

**Decision making about breech presentation: exploring
women's experiences and developing decision support**

Rebecca Emily Say

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Abstract

Breech presentation affects 3-4% of women pregnant with a single baby after 37 weeks of pregnancy. These women face two key decisions: firstly, whether or not to attempt to turn their baby by external cephalic version (ECV). Secondly, if they decide not to attempt this, or it is unsuccessful, then they need to decide how to give birth to their baby, either by planned caesarean section (CS) or vaginal breech birth (VBB). This thesis explores the process of decision making about breech presentation from both women's and health professionals' perspectives and documents the development of a patient decision aid (PDA), consisting of an animated film and website, for women facing these decisions in the future.

In this qualitative study, data were collected using observed consultations, semi-structured interviews, with both women and professionals, and user-centred design workshops. Thirty nine women and 30 health professionals were respondents. Data were analysed using constant comparison.

The results show that the diagnosis of breech presentation often comes late in pregnancy and begins with uncertainty, partly because many professionals are reluctant to provide information about options until the diagnosis is confirmed by ultrasound examination. Professionals are concerned about causing unnecessary anxiety to women who do not have a breech presentation confirmed, but such an approach fails to take account of women's clear preference for information as soon as the possibility of breech presentation is raised. Women report researching options online and amongst their social contacts, as they strongly value experiential accounts. However they may struggle to find trustworthy information from these sources as they are frequently told horror stories. Women may also be directly counselled by professionals who have a clear preference for attempting ECV. In response to these themes, a PDA was developed which is freely available to women and includes a website summarising the evidence about the different options.

In relation to decision making, women described five key values: wanting to keep their baby safe; wanting to experience a natural birth and to breastfeed; preferring to avoid surgery; needing to be able to care for other children; and wanting to have control. Postnatally, they shared vivid accounts of their experiences of ECV and

birth, which were used to inform the script for the animated film that aims to provide the experiential information women wanted and also help them to explore their own values about decision making.

Dedication

This thesis is dedicated to my partner Jack, my son Daniel and the baby we are expecting in May 2016.

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Glossary of Terms

This glossary explains the jargon used in this thesis. If definitions are taken from available health information glossaries the references are provided. Definitions with no references were developed from my own understanding.

Abdomen	The tummy area from the lower ribs to the pelvis (RCOG, 2015)
Absolute risk	A measure of the size of the risk of developing a particular condition or outcome (NHS Choices, 2009)
Amnioinfusion	Increasing the amount of fluid around the baby by infusing warm sterile fluid through a tube into the womb
Amniotic fluid	The watery liquid surrounding and protecting the growing baby in the womb (RCOG, 2015)
Amniotic fluid index	A measure of the amniotic fluid
Antenatal	Before birth (RCOG, 2015)
Apgar score	A measure of the physical condition of a newborn baby
Augmentation of labour	Artificial stimulation of contractions to help labour to progress
Base deficit	The amount of acid (or alkali if negative) required to return the pH of a sample of blood to neutral (7.40). In obstetrics this is used as part of an assessment of how much oxygen a baby has received during labour

Birth asphyxia	When a baby has experienced a reduced level of oxygen around the time of birth. Affected babies may not breathe normally and may have a low heart rate (RCOG, 2015)
Birth trauma	Damage to a baby caused during childbirth
Bradycardia	An abnormally slow heartbeat
Breech presentation	When the baby is lying bottom first in the womb (RCOG, 2015)
Caesarean section	An operation to deliver the baby by cutting through the wall of the lower tummy and the womb (RCOG, 2015)
Cephalic	When the baby is lying head-first in the womb (RCOG, 2015)
Cervix	The entrance or neck of the womb, at the top of the vagina (RCOG, 2015)
Cohort study	A type of observational research study which identifies a group of people and follows them over a period of time, collecting data about their exposures (for example having a VBB) and outcomes (for example having a healthy baby) (RCOG, 2015)
Composite outcome	An outcome in a clinical trial which combines multiple results of interest

Confidence interval	An expression of the precision of an estimate. Usually the 95% confidence interval is given which is the range within which the true result will lie 95% of the time (NHS Choices, 2009)
Congenital abnormalities	Structural or functional anomalies that occur during development in the womb
Cord entanglement	When the umbilical cord becomes wrapped around the baby which may cause a reduction in blood flow to the baby
Cord pH	A sample of blood from the umbilical cord taken to measure whether a baby's blood was acid, alkali or neutral at the end of labour. An acid result suggests the baby may have had insufficient oxygen during the birth
Decisional conflict	When a person is uncertain about which course of action to take
Engaged	If the presenting part of the baby (head or bottom) has entered the mother's pelvis ready for birth
Epistemology	The philosophy of the nature, methods and limits of human knowledge
Ethnography	The study of people and their behaviours in their natural setting
External cephalic version	Gentle pressure applied to the abdomen, if the baby is breech, by the obstetrician or midwife towards the end of

	pregnancy to help the baby turn in the womb so it lies head first (RCOG, 2015)
Feminism	A collection of social and political movements which seek to obtain equal rights for women
Fetal acoustic stimulation	Sound being used to stimulate the baby in the womb
Fetomaternal haemorrhage	The loss of fetal blood into the maternal circulation
Fetus	An unborn baby (RCOG, 2015)
Gerunds	A noun made from a verb by adding 'ing'
Gestation	The time between pregnancy and birth, when the baby grows and develops inside the mother's womb (RCOG, 2015)
Gillick competence	If a child under the age of 16 has capacity to consent to medical examination and treatment (House of Lords, 1985; Care Quality Commission, 2015)
Head entrapment	When a baby's head is caught in the uterus and cannot exit through a cervix which is not fully dilated
Hypoxic ischaemic encephalopathy	Brain injury caused by asphyxia
Induction of labour	When labour is started artificially (RCOG, 2015)

Intrapartum	During birth (RCOG, 2015)
Lithotomy position	A position in which a woman lies on her back with flexed hips and knees and her thighs apart. Her legs may be supported in stirrups
Meta-analysis	A mathematical technique to of combine and contrast results from different quantitative studies with the aim of finding underlying patterns common to all (RCOG, 2015)
Meta-synthesis	A way of combining and contrasting results from different qualitative studies with the aim of finding underlying patterns common to all
Morbidity rate	How often a disease occurs in the population of interest in a particular timescale
Mortality rate	How often death occurs in the population of interest on a particular timescale
Moxibustion	A Chinese herb which is burned at an acupuncture point at the tip of the fifth toe (Bladder 67) and is believed to encourage a breech baby to turn around in the womb
Multiparous	Having given birth to more than one baby
Neonatal deaths	Deaths in the first 28 days of life
Neurodevelopmental delay	Disabilities in the functioning of the brain which affect a child's ability to learn

Neurological	Relating to the nervous system (brain, spinal cord and nerves)
Nulliparous	Having never given birth before
Objectivity	The concept that things may be true and not influenced by an individual's biases, interpretations and feelings
Observational studies	Studies in which researchers collect data about a particular population without attempting to change their exposures or behaviour in any way
Ontology	The philosophy of the nature of being and reality
Opioid drugs	Strong pain relieving drugs which act in a similar way to morphine
Parity	The number of times a woman has given birth to a baby of more than 24 weeks gestation
Patriarchy	A society in which men hold the power
Perinatal deaths	Deaths during labour or in the first seven days of life
Perineum	The area of skin between the vagina and the anus (RCOG, 2015)
Placental abruption	When the placenta separates from the wall of the womb before the baby is born, potentially life-threatening for mother and baby

Polyhydraminos	Too much amniotic fluid surrounding the baby in the womb (RCOG, 2015)
Posterior placenta	A placenta which is attached to the back wall of the womb
Postmodern	Based on the late-20 th century philosophical movement
Postpartum haemorrhage	Heavy blood loss after the delivery of the baby (RCOG, 2015)
Postnatal	After birth (RCOG, 2015)
Presenting part	The leading part of the baby in the womb (head or bottom)
Primiparous	Having given birth once
Qualitative research	Research which collects and analyses numerical data
Quantitative research	Research which collects and analyses data which are not numerical
Randomised controlled trial	A study which tests the effectiveness and safety of treatments or procedures as fairly and objectively as possible. By randomly assigning patients to different treatments for the same problem, the results can be assessed equally with the aim of discovering the best possible procedure for the condition (RCOG, 2015)

Reflexivity	The reflective analysis of the relationship between researcher and respondents and the researcher and the data
Regional analgesia	Loss of sensation in a particular area of the body achieved by applying anaesthetic to the nerves supplying that area. In relation to childbirth this means epidural or spinal anaesthesia
Relative risk	A comparison of the risk of a condition between two different groups (NHS Choices, 2009)
Relativism	A belief that knowledge exists in relation to culture and society and is not absolute
Reversion	When a baby reverts from a cephalic presentation to a breech presentation following a successful ECV
Seizure	Uncontrolled electrical activity in the brain accompanied by altered consciousness and/ or other effects on brain activity
Subjectivity	The concept that things may only be considered true for an individual and are influenced by that person's biases, interpretations and feelings
Systematic review	A review of evidence from a number of studies on a particular topic. The review uses standardised methods to analyse results and assess conclusions (RCOG, 2015)
Term	Between 37 and 42 weeks of pregnancy (RCOG, 2015)

Tocolytic drugs, tocolysis	Treatments used to stop the uterus contracting (RCOG, 2015)
Transient tachypnoea of the newborn	A self-limiting period of rapid breathing in a newborn baby which usually lasts 24-48 hours. Treatment with oxygen may be required and antibiotics may be given until an infection is ruled out
Umbilical cord prolapse	When the umbilical cord comes out of the cervix before the presenting part (head or bottom)
Underpowered	A research study having not enough participants to investigate a particular outcome
Uterine rupture	A tear in the uterus
Uterus	The womb (RCOG, 2015)

Abbreviations used in this thesis

ACF	Academic clinical fellow
CD	Compact disc
CI	Confidence interval
CS	Caesarean section
ECV	External cephalic version
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health Research
NRES	National Research Ethics Service
NTW CLRN	Northumberland, Tyne and Wear Comprehensive Local Research Network
PDA	Patient decision aid
R&D	Research and Development
RCOG	Royal College of Obstetricians and Gynaecologists
RCT	Randomised controlled trial
REC	Research ethics committee
RR	Relative risk
SDM	Shared decision making
UK	United Kingdom
VBAC	Vaginal birth after caesarean section
VBB	Vaginal breech birth

Chapter 1. Introduction

This thesis focuses on the experiences of women who had a breech baby at the end of pregnancy and who made decisions about external cephalic version (ECV), vaginal breech birth (VBB) and planned caesarean section (CS). It explores the process of decision making about breech presentation from both women's and health professionals' perspectives and documents how a patient decision aid (PDA), consisting of a website and animated film (breech-decisions.ncl.ac.uk), was developed from this qualitative work. In this chapter, I set out the context of this research, give an overview of the thesis and provide a rationale for the nomenclature I have chosen to use throughout.

