide further insights into women's experiences of medical authority in hospital birth settings. Examination of the ways in which both women and medical professionals make sense of, and account for, childbirth experiences in other naturalistic settings – such as birthing and parent education classes, clinic visits, during labour and birth, and at post-natal checkups – may provide additional useful insights into the nature of what is often a difficult, complex and contested experience for women. In the context of increased focus on woman-centered care in maternity services, knowing more about how actual interactions around decision-making are routinely managed is likely to yield significant benefit for the continuing development of policy and practice.

Ethical statement

Not applicable.

Disclosure statement

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