Breech presentation means that a fetus' buttocks or feet are closest to the cervix and would be the first body part to be born. Most babies are cephalic at the end of pregnancy, but breech presentation affects 3-4% of pregnant women at term (RCOG, 2006b). In the UK, the National Institute for Health and Care Excellence (NICE) states that all women who have an uncomplicated singleton breech pregnancy at 36 weeks should be offered ECV and that if ECV is unsuccessful or contradicted they should be offered a planned CS (NICE, 2012; NICE, 2013). This means women have two key decisions to make. Firstly, whether or not to attempt ECV, which is an outpatient procedure to turn the baby into a cephalic presentation. Secondly, how they want to give birth if their baby remains breech, either by planning a CS or a VBB. The research evidence which may inform these decisions is summarised in Chapter 2.

Uptake rates of ECV, VBB and planned CS for breech are variable. For example, reported uptake of ECV varies from 24% to 74% (Lau et al., 1997; Hofmeyr and Kulier, 2000b; Yogev et al., 2002; Collins et al., 2007; Kok et al., 2008b). Cross sectional surveys demonstrate that women have varied attitudes towards ECV. Reasons given for choosing ECV included a desire to avoid CS and to deliver naturally and doctor's advice (Leung et al., 2000; Caukwell et al., 2002). Positive features of ECV respondents reported included having an additional ultrasound examination and the fetal monitoring during the procedure (Rijnders et al., 2010). Reasons given for declining ECV included their doctor's advice; concerns about safety (including cord entanglement and abruption); the failure rate; fear of reversion;

pain; a perception that ECV is unnatural; inability to guarantee vaginal delivery even if ECV is successful; and a preference for CS (Leung et al., 2000; Caukwell et al., 2002; Raynes-Greenow et al., 2004). Cross-sectional survey data suggest that women who experience VBB do not have worse experiences than women who experience cephalic vaginal births, but may feel they have less control over birthing positions and pain relief (Toivonen et al., 2012). Cross-sectional surveys are limited in their ability to collect in-depth data about women's attitudes and two of the studies surveyed pregnant women who did not have personal experience of breech presentation, so these women's responses were theoretical. As part of the literature review for this thesis, I appraise qualitative research exploring women's attitudes towards breech presentation, ECV, VBB and planned CS (see Chapter 2).

Enabling pregnant women to be involved in decisions about their antenatal, intrapartum and postnatal care has become an important focus of maternity care (NICE, 2012). Shared decision making (SDM) is "an approach where clinicians and patients make decisions together using the best available evidence" (Elwyn et al., 2010). It involves health professionals and patients communicating together so that clinicians can share evidence-based information about options with patients; support patients in deliberating about the options; facilitate patients developing informed preferences for treatment (or screening) based on their values and health goals; and help implement the decisions made (Elwyn et al., 2010). Internationally, SDM has become widely advocated as the ideal model of decision-making in many clinical situations, including within maternity care (Elwyn et al., 2010; Gee and Corry, 2012). It is particularly appropriate when there is no overall best choice or when there is unwarranted variation in the use of treatments or tests, meaning that differences in intervention rates are not accounted for by clinical need (Elwyn et al., 2010; Gee and Corry, 2012). However, Gee and Corry (2012) argue that frequently women do not experience SDM in maternity care. This may be because professionals feel compelled to follow institutional guidelines or because SDM may be challenging for clinicians (Say and Thomson, 2003; Gee and Corry, 2012).

PDA's can be used to support patients' involvement in decision-making and improve clinical practice (Sepucha et al., 2008; Stacey et al., 2014). Stacey et al (2014) define PDA's as "evidence-based tools designed to help patients to participate in making

specific and deliberated choices among healthcare options”. They are intended to supplement rather than replace healthcare professionals counselling patients about options. PDAs have three key aims (Stacey et al., 2014):

1. To explicitly define the decision or decisions that need to be made
2. To provide evidence-based information about the condition, options, benefits and risks (including explaining any uncertainties)
3. To clarify (either explicitly or implicitly) the values that users place on these benefits and risks and help them ascertain which are most important to them.

The benefits of using PDAs include patients having improved knowledge of treatment options; feeling better informed about options; having a better understanding of potential risks and benefits; being clearer about what matters most to them; being more involved in decision making; and making decisions which are more consistent with their values (Stacey et al., 2014). In terms of clinical outcomes, using decision aids has a varied effect on the choices patients make but their use has been consistently shown to reduce rates of elective surgery (Stacey et al., 2014). They improve communication between clinicians and patients and do not worsen health outcomes (Stacey et al., 2014).

Following this introduction, Chapter 2 reviews the literature on the management of breech presentation; women’s attitudes towards the options of ECV, VBB and planned CS and the potential benefits and harms of these options; and the evidence for using decision aids in maternity care. Following the literature review, I outline the aims and objectives of this study before describing the methodology and methods used in Chapter 3. In Chapters 4-7, I present the results of the study and explain how they informed the development of a PDA consisting of a website and an animated film. In Chapter 4, I examine the process of diagnosis of breech presentation and how women search for information and support during this, at home and in the hospital. In Chapter 5, I consider the content of information about breech presentation given to women by health professionals and lay people and describe how this contributed to decision making. In Chapter 6, I describe women’s values that underpin decision making about breech presentation, considering women’s attitudes towards ECV, VBB and CS and how these relate to the values they describe and their accounts of how they made decisions. In Chapter 7, I explore respondents’ experiences of breech

presentation and, in particular, ECV, VBB and planned CS and relate these to the values they had described. In Chapter 8, I further discuss the key themes of the study, review the potential benefits and limitations to the PDA developed and consider the limitations of this study. Finally, I make recommendations for clinical practice, policy and future research.

I have chosen to write this thesis in the first person. In Chapter 3, I explain how this was informed by the feminist methodology I employed which rejects traditional notions of objectivity in research, rather emphasising the social nature of research and the importance of using the first person to facilitate reflexivity (Letherby, 2003). Also, in order to make this thesis as accessible as possible to anyone who chooses to read it, I have endeavoured to avoid using both medical and social science jargon, or, when I have needed to use it, I have defined it in the Glossary of Terms. Wherever possible, I have also tried to adopt the language of respondents in the study. For example, in the results and discussion chapters I refer to 'breech baby' rather than 'breech fetus' and use 'birth' rather than 'delivery'.

Chapter 2. Literature Review

Prior to conducting the research, which constitutes the main body of this thesis, I undertook a review of the literature to examine the following areas:

1. The management of breech presentation at term
2. Women's attitudes towards ECV, VBB and planned CS
3. Decision aids for pregnant women

These were not systematic reviews but I did search the literature in a systematic way, described below.

2.1 The management of breech presentation at term

The aims of this review were to:

- Understand the evidence which may be used to support decision making about breech presentation
- Inform the development of a list of key factual information to be included in future decision support
- Understand the clinical context of the management of breech presentation in the UK in order to inform my research plan

I identified key evidence in a variety of ways. Prior to designing the study, I was aware of various guidelines that informed clinical practice in the United Kingdom, in particular the Royal College of Obstetricians and Gynaecologists (RCOG) guidelines 'The Management of Breech Presentation' (RCOG, 2006b) and 'External Cephalic Version and Reducing the Incidence of Breech Presentation' (RCOG, 2006a). In addition to reviewing these guidelines, I also undertook electronic searches of Medline, Embase, Google Scholar and the Cochrane Library databases, targeting citations on the management of breech presentation from February 2011 until October 2015. Search terms were: breech, external cephalic version, fetal version, vaginal breech birth, vaginal breech delivery, breech caesarean section, breech mode of delivery. The reference lists of guidelines, primary and review articles were examined to identify any cited articles not captured by electronic searches.

Although the decision whether or not to attempt ECV comes first for many women, in order to explain why women are offered it, I will first consider the evidence about mode of delivery for breech presentation. Whilst breech presentation only affects 3-4% of pregnancies after 37 weeks, before term it is common, for example, one in five babies are breech at 28 weeks of gestation (RCOG, 2006b). Most babies spontaneously turn into a cephalic position as pregnancy advances. However, after 36 weeks of pregnancy only 8% of breech babies will spontaneously turn (RCOG, 2006a). Persistent breech presentation may be associated with congenital abnormalities, an abnormal placental position, an abnormal amniotic fluid volume or uterine abnormalities, although in many cases no obvious cause is identified (RCOG, 2006b).

Being breech is associated with increased perinatal morbidity and mortality (RCOG, 2006b). Therefore, health professionals, pregnant women and their supporters have been motivated to identify ways to reduce the occurrence of poor perinatal outcomes related to breech presentation. Some of these poor outcomes relate to prematurity, as premature babies are more likely to still be breech at birth, or the association with congenital malformations (RCOG, 2006b). However, others may relate to complications at the time of birth as VBB increases the risk of compression of the umbilical cord, umbilical cord prolapse, head entrapment and birth trauma (Hofmeyr et al., 2015a). Because of this, particular attention has been given to establishing the safest way for women to give birth to a baby breech at term. This has been investigated, using both randomised controlled trials (RCTs) and observational studies, to compare planned vaginal delivery to planned CS.

At the time of my research, as I will show in Chapter 5, knowledge was based on a Cochrane review of the RCTs (Hofmeyr and Hannah, 2003) and the Term Breech Trial (Hannah et al., 2000), the largest international, multi-centre RCT comparing VBB to planned CS. The Cochrane review showed a relative risk (RR) of 0.33 (95% confidence interval (CI) 0.19 to 0.56) for babies in the planned CS group of perinatal or neonatal death or serious short-term neonatal morbidity (defined as the baby having seizures, birth asphyxia, hypoxic ischaemic encephalopathy, birth trauma; Apgar score of less than four at five minutes; cord pH less than 7.0; base deficit at least 15 mmol/L; and neonatal intensive care admission (Hofmeyr and Hannah, 2003).

The authors did not report estimates of absolute risks but Hannah et al. (2000) provided data on the absolute risk of this composite outcome as five in 100 for planned VBB and 1.5 in 100 for planned CS.

The Term Breech Trial (Hannah et al., 2000) has been criticised for a number of reasons. For example, some of the vaginal births were attended by professionals with little or no training or experience of breech birth. Some of the women had labour induced or augmented which would not be usual practice with breech presentation in the UK. A complex composite outcome was used (see above) which encompassed outcomes ranging from death to a baby that would be expected to make a full recovery, such as needing to be fed with a tube. As the risks were not given separately it may be hard to interpret the data and explain to women what such an absolute risk actually consists of. The trial was also criticised as the 13 reported neonatal deaths in the VBB arm were not connected to the mode of delivery or labour (Glezerman, 2006; Lawson, 2012).

In contrast, observational data provided a clearer breakdown of risks. The PREMODA study (Goffinet et al., 2006) was a large prospective cohort study in European hospitals where all professionals were trained and had experience with VBB. This study showed no difference between planned VBB and planned CS in the risks of death, neurodevelopmental delay before two years of age or neonatal intensive care unit admission. It did show an increased risk of birth trauma for babies in the planned VBB group (2 in 100) compared to planned CS (0.5 in 100) (Goffinet et al., 2006).

Therefore, at the time of data collection, controversy remained regarding the benefits of planned CS for breech. This has been addressed in part by a meta-analysis undertaken by Berhan and Haileamlak (2015), which included both randomised and observational studies, including the Term Breech Trial (Hannah et al., 2000) and PREMODA (Goffinet et al., 2006), as well as 25 other studies involving 258, 953 term singleton breech presentations. The overall perinatal mortality rates presented were 253/75193 (0.3%) for VBB and 79/160343 (0.05%) for planned CS with absolute risks of 1 in 300 and 1 in 2000 respectively (Berhan and Haileamlak, 2015). Absolute risks of birth trauma were about 1 in 150 (0.7%) for planned VBB and 1 in 600 (0.17%) for planned CS (Berhan and Haileamlak, 2015). The risk of birth

asphyxia was about 3 in 100 (3.3%) for planned VBB and about 1 in 180 (0.6%) for planned CS (Berhan and Haileamlak, 2015). The absolute risks of the baby needing to be admitted to the neonatal intensive care unit were about 5 in 100 (5%) for planned VBB and 2.5 in 100 (2.5%) for planned CS (Berhan and Haileamlak, 2015). The absolute risks of neurological morbidity were 1 in 150 (0.7%) for planned VBB and 1 in 1000 (0.1%) for planned CS (Berhan and Haileamlak, 2015). The authors suggest that although their study confirmed that there is an increased risk to babies from planned VBB, as the absolute risks are so low this should still be an option for women and they acknowledge the limitations to the available studies such as those of the Term Breech Trial (Hannah et al., 2000) discussed above (Berhan and Haileamlak, 2015).

A recently updated Cochrane review (Hofmeyr et al., 2015a) also demonstrated a reduction in the risk of perinatal death, neonatal death or severe neonatal morbidity for planned CS (RR 0.07 (95% CI 0.02-0.29)) with absolute risks of 4 per 1000 for planned CS and 57 per 1000 for planned VBB (Hofmeyr et al., 2015a). No statistically significant differences were found in the rates of birth trauma or death or neurodevelopmental delay at age two years (Hofmeyr et al., 2015a). Long-term maternal outcomes were also investigated. Whilst there was an increase in rates of constipation for women in the planned CS group (RR 1.34, 95% CI 1.06 to 1.70), no differences were found in the long-term (two year) rates of incontinence, pain in the abdomen or perineum, painful or heavy periods, sexual problems, relationship problems with partner, relationship problems with baby, depression, women becoming pregnant again, or women breastfeeding at three months (Hofmeyr et al., 2015a). This review included three RCTs but was dominated by the Term Breech Trial (Hannah et al., 2000), which contributed 2088 of the 2396 pregnancies included in the meta-analysis (Hofmeyr et al., 2015a).

In response to the evidence suggesting planned CS is safer for babies, as well as clinicians' own concerns about the risks of VBB based on their own experiences, the rates of planned CS for breech presentation in the UK and many other countries have increased (Berhan and Haileamlak, 2015). This has contributed in part to the rise in CS rates internationally, which is an issue of concern to health professionals, policy makers and women alike (Schiller, 2015).

One of the main concerns about rising rates of CS is the risk to women from the surgery. Whilst evidence suggests that a planned CS may be safer for breech babies, there are a number of risks for mothers. Hofmeyr et al (2015a) demonstrated an increase in the risk of short term maternal morbidity (a composite outcome including the risks of death, admission to intensive care, severe infection, heavy bleeding, being unsatisfied with care, blood transfusion, wound infection and anaemia) from planned CS (relative risk 1.29 95% CI 1.03-1.61). The absolute risks of this composite outcome were 86 per 1000 for VBB and 111 per 1000 for planned CS (Hofmeyr et al., 2015a). Berhan and Haileamlak (2015) did not include maternal mortality or morbidity in their review. There are also implications of having a CS for subsequent pregnancies. A Dutch cohort study involving 15605 pregnant women who had had a breech baby in their last pregnancy showed an increased risk of uterine rupture (0.7% for VBB 2.2% for planned CS, odds ratio 3.8, 95% CI 1.4-10.3) and postpartum haemorrhage of more than 1000ml (42.1% for VBB 57.1% for planned CS, OR 1.4, 95% CI 1.2-1.6) Vlemmix et al. (2013a).

In response to these concerns there have been calls to reduce the rate of primary CS. For example, the NHS Institute for Innovation and Improvement (2007) made recommendations to reduce England's CS rate by setting targets for the uptake of vaginal birth after CS (VBAC) and recommending that all eligible women should be offered ECV. Internationally, increasing ECV uptake has also been identified as a potential way to reduce CS rates (Cho et al., 2012).

ECV is a procedure to turn a breech baby into a cephalic position in the uterus. The operator uses manual pressure through the mother's abdominal wall to perform the turn. ECV is available to most women but the RCOG (2006a) lists the following absolute contraindications: CS indicated for another reason; antepartum haemorrhage in the previous seven days; abnormal cardiotocography; major uterine abnormality; ruptured membranes; multiple pregnancy.

A Cochrane review undertaken by Hofmeyr and Kulier (2000b) demonstrated that ECV is associated with a reduction in non-cephalic birth (RR 0.46, 95% CI 0.31 to 0.66) and CS (RR 0.63 95% CI 0.44 to 0.90) and is not associated with increased perinatal morbidity or mortality (RR 0.44, 95% CI 0.07 to 2.92).

There may be transient alterations in parameters of fetal wellbeing such as fetal bradycardia and reduced fetal heart rate variability during or immediately after the procedure (RCOG, 2006a). These changes are of unknown significance but the RCOG recommends that an emergency CS rate of 0.5% should be quoted to women considering ECV (RCOG, 2006a). Furthermore, serious but rare complications have also been reported including placental abruption, uterine rupture and fetomaternal haemorrhage (RCOG, 2006a). However, research studies are likely to be underpowered to demonstrate the risk of these rare events (RCOG, 2006a). Despite the evidence in favour of attempting ECV, reported uptake varies from 24% to 54% (Yogev et al., 2002; Raynes-Greenow et al., 2004) and women's attitudes towards ECV are not clear (see below).

Reported success rates of ECV vary from 18-76% (Lau et al., 1997; Hofmeyr and Kulier, 2000b; Yogev et al., 2002; Collins et al., 2007; Kok et al., 2008a). The RCOG (2006a) suggest a 40% success rate in nulliparous women and a 60% success rate in multiparous women can usually be achieved. ECV has been found to be more successful if women are multiparous, from Africa, if the presenting part is not engaged, if the uterus is not tense, if the placenta is posterior, and if there is polyhydramnios (Newman et al., 1993; Mauldin et al., 1996; Regalia et al., 2000; Nassar et al., 2006b). Five per cent of successfully turned babies will revert back to a breech presentation (RCOG, 2006a).

Due to the variable success rates of ECV, interventions to increase the success rate have been investigated. A Cochrane review (Cluver et al., 2015) reported that use of tocolytic drugs was associated with decreased failure of ECV (RR 0.79, 95% CI 0.70-0.89); increased incidence of cephalic presentation at birth (RR 1.38, 95% CI 1.03 to 1.85); and a reduced incidence of CS (RR 0.82, 95% CI 0.71 to 0.94) with no increased risk of fetal bradycardia (RR 0.95, 95% CI 0.48 to 1.89). The success rate of ECV was also further increased if regional analgesia was used as well as tocolysis (RR failed ECV 0.67, 95% CI 0.51 to 0.89) (Cluver et al., 2015). There was insufficient data to support the use of fetal acoustic stimulation, amnioinfusion or systemic opioids (Cluver et al., 2015).

Alternative approaches to turning a breech baby include postural management (adopting particular postures to encourage the fetus to turn) or the Chinese herb

moxibustion (burned at an acupuncture point Bladder 67 at the tip of the fifth toe) but the RCOG (2006a) advises that there is insufficient evidence to support either of these interventions. However, since publication of this guidance an updated Cochrane review has shown that, when combined with acupuncture, use of moxibustion resulted in fewer non-cephalic presentations at birth (RR 0.73, 95% CI 0.57 to 0.94) and fewer CS (RR 0.79, 95% CI 0.64 to 0.98) (Coyle et al., 2012). However, the authors report that the quality of the methods used in included studies was limited and suggest that more research is needed to establish the safety and efficacy of moxibustion (Coyle et al., 2012).

In conclusion, there is research evidence to support women making decisions about ECV, VBB and planned CS. Whilst some high quality evidence suggests that planned CS is safer for babies there are risks to women from surgery and important implications for subsequent pregnancies. The absolute risks of harm to babies during VBB are low. Therefore, despite the evidence in favour of planned CS, women need to make a decision about mode of delivery, considering their attitudes to all the potential benefits and harms and what is best for them and their families. For some women, ECV is a good option as if it is successful they need not choose between planned CS and VBB. Nevertheless, ECV has potential risks which will not be acceptable to some women and the overall success rate is only 50%. This means that some women will continue to have a breech baby at term and need to decide about mode of delivery. Little is known about alternative approaches to turning the baby, such as postural management and acupuncture, and more research is needed to establish the safety and efficacy of these approaches.

2.2 Women's attitudes towards ECV, VBB and planned CS

The aims of this review were to:

- Explore what is known from qualitative studies about women's attitudes to ECV, VBB and planned CS
- Develop understanding about what factors may influence pregnant women's decision making about ECV and mode of delivery for breech presentation
- Explore what is known from qualitative studies about health professionals attitudes to ECV, VBB and planned CS

I undertook electronic searches of Medline, Google Scholar and Embase targeting qualitative studies about women's and health professionals' attitudes towards ECV, VBB and planned CS from February 2011 until October 2015. Search terms were: breech, external cephalic version, vaginal breech birth, vaginal breech delivery, patients' attitudes, women's attitudes, patients' preferences, women's preference, patients' values, women's values. The reference lists of primary and review articles were examined to identify any cited articles not captured by electronic searches. One of the studies included is my own research (Say et al., 2013), conducted as background work for my PhD, but it did not report any data contained in this thesis.

Six qualitative studies were identified which explored women's experiences of breech presentation, their experiences of decision making about breech, their attitudes towards and experiences of ECV, their attitudes towards and experiences of planning a VBB and their attitudes towards planned CS. The methods used and key themes found in these studies are summarised in Table 1.

Table 1 Studies exploring women's experiences of breech presentation

Study	Founds (2007)	Guittier et al. (2011)	Homer et al. (2015)	Menakaya and Trivedi (2013)	Rosman et al. (2014)	Say et al. (2013)¹
Aim	To increase understanding of women's and provider's experiences of breech	To explore women's experiences and decision-making processes regarding the choice of birth mode for breech	To explore the experiences of women who had planned a VBB in the preceding seven years	To provide a consumer perspective on ECV from women who had an unsuccessful ECV	To identify barriers and facilitators for ECV among professionals and women with a breech baby at term	To explore the attitudes of women with a breech baby and health professionals to ECV
Research design	Semi-structured interviews, observations and birth log reviews	Semi-structured interviews	Semi-structured interviews	Focus groups	Focus groups and semi-structured interviews	Semi-structured interviews
Setting	Rural parish in Jamaica 2003	University Hospitals of Geneva, Switzerland Jan-Oct 2009	Two public maternity units in urban and metropolitan areas in Australia March-Dec 2013	Secondary obstetric facility, Melbourne, Australia. Dates not provided	Dutch hospitals and seven midwife practices (no further details given). Dates not provided	Two hospitals in north east England May-July 2009
Respondents	9 women who gave birth to a breech infant in a community hospital An obstetrician, a general physician, two hospital midwives and a district midwife	12 pregnant women diagnosed with a singleton breech fetus after 38 weeks of pregnancy, fluent in French with no contraindications to vaginal childbirth	22 women who had planned a VBB for a singleton pregnancy in the past seven years who could read and speak English 12 had a VBB and 10 had an emergency CS	Five women who experienced unsuccessful attempts at ECV	20 midwives and obstetricians 24 women who had made a decision about whether to undergo ECV	11 pregnant women with a breech baby at term. 4 declined ECV and 7 chose to attempt it 10 obstetricians and 1 midwife

¹ Please note this was a previous study and did not include any of the data collected during my doctoral research.

Table 1 Studies exploring women’s experiences of breech presentation

Study	Founds (2007)	Guittier et al. (2011)	Homer et al. (2015)	Menakaya and Trivedi (2013)	Rosman et al. (2014)	Say et al. (2013)¹
Sampling	Purposive	Purposive	Convenience	Convenience	Convenience sample of clinicians Purposive sample of women	Convenience sample of clinicians Purposive sample of women
Data collection	Semi-structured interviews in women’s homes/ postnatal clinics/ providers offices. Field notes taken and reflective diary kept. Interview schedule provided. Interviews were audio taped and transcribed. Interviews lasted 45-60 minutes	Semi-structured interviews were conducted in the maternity unit/ women’s homes. Interview schedule provided. Interviews were recorded and transcribed. Interviews lasted 30-90 minutes	Semi-structured interviews were conducted in women’s homes. Interview schedule provided. Interviews lasted about 60 minutes	Focus group using a pre-piloted questionnaire (not provided). The focus group was audio-recorded and an assistant kept notes of non-verbal cues. Length of focus group not given	Professionals: four focus groups Women: telephone or face-to-face interviews depending on woman’s preference	Semi-structured interviews. Interview schedule provided. Interviews were audio-recorded and transcribed. Interviews lasted up to 45 minutes
Reflexivity	Discusses how her professional role and relationships facilitated recruitment but otherwise does not discuss reflexivity	Not discussed	Researchers took notes for personal reflections after interviews and when reviewing audio-files	Not discussed	Not discussed	Discuss potential impact of the researcher on interviews in the discussion

¹ Please note this was a previous study and did not include any of the data collected during my doctoral research.

Table 1 Studies exploring women’s experiences of breech presentation

Study	Founds (2007)	Guittier et al. (2011)	Homer et al. (2015)	Menakaya and Trivedi (2013)	Rosman et al. (2014)	Say et al. (2013)¹
Ethical issues	Institutional ethics committee approval Approval given for verbal consent process due to illiteracy amongst respondents	Institutional ethics committee approval Written informed consent obtained from all participants	Institutional ethics committee approval Written consent obtained	Institutional ethics committee approval Process of consent not discussed	Clinicians assured of confidentiality Process of consent not discussed No details given about ethical approval	Institutional ethics committee approval
Data analysis	Content analysis with description of how codes and themes were developed	Thematic analysis by three investigators. Clear description of the development of themes	Inductive thematic analysis by three researchers. Clear description of how this was done	Thematic analysis, no details given	Framework analysis with reference for framework used	Thematic analysis. Clear description of how this was done

¹ Please note this was a previous study and did not include any of the data collected during my doctoral research.

Table 1 Studies exploring women’s experiences of breech presentation

Study	Founds (2007)	Guittier et al. (2011)	Homer et al. (2015)	Menakaya and Trivedi (2013)	Rosman et al. (2014)	Say et al. (2013) ¹
Main themes	<p>Realising the baby was breech; interpreting what breech meant; reacting to breech; and identifying the impact of breech.</p> <p>Women’s experiences of breech presentation were shaped by providers through their provision of information to women. Women’s experiences were also affected by their own experiences and their socio-cultural networks.</p> <p>Representative quotations included and disconfirming cases discussed.</p>	<p>Emotional reaction to diagnosis of breech; perceptions of risks related to CS; perceptions of risks related to VBB; ideas and experiences regarding the decision-making process; and the moment at which childbirth method was decided.</p> <p>Some analysis quite superficial or findings descriptive rather than analytical.</p>	<p>Reacting to a loss of choice and control; wanting information that was trustworthy; fighting the system and seeking support for VBB; the importance of ‘having a go’ at VBB.</p>	<p>Emotions associated with CS; activities to turn breech to cephalic; emotional consequences of unsuccessful ECV; management of breech seen as medicalised process; women wanted help to deal with emotional conflicts.</p> <p>Little detail provided. Descriptive account given with little in-depth analysis.</p>	<p>Barriers to ECV included: inadequate counselling, fear of harm to the fetus, short period between diagnosis and ECV, lack of adequate patient information, women preferring CS, underestimating the risks of CS, subjective information sources, negative perception of the success rate.</p> <p>Facilitators: written information, directive counselling, offering ECV in specialist centres, low complication rate, positive perception of the success rate, fetal monitoring, involving partner, being advised they could stop at any time, early information, supportive social network.</p>	<p>Main themes: ECV as a means of enabling natural birth; concerns about ECV; lay and professional accounts of ECV; breech presentation as a means of choosing planned CS; directive counselling and professional attitudes towards lay beliefs about ECV and breech presentation.</p> <p>Some analysis but no use of theory.</p>

¹ Please note this was a previous study and did not include any of the data collected during my doctoral research.

Table 1 Studies exploring women’s experiences of breech presentation

Study	Founds (2007)	Guittier et al. (2011)	Homer et al. (2015)	Menakaya and Trivedi (2013)	Rosman et al. (2014)	Say et al. (2013)¹
Value of the research	<p>The findings may not be generalisable to other healthcare systems with more resources.</p> <p>Limitations of this study not discussed.</p>	<p>Limitations not discussed.</p> <p>Identified need for further research to establish how best to support women making decisions about mode of delivery for breech presentation.</p>	<p>Discuss limitations of study, particularly recruiting women from units which support VBB and having a convenience sample. Discuss generalisability.</p> <p>Identifies need for support for shared decision making in this context.</p>	<p>Discuss some limitations, including size of focus group and limited generalisability. State unlikely to have reached data saturation. State aim of publication to stimulate further work.</p>	<p>Discuss some limitations including the difficulty recruiting women who declined ECV. Did not discuss the limitations of using a framework. Brief discussion of generalisability and suggest need to triangulate findings with quantitative research. Do not compare findings to the literature.</p>	<p>Limitations discussed including interviewer being open with participants about her being a trainee obstetrician, the difficulty accessing underlying beliefs of professions, and interpretive limitations such as over-complexity or reductionism.</p> <p>Generalisability discussed.</p>

Table 1 Studies exploring women's experiences of breech presentation.

¹ Please note this was a previous study and did not include any of the data collected during my doctoral research.

Four studies report that women describe an emotional reaction to the diagnosis of breech presentation. Guittier et al. (2011) found that women need a process of acceptance of the breech presentation and seek explanations for it. Homer et al. (2015), focusing on the experiences of women who planned a VBB, suggest that the diagnosis of breech presentation results in distress for women about perceived lack of choice and control over birth. Founds (2007) shows that some women experience significant anxiety about breech presentation. Menakaya and Trivedi (2013) report that women perceive the management of breech presentation to be a medicalised process and want help dealing with the emotions they experience. Both Guittier et al. (2011) and Menakaya and Trivedi (2013) describe how some women actively seek alternative treatments to help turn their baby including acupuncture, moxibustion, physical activities and massage. Women may see such interventions as a means of resisting being medicalised.

In relation to decision making about breech presentation, women value trustworthy information and both women and professionals value suitable patient information materials (Rosman et al., 2014; Homer et al., 2015). Poor communication by health professionals is problematic for women as it is a barrier to them accessing appropriate information (Guittier et al., 2011; Rosman et al., 2014).

In addition to obtaining information from health professionals, women also look to their wider social networks (Founds, 2007; Guittier et al., 2011; Say et al., 2013; Rosman et al., 2014). However, Guittier et al. (2011) report that information obtained via social networks may not be reassuring for women leaving them feeling alone during decision making. Founds (2007) describes how lay people focus on the perceived risks of breech including the risks of maternal and infant death during VBB. She also describes some cultural beliefs about breech babies including that they were more troublesome infants (Founds, 2007). As well as hearing negative accounts of VBB, women may also receive negative reports of ECV from friends and relatives (Say et al., 2013; Rosman et al., 2014).

Regarding the options for managing breech, women report varied attitudes. For example, some women see ECV as a means to enable vaginal birth, which is generally highly valued (Menakaya and Trivedi, 2013; Say et al., 2013; Rosman et al., 2014). However, other women are concerned about pain during the procedure, the

success rate and the risks of ECV and some perceive that it is unnatural or believe that nature, or god, intended their baby to be breech (Menakaya and Trivedi, 2013; Say et al., 2013; Rosman et al., 2014). No studies identified in this review explored women's experiences of the procedure of ECV or of childbirth following an attempt at ECV.

As well as being worried about the risks of ECV, the research suggests that women are also concerned about the risks of VBB, particularly about risks to their baby and of pain during a VBB (Founds, 2007; Say et al., 2013). However, some women perceive that VBB is much less risky to them than planned CS and are keen to experience labour even if they go on to need a CS (Homer et al., 2015). These women feel like they need to fight the system in order to be able to plan a VBB (Homer et al., 2015). In contrast, other women report that the experience of giving birth to a breech baby is sufficiently traumatic as to put them off having future pregnancies (Founds, 2007). It is important to note that neither Homer et al. (2015) nor Founds (2007) provide any details of women's actual experiences of VBB.

Four studies (Founds, 2007; Guittier et al., 2011; Menakaya and Trivedi, 2013; Say et al., 2013) considered women's attitudes towards CS. Three found that respondents were scared of the procedure (Founds, 2007; Guittier et al., 2011; Menakaya and Trivedi, 2013). Guittier et al. (2011) also noted that women were concerned about being separated from their infant at birth and psychological consequences as a result of not experiencing vaginal birth. Nevertheless, some women prefer a planned CS (Rosman et al., 2014) and therefore decline ECV, either because they think it is less risky for their baby or because they perceive it to be convenient and a way to avoid the pain, risk of perineal injury and risk of needing an emergency CS associated with a vaginal birth (Say et al., 2013). None of these studies explored women's experiences of planned CS for breech.

Three of these studies also examined professionals' attitudes towards breech (Founds, 2007; Say et al., 2013; Rosman et al., 2014). Founds (2007) describes how breech presentation was seen as abnormal by professionals with risks for mother and fetus which they are keen to avoid. Professionals in her study in Jamaica were aware of ECV but did not perform it routinely. They valued training and experience in vaginal breech deliveries. In my own study in the UK (Say et al., 2013), we report that

professionals gave accounts of directly counselling women towards ECV, which they perceived as safe and an effective way to avoid a CS. Professionals are frustrated by negative accounts of ECV in the community and perceived that women have unrealistic expectations of birth, particularly of CS as a result of media reporting of celebrities births (Say et al., 2013). Rosman et al. (2014) also found that professionals perceived that subjective information sources are a barrier to ECV. They are also concerned about lack of adequate patient information and professionals' negative attitudes towards ECV which might result from a lack of knowledge or from over-estimating risks of ECV which they experience occurring in their clinical practice (Rosman et al., 2014). Professionals also recognise that some women have a preference for CS and may underestimate the risks of surgery (Rosman et al., 2014).

Despite the similarities in some of the themes found in these six studies there were some important differences, as can be seen above and in Table 1. Some of these differences are likely to reflect the very different groups of women participating and the different research questions addressed. For example, in Founds' (2007) study the women were poor, the healthcare system in Jamaica had limited resources, ultrasound examinations were too expensive for some women to afford and ECV was not routinely available. This is in contrast to the other studies where women were receiving care in specialist centres in developed countries.

The studies were also of variable methodological quality. For example, Menakaya and Trivedi (2013) were only able to recruit five women to participate in a single focus group and used convenience sampling, suggesting they did not reach data saturation and that their results may have limited generalisability. There were also limitations to the way studies were reported. For example, three studies did not discuss reflexivity (see Table 1). Rosman et al. (2014) did not discuss ethical approval nor the consent process. They state that clinicians were assured confidentiality but do not comment on how they approached this with women, which makes it impossible to assess how this may have impacted on the data collected.

As none of these studies aimed to explore women's experiences of planned CS, I also searched for qualitative studies exploring women's experiences of planned CS in general, not necessarily for breech presentation. Whilst women's experiences of emergency CS have been more widely explored in both the qualitative and quantitative literature, less is known about women's attitudes towards planned CS (Lewis et al., 2014). Nine qualitative studies addressing these were identified summarised in Tables 2 and 3 below. As can be seen, some of these studies had respondents who had experience of breech presentation although frequently no information was provided about the indications for respondent's CS.

In addition, Puia (2013) conducted a meta-synthesis of women's experiences of CS including studies examining both emergency and planned CS. Key themes included: women being scared to death; women being in health professionals' hands; women feeling out of control; and women feeling that they had a broken body and soul (Puia, 2013). She included 10 studies published between 2003 and 2010 but did not explain her inclusion criteria fully. However, she did not include some of the studies I identified in this review and did include three studies where the qualitative component was a free-text question in a cross-sectional survey. These studies were therefore significantly limited by the length of responses and the researchers not being able to explore women's responses in any detail.

Table 2 Studies exploring women's attitudes towards planned CS (part 1)

Study	Bayes et al. (2012a)	Bayes et al. (2012b)	Bryant et al. (2007)	Fenwick et al. (2009)	Kealy et al. (2010)
Aim	To explore how women experience becoming in need of and anticipate giving birth by elective CS for a medical reason that emerged during pregnancy	To describe women's experiences of medically necessary elective CS	To explore the beliefs underpinning decisions about CS and consider how these might contribute to the increasing rate of CS	To explore women's experiences of CS	To describe women's accounts of recovery after CS, from shortly after discharge to between five months and seven years after surgery
Research design	Grounded theory	Grounded theory	Grounded theory	Qualitative interview study	Interview study
Setting	Australian tertiary level maternity hospital Oct 2006-March 2008	Australian tertiary level maternity hospital Oct 2006-March 2008	Three consultant units South West England. Dates not provided	Public teaching hospital in Sydney Australia. Dates not provided	Tertiary hospital in Victoria, Australia Dec 2003-Dec 2005
Respondents	28 women advised they needed to birth by CS, indications not given Maternity health professionals	28 Women advised they needed to birth by CS, indications not given	18 women who had experience of CS 12 hospital based midwives 6 obstetricians	21 mothers who had experienced planned and unplanned CS. 3 had planned CS for breech and 2 had unsuccessful attempts at VBB and had emergency CS	32 women who had experienced at least one CS, indications not given
Sampling	Purposive and theoretical	Purposive and theoretical	Purposive and pragmatic	Purposive	Mix of pragmatic and purposive sampling

Table 2 Studies exploring women's attitudes towards planned CS (part 1)

Study	Bayes et al. (2012a)	Bayes et al. (2012b)	Bryant et al. (2007)	Fenwick et al. (2009)	Kealy et al. (2010)
Data collection	Semi-structured interviews with women, the first 4-48 hours prior to CS and 10-14 weeks postpartum. Lasted 1 hour 49 mins. Interview schedules not provided Semi-structured interviews with professionals	Semi-structured interviews with women 10-14 weeks postpartum. Average length 1 hour 53 minutes. Interview schedules not provided Observations of 14 CS	Face-to-face semi-structured interviews 20-45 mins Interview guide discussed but not provided	Unstructured interviews in women's homes or preferred location approximately 1 hour	Semi-structured interviews. Interview schedule not provided
Reflexivity	Discussed in detail, findings discussed with women and feedback sought	Not discussed	Not discussed	Detailed discussion, reflexive diary, constant comparison	Not discussed
Ethical issues	Institutional ethics committee approval	Institutional ethics committee approval	Not discussed	Institutional ethics committee approval. Consent for interviews discussed	Institutional ethics committee approval. Ethics of interviewing discussed
Data analysis	Grounded theory, constant comparison	Grounded theory, constant comparison	Thematic analysis	Grounded theory, clear description	Iterative thematic analysis

Table 2 Studies exploring women's attitudes towards planned CS (part 1)

Study	Bayes et al. (2012a)	Bayes et al. (2012b)	Bryant et al. (2007)	Fenwick et al. (2009)	Kealy et al. (2010)
Main themes	Feeling robbed; trying to make it feel real; making sure CS necessary; broadcasting the news; searching for information; becoming a persona non grata; focus on logistics; prioritised needs of procedure; travelling a new path blindly; trying to make the best of it; rehearsing to deal with fear; expecting birth would be natural; CS is hospital not women's business; feeling out of control; loss of the opportunity to give birth naturally; loss of role and responsibility for birth; loss of the opportunity to complete certain rites of childbearing	Being off everybody's radar; feeling invisible; being just another case on an operating list; striving to be included while trying to behave; being unable to be baby's mum; having to wait to hold baby; mother and baby not together in theatre	Women as neoliberal consumers, women valued control; indisputability of medical indications; safe CS and unsafe vaginal birth; CS as ordered and controlled; CS best choice for women who wanted to protect their babies	Mismatch between expectations and reality; missed out on physical process of giving birth; feeling unprepared; inadequate communication during postnatal period; women wanted to be in control of birth; women felt more positive is they felt informed; feelings of failure as a woman; caring for newborn challenging during recovery period; loss of familiar, healthy body; transition to motherhood hadn't followed expected pattern; felt excluded from society of mothers; lack of support in hospital	Difficulties following postoperative advice; experiencing unexpected pain and reduced mobility; abdominal wound complications; struggling to get reassurance from doctors; finding late postpartum haemorrhage frightening; experience of urinary incontinence

Table 2 Studies exploring women’s attitudes towards planned CS (part 1)

Study	Bayes et al. (2012a)	Bayes et al. (2012b)	Bryant et al. (2007)	Fenwick et al. (2009)	Kealy et al. (2010)
Value of the research	Limitations discussed including limitations to generalisability (women under 18 and non-English speakers excluded) and recommendations for future made. Data presented to women	Limitations discussed including limitations to generalisability (women only recruited from one unit) and recommendations for future made	Limitations discussed (studies discourse about CS rather than behaviours, obstetricians worked both in public and private practice, did not explore why medical opinions dominate practice)	Limitations and implications for clinical practice discussed. Limitations included not knowing education status of respondents and not following up women to see if their experiences impacted on their subsequent choices about birth	Limitations discussed (women only interviewed once and some many years after the birth) and recommendations made

Table 2 Studies exploring women’s attitudes towards planned CS (part 1)

Table 3 Studies exploring women’s attitudes towards planned CS (part 2)

Study	Kennedy et al. (2013)	Liamputtong and Watson (2006)	Tully and Ball (2013)	Lewis et al. (2014)
Aim	To explore the complexities of women’s and clinician’s choices around elective CS	To examine the meanings and experiences of CS among Cambodian, Lao and Vietnamese Immigrant Women in Australia	To document the circumstances in which CS was deemed to be appropriate in one UK hospital through the eyes of women and their partners experiencing CS	To add to knowledge around women’s perceptions of their preparation for an actual experience of a recent planned CS
Research design	Ethnography	Ethnography	Interview study	Mixed methods (survey and interviews)
Setting	Two NHS maternity service providers in an inner city setting	Melbourne, Australia	NHS hospital north east England Feb 2006- Oct 2008	Public obstetric tertiary hospital in Western Australia Aug-Dec 2012
Participants	27 women who had recently given birth (all modes of delivery) 34 clinicians	91 Cambodian, Lao and Vietnamese women living in Melbourne. Only 18 women had experienced CS. Indications not given	48 women who experienced emergency CS and 67 women who experienced planned CS. At least 18 years, in good health, fluent in verbal and written English 13 women had a breech baby	38 English speaking women who had delivered their baby at the King Edward Memorial Hospital by planned CS
Sampling	Purposive	Theoretical, purposive and snowball	Pragmatic	Convenience

Table 3 Studies exploring women’s attitudes towards planned CS (part 2)

Study	Kennedy et al. (2013)	Liamputtong and Watson (2006)	Tully and Ball (2013)	Lewis et al. (2014)
Data collection	Semi-structured interviews. Interview schedule provided. Women also contacted by phone to clarify answers. Observations (professionals only) Document review	Semi-structured interviews in women’s languages. Interview schedule not provided	Semi-structured interviews	Semi-structured telephone interview 5-25 minutes
Reflexivity	Not discussed	Not discussed	Not discussed	Not discussed
Ethical issues	Ethical approval	Ethical approval	Ethical approval	Ethical approval and data protection discussed
Data analysis	Narrative analysis	Thematic analysis	Thematic analysis	Thematic analysis

Table 3 Studies exploring women’s attitudes towards planned CS (part 2)

Study	Kennedy et al. (2013)	Liamputtong and Watson (2006)	Tully and Ball (2013)	Lewis et al. (2014)
Main themes	Culture of caesarean; directive counselling; perceptions of choice (variable, confusing and conflicting info); negotiating the rules	Baby’s safety; deficiency of women’s bodies; fear of surgery and consequent health problems; concern about recovery and scar; difficulty breastfeeding; being unable to observe traditional confinement practices; trusting the doctor and modern technology; believing CS would be pain free and safe; loss of self-agency; difficulty communicating; CS unexpected	The terms ‘emergency’ and ‘elective’ unreflective of maternal perceptions; breech presentation seen as a firm medical indication; family and friends advised CS easier and safer than VBB; CS last resort; planned CS prophylactic to psychological or physical harm; not an easy option, defending against social critique of the operation; felt treated as individuals; scheduling a CS without a medical indication was perceived as maximising maternal/ infant wellbeing	Positive reflections included: birth could not have been better; felt involved in care; felt informed throughout; valued skin to skin contact; felt received high quality care Negative reflections included: reduced to being just a number; having no option; having unanswered questions; being separated from baby and partner; birth plan not happening
Value of the research	Only one respondent had a planned CS. Limitations discussed (potential limitations to generalisability of recruiting women from two units in England and professionals all being in favour of VBAC). Recommendations for future made	Discuss limitations to generalisability and of using convenience sampling	Limitations not discussed in detail (mention not interviewing clinicians). Suggestions for clinical practice given	Limitations not discussed

Table 3 Studies exploring women’s attitudes towards planned CS (part 2)

Within the nine studies a range of themes were discussed. Women report varied attitudes towards planned CS. For some it is a positive experience. For example, Lewis et al. (2014) report that some women in their study felt their birth could not have been better. Tully and Ball (2013) describe how some women perceived that planning a CS, even if medically unnecessary, is seen as a way to maximise maternal and infant wellbeing and avoid the potential for psychological and physical harm associated with vaginal birth. Bryant et al. (2007) also report that planned CS may be perceived as safer than a vaginal birth and that CS is valued as ordered and controlled.

In contrast, other women perceive planned CS as a negative experience and one which reduces the control they have over birth. Bayes et al (2012a; 2012b) and Fenwick et al (2009) describe how some women they interviewed felt they had missed out on a vaginal birth. Bayes et al (2012a; 2012b) also suggest that some women felt that having a CS was depersonalising and felt like they were reduced to being just a case on an operating list, a perception which women interviewed by Lewis et al. (2014) also shared.

Kealy et al. (2010) report women's experiences of complications following surgery- such as wound infections, unexpected pain and heavy vaginal bleeding- and their experiences of needing further medical interventions for these. Other studies found that the women they spoke to felt that having a CS limited their ability to mother their baby (Fenwick et al., 2009; Bayes et al., 2012b; Lewis et al., 2014). Often women feel unprepared for the challenges they faced and that communicating with health professionals during the postpartum period was problematic (Liamputtong and Watson, 2006; Fenwick et al., 2009; Kealy et al., 2010).

In terms of the process of decision making, the studies identified a wide variation in women's accounts. Some felt they had experienced directive counselling and had no choice, particularly if they were seeking care outside of clinical guidelines (Kennedy et al., 2013). Certain medical indications for CS were seen as indisputable by women (Bryant et al., 2007). Tully and Ball (2013) found that breech presentation was perceived as a firm medical indication for CS by women, although they may see it as a last resort. Other women report feeling fully involved in decision making (Lewis et al., 2014). If women seek a planned CS they may feel the need to defend their decision to others because of negative social attitudes towards CS (Tully and Ball,

2013). After they have had a CS they may feel excluded socially by other mothers who have had a vaginal birth (Fenwick et al., 2009; Bayes et al., 2012a).

In conclusion, women's attitudes towards breech presentation, ECV, VBB and planned CS have been explored in only a small number of qualitative studies. Few of these studies examined women's actual experiences of the interventions in any detail, instead focusing on decision making and their attitudes and beliefs about them. Therefore, there is little experiential data to support future women making decisions.

2.3 Decision aids in obstetrics

The aims of this review were:

- To identify and critically appraise all randomised controlled trials evaluating PDAs for pregnant women
- To examine the effects of using PDAs on a range of decision making process, clinical and psychosocial outcomes

At the beginning of this study, little was known about the potential benefits or risks of pregnant women using PDAs. With my supervisors, I published the first systematic review of PDAs for pregnant women, undertaken as background work for this study (Say et al., 2011). Since then three further systematic reviews have been published, reflecting the growing interest in SDM in maternity care. Two examine PDAs for any decision in pregnancy (Dugas et al., 2012; Vlemmix et al., 2013b). Horey et al. (2013) examine PDAs for women making decisions about vaginal birth after CS.

In preparing this updated review for my thesis, I undertook a further electronic literature search targeting citations about PDAs for pregnant women (key words: decision support techniques, shared decision making, pregnancy, parturition, prenatal diagnosis). I searched Medline, Embase, Google Scholar, the Cochrane Library and the Medion database from February 2011 until October 2015. The reference lists of primary and review articles were examined to identify cited articles not captured by electronic searches. As for my original systematic review, eligibility criteria included randomised controlled trials which reported on PDAs for pregnant women facing any treatment decision, published in English. Studies evaluating health education material which did not address women's values and preferences were excluded.

PDA's are available to support pregnant women making a range of different decisions including prenatal testing, vaginal birth after CS (VBAC), pain relief in labour and ECV (Say et al., 2011; Dugas et al., 2012; Vlemmix et al., 2013b). They appear to have the potential to improve maternity care as their use is associated with a number of positive effects including reduced anxiety, lower decisional conflict, improved knowledge, improved satisfaction and increased perception of having made an informed choice. However, the reported effects are not consistent between studies (Say et al., 2011). Meta-analysis of these studies is challenging, as there is heterogeneity in the primary outcomes used. Both Dugas et al. (2012) and Vlemmix et al. (2013b) demonstrate that PDA use reduces anxiety but their other results were not consistent¹. Vlemmix et al. (2013b) demonstrate a reduction in decisional conflict (mean difference -3.66 (95% CI -6.65, -0.68) p=0.016), which was not found by Dugas et al. (2012), and improved knowledge (mean difference in knowledge score 11.06, 95% CI 4.85, 17.27). Dugas et al. (2012) state that they were not able to perform a meta-analysis for knowledge because of the heterogeneity in outcomes measures used. The differences between these two studies are likely to reflect differences in the studies they included and possibly the statistical techniques used. Horey et al. (2013) found that use of PDA's for VBAC was associated with lower decisional conflict (standardised mean difference -0.35, 95% CI -0.47 to -0.02) and improved knowledge (standardised mean difference 0.74, 95% CI 0.46 to 1.03).

Consistent with a systematic review of PDA's in all clinical areas (Stacey et al., 2014), PDA use has variable effects on the actual decision made. PDA use by pregnant women may not impact on intervention rates but further research is needed to clarify this. Other possible explanations include: that the trials were not sufficiently powered; that high quality information was provided to women in control groups; that women have high baseline knowledge; that effects depended on the acceptability of interventions; or the timing of delivery of the PDA (Say et al., 2011).

¹ Dugas et al demonstrated a mean difference in anxiety scores of -0.18, 95% CI -0.25, -0.12 and Vlemmix et al a mean difference of -1.59, 95% CI -2.75, -0.43

At present there appears to be no ideal primary outcome for evaluating PDAs. The Decisional Conflict Scale measures uncertainty and includes a subscale which measures 'perceived effective decision making' (O'Connor et al., 2009). While this provides a numerical score which is useful for comparing between groups and has been found to be reliable and sensitive to change, it is limited by lacking clinical applicability and does not consider whether patients' choices match their values and preferences (Say et al., 2011). Uptake rates for interventions are also limited as a primary outcome as they do not discriminate between 'warranted' and 'unwarranted' variations in practice (Sepucha et al., 2004; Sepucha and Mulley, 2009). Unwarranted variation results from care being less evidence-based whereas warranted variation results from patient-centered care where clinicians and patients choose the most appropriate treatments for individual patients (Sepucha et al., 2004; Sepucha and Mulley, 2009).

A range of different formats have been used for PDAs for pregnant women including: computer-based PDAs, paper-based PDAs and films (Say et al., 2011; Dugas et al., 2012; Vlemmix et al., 2013b). The most appropriate type and format for PDAs for pregnant women is not known.

While the potential benefits of PDAs for pregnant women can be demonstrated in research setting, little is known about implementing them in routine clinical practice. Rees et al. (2009) explored healthcare professionals' views on two computer-based PDAs for women considering VBAC. While the majority of health professionals interviewed were positive about the PDAs, they identified potential barriers to routine use including service issues, communication issues and personality issues.

Having considered PDA use by pregnant women in general, I will now discuss the only previously available PDA for women with a breech baby. Nassar et al. (2007) evaluated a PDA for women considering ECV which consists of a 24 page booklet, 30 minute audio CD and worksheet. Women who used the PDA had higher knowledge scores, lower decisional conflict scores, were more satisfied with the amount of information they had been given and were more likely to state they intended to have an ECV. There was no difference in the proportion of women actually choosing ECV, or in anxiety levels. This was a well-conducted study with appropriate randomisation and intention-to-treat analysis. However, although antenatal staff were

blinded, women were not, which may have influenced the results, particularly of outcomes such as satisfaction.

While the results of this study seemed promising, there are a number of limitations to the PDA which means it is not fit-for purpose for UK women. For example, it did not contain information about VBB and contained practical details regarding the process of ECV and aftercare which were not applicable in the UK. Also, development did not include an initial assessment of what women and health professionals needed to support the decision making process. As it was designed for use with Australian women within the Australian health system, generalisability of the results of the trial may also be limited. Furthermore, as part of background work for this study, I showed the PDA to obstetricians and midwives in two hospitals in north east England. They felt it could not be adapted for local use perceiving that it was too long, too complicated, culturally inappropriate, biased in favour of CS, lacking information about VBB and lacking a demonstration of ECV (unpublished data).

In conclusion, development and evaluation of PDAs for pregnant women is an evolving field. Promising effects of using them, such as increased knowledge, reduced decisional conflict and reduced anxiety, suggest that implementing PDAs in routine practice may improve maternity care. This is supported by wider research into the benefits of PDAs. However, results are inconsistent as the studies in pregnant women involve heterogeneous PDAs and outcomes so further research is needed. At present PDAs only exist for a limited number of decisions in pregnancy and those developed in other countries may not be suitable for use in the UK.

2.4 Conclusions

Having reviewed the literature about the management of breech presentation; women's attitudes towards ECV, VBB and planned CS; and PDAs for pregnant women, a number of key questions have arisen or remained unanswered. Whilst high quality evidence exists to support women making decisions about breech presentation little is known about what sorts of information women themselves value or what information clinicians routinely provide. The evidence is complex and it may be hard for both women and clinicians to understand. Little is known about women's attitudes towards and experiences of ECV, VBB and planned CS. A small body of

qualitative research has addressed these but the studies all had different research questions and many had significant methodological limitations. Research suggests that using PDAs may have a number of beneficial effects for pregnant women. One PDA exists for decision making about ECV but does not address VBB at all and was designed for use by women in the Australian healthcare system. Little is also known about what type of PDA women prefer. This thesis aims to address these unanswered questions and describe the development of a PDA for pregnant women with a breech baby. The aims and objectives of the present study on which it is based are listed in Chapter 3.

Chapter 3. Methodology and Methods

3.1 Aims and objectives

This was a qualitative study which aimed to understand the experiences of women who had a breech baby at the end of pregnancy; explore the processes of decision making about breech presentation from both women's and health professionals' perspectives; and develop a PDA for future women facing these decisions.

The objectives of the study were:

- 1 To explore women's attitudes towards and experiences of decision making about breech
- 2 To understand the sorts of information women and healthcare professionals view as important to underpin decision making about breech
- 3 To describe women's values which affect decisions about breech
- 4 To explore women's attitudes towards and experiences of ECV, VBB and planned CS
- 5 To develop a PDA for pregnant women with a breech baby addressing ECV, VBB and planned CS

3.2 Introduction

In this chapter, I address the theoretical and practical issues involved in conducting the research, describing the methodological standpoint which I chose and documenting the processes of fieldwork and data analysis. I detail my methods alongside a reflexive account of the challenges I experienced during fieldwork and the changes I made to my original research plan in order to address them. I also present a critique of the methods used. I begin by explaining the feminist methodology I employed and discussing anticipated ethical issues. Next I discuss the processes of data collection and analysis, starting by describing the research setting and sampling and recruitment issues. I then introduce the respondents in the study. I chose to use three methods of data collection - observed consultations, interviews and design workshops – which I describe and scrutinise. After that I document the process of data analysis. Finally, I discuss the methods used to develop decision support after data collection was complete.

3.3 Theoretical perspective: a feminist methodology

Feminism is a collection of social and political movements which seek to obtain equal rights for women. While all feminisms are similar, in that they focus on the oppression of women, they are different in their philosophies and ways of challenging oppression (Campbell and Wasco, 2000). Historically, feminism is divided into three stages commonly referred to as 'waves' (Gillis et al., 2007 p21-34). While some feminists reject this classification as too reductionist (Gillis et al., 2007), I believe they provide a useful model to contextualise my decision to employ a feminist methodology. First wave feminists in the nineteenth century responded to the exclusion of women from politics as well as social and public life (Gillis et al., 2007). They fought successfully to extend the role of women as citizens, for example women's suffrage, as well as raising awareness of women's oppression at work and in the home (Gillis et al., 2007). Second wave feminists in the 1960s and 1970s focused on social relations, challenging the oppression of women in their roles as biological reproducers, mothers and domestic labourers (Gillis et al., 2007). They also challenged sexual violence and fought for women to express their sexuality more freely (Gillis et al., 2007). Second wave feminists also contributed to social movements advocating peace and opposing racism, focusing on the effects of these issues on women (Gillis et al., 2007).

Third wave feminism is a contemporary phenomenon which seeks to develop feminism beyond the second wave to reinvigorate debates around equality and attract a new generation of feminists (Gillis et al., 2007). For example, addressing unequal pay or unequal attitudes towards sexual morality (Walter, 2010). Many third wave feminists seek to draw attention to the differing experiences of women in a particular society (for example, women in different social classes) or between societies (Gillis et al., 2007). In this way third wave feminism is influenced by, and has contributed to, postmodernism (opposing essentialism and the concept of a single reality for women) and poststructuralism (focusing on power relationships and how these are constructed by and for women through various discourses) (Letherby, 2003).

The methodology I have chosen and will go on to discuss is influenced most significantly by postmodern feminism and I identify myself as a third wave feminist. First, I want to acknowledge the influence of second wave feminists who challenged

the oppression of women in their roles as reproducers and mothers, by a paternalistic, and at times misogynistic, healthcare system (Oakley, 1980; Davis-Floyd, 2003b). Second wave feminists also criticised biomedical and social science research for being dominated by a male agenda (Letherby, 2003; Oakley, 2005). They contrasted the objective, detached, rational and institutional knowledge which many positivist biomedical and social scientists sought to produce with the subjective, involved, emotional, everyday knowledge which they were interested in (Edwards and Ribbens, 1998; Letherby, 2003). I believe this remains relevant to the study of pregnancy and childbirth as during these experiences women function both as ‘biological reproducers’ and as ‘social people’ (Oakley, 2005 p155). This means that whilst they may benefit from advances in biomedical research, they are also disadvantaged by the lack of attention given to their social and emotional experiences by researchers and healthcare professionals.

When I began this study I was a woman doctor training to be a consultant obstetrician and gynaecologist and a clinical academic. I was grateful for the progress that had been made by feminists (and others) in our society which had enabled me to take on these traditionally male roles. Nevertheless, I believed that the UK healthcare system remained paternalistic and wanted to contribute towards achieving more woman-centred care, by helping to develop understanding of women’s experiences of pregnancy and childbirth. This led me to choose a feminist methodology. Whilst undertaking this research I experienced pregnancy, birth and becoming a mother myself and I met a lot of other pregnant women and new mothers who shared their accounts of maternity care with me. All of these experiences further reinforced my belief that all women are entitled to respectful healthcare during pregnancy, birth and beyond. I also renewed my commitment to trying to improve the current UK system which sometimes fails to protect women’s rights to dignity, autonomy and equality (Birthrights, 2015).

Cook and Fonow (1986) defined five epistemological components of feminist research which have influenced my own stance (Figure 1).

- 1 Continuously and reflexively exploring the significance of gender relations in social life including the conduct of research
- 2 The importance of consciousness-raising
- 3 The need to challenge traditional constructions of subjectivity and objectivity
- 4 Concern with research ethics
- 5 Emphasis on empowering women and transforming patriarchy

Figure 1 Epistemological components of feminist research (Cook and Fonow, 1986)

Reflexivity is key to many of these epistemological components. By reflexivity, I mean the examination I have made of my own position in my research experience, including the decisions I have made throughout the processes of data collection and analysis as well as my interpretations of my data (Charmaz, 2006). Reflexivity is important to all qualitative researchers and, thus, is not unique to feminist research. However, as a feminist researcher I have used reflexivity to consider gender and power relationships throughout data collection and analysis.

Methods are the techniques used to carry out research; for example semi-structured interviews are a method of data collection. There are no distinct feminist methods; rather feminist researchers seek to employ the most appropriate methods to meet their objectives and acknowledge that all methods can be used in a 'pro-feminist or non-feminist way' (Letherby, 2003 loc 119 (5%)). When selecting methods I reflected on how respondents would be positioned during data collection and analysis and chose methods that ensured that women themselves would be at the centre of the design process for the PDA. For example, by choosing a human-centred design process I focused on women's needs and ensured they were partners in the design process (British Standards Institution, 2010).

Consciousness-raising involves reflexively examining the effect of the research process on both researcher and respondents (Cook and Fonow, 1986). Feminists have drawn attention to the potential dilemma of women studying women having acknowledged the potential for researchers to oppress the people they research (Letherby, 2003). Consciousness-raising seeks to limit this oppression by drawing attention to any inequalities as they arise (Cook and Fonow, 1986). I have therefore critically examined my role in the design and conduct of the study; addressed how conducting the research impacted on me; and how the design of the study potentially impacted on respondents. For example, I discuss below the impact of professionals presenting me as an obstetrician to women during observed consultations may have had on antenatal interviews. A further example is how I reflect on how my own pregnancy impacted on data collection and analysis. Even if I did not talk about it directly during interviews or workshops, my pregnant body will have showed respondents that I also had experience of pregnancy. This may have affected their willingness to share their experiences with me. I also found analysing data about pregnancy loss more distressing after I lost a pregnancy myself.

By recognising the impact that both researcher and research respondents may potentially have on the study, I acknowledge that research is unavoidably a 'subjective, power-laden, emotional, embodied experience' (Letherby et al., 2013 p153). Rather than seeking to pursue objectivity (which I believe is unobtainable), I seek to constantly interrogate the impact I have on the knowledge which I am producing which I believe to be 'situated and contextual' (Letherby et al., 2013 p79). Letherby et al. (2013, p 135) described this as focusing on 'the relationship between the process and the product'. They argue for 'theorised subjectivity': accepting subjectivity in the process of research and striving to understand the complex ways subjectivity may impact on the research products (Letherby et al., 2013 p78-101). They do not reject objectivity outright, rather argue for a 'good enough objectivity' achieved by a constant reflexive interrogation of subjectivities (Letherby et al., 2013 p83-153). Thus, I also employed reflexivity to examine my own subjectivity and also sought to explore the subjectivities of research respondents. As part of this approach, I decided to write my thesis in the first person rather than the passive third person favoured by positivist researchers (see Chapter 1).

Concern with ethics should clearly be important to all researchers. Nevertheless, feminists have drawn attention to particular ethical issues such as developing non-exploitative relationships (Cook and Fonow, 1986; Cotterill, 1992). In order to achieve this I attempted to develop non-hierarchical relationships with respondents whilst remaining mindful of the limits of the researcher-respondent relationship. Cotterill (1992) suggests that researchers should take the role of a ‘friendly stranger’ who avoids exerting control over respondents but maintains awareness that the relationship exists for the purpose of the research.

Finally, the intention of the study is to empower pregnant women with a breech presentation. By aiming to facilitate shared decision making - an approach to healthcare in which professionals and patients can participate as equals and recognise each other’s complementary expertise (Elwyn et al., 2010) - the study may contribute towards addressing the power imbalances which currently exist between pregnant women and health professionals.

Thus, I have adopted a postmodern feminist relativist ontology which means I believe that reality is socially constructed and, in a research setting, specifically co-constructed by the researcher and research respondent (Letherby, 2003). Within this thesis, I enact this position by aiming to develop a rich and varied understanding of the experiences of women with breech presentation, by exploring their socially constructed beliefs and understandings of the world. I believe this account may be useful to individual women, health professionals, and academics by contributing to the understanding of how women make decisions about breech presentation, enabling comparison with and criticism of other accounts and informing the development of a PDA for women with a breech baby.

3.4 Overview of the research process

Qualitative research seeks to understand how people interpret the social world, in particular social phenomena such as behaviours and interactions, by studying them in their natural settings (Pope and Mays, 2006). I chose to collect data in three phases. Table 4 summarises the initial research plan and Table 5 summarises the fieldwork I undertook. The changes to the original research plan are described in more detail below.

I chose to observe consultations to enable me to explore the nature and content of interactions between women with a breech baby and obstetricians and midwives. I also aimed to use them to triangulate data from interviews with women and professionals (see below). I had myself been involved in many such consultations before in my clinical role and so they were useful for me to be able to examine the approach of other professionals and consider how this differed from my own.

In-depth semi-structured interviews were chosen to explore in detail the perspectives of individual women and professionals. In-depth interviews allow researchers to understand the personal context; explore specific issues in detail; and develop understanding of complex processes and sensitive subjects (Legard et al., 2003). Charmaz (2006, p27) argues that during interviews respondents have particular conversational prerogatives, which fitted with my feminist perspective, including enabling them to: be acknowledged as experts; have control over what they say and how they share their experiences; “break silences” and discuss thoughts and emotions which might be taboo in other situations; reflect on their experiences; and be treated with appreciation and empathy.

I chose to use design workshops to develop the PDA to ensure it was an iterative user-centred process and generate multiple sets of feedback on the design prototype. This approach was based on the experiences of colleagues in other successful projects, for example in developing decision support for stroke prevention (Flynn et al., 2011) and atrial fibrillation (Thomson et al., 2002; Thomson et al., 2007).

Study phase	Method	Proposed number of respondents
1	Observed videoed consultations	16 women 8 professionals
2	Follow-up semi-structured interviews	16 women 8 professionals
2	Design workshops and face-to-face feedback sessions	16 women 8 professionals

Table 4 Original research plan

Study phase	Method	Actual number of respondents
1	Observed digitally recorded consultations	7 women 5 professionals
	Digitally recorded consultations	8 women 3 professionals
2	Antenatal interviews	13 women
	Professional interviews	8 professionals
	Postnatal interviews	11 women
3	Design workshops	7 women 20 professionals

Table 5 Research undertaken for this thesis

3.5 Ethical issues

Ethical approval for the study was given by the National Research Ethics Service (NRES) Committee North East – Sunderland (reference 11/NE/0177). Two substantial amendments were notified to the Committee and approval given for the changes to the research plan described below. I chose to seek ethical approval from Sunderland Research Ethics Committee as they had approved the background research for the project, which I had completed as an academic clinical fellow (ACF). I attended the Committee meeting and gained a favourable opinion for the study after some straightforward changes to the protocol and documentation. For example, the Committee recommended I extend recruitment to women under 18 years of age who were Gillick competent.

Obtaining individual unit research and development (R&D) department approvals was a more lengthy process particularly in Unit Two where there were some major staffing changes going on in the R&D department. This meant that whilst recruitment in Unit One began in October 2011, recruitment in Unit Two could not start until March 2012. Recruitment in Unit Three began in January 2013. Recruitment in all three units finished in December 2013.

The key ethical issues which I identified in this research were:

1. Needing to be sensitive and responsive to the needs of women who might still be coming to terms with having a breech baby and being faced with the decisions required of them
2. Needing to be sensitive to the time constraints of women who were heavily pregnant or new mothers
3. The possibility of sensitive or controversial issues being discussed in interviews with health professionals
4. Consent
5. Confidentiality

3.5.1 *Needing to be sensitive and responsive to respondents*

I had previously interviewed pregnant women about involvement in decision making about breech presentation at term as part of a study which informed my NIHR

Doctoral Research Fellowship application (Say et al., 2013). As a specialty training registrar in obstetrics and gynaecology, I had experience of discussing sensitive issues with pregnant women. Had it been required I would have referred women with particular concerns to their midwife, obstetrician or general practitioner as appropriate. I informed respondents that they might not directly benefit from participation in the study. Every attempt was made to organise sessions in a responsive way to maximise the engagement of women but minimise the burden of participation (see below). I was not able to offer counselling to professionals but had it been required or requested I had the option of referring respondents to counselling services provided by the occupational health departments of each unit.

3.5.2 Consent and confidentiality

The consent processes are documented and discussed below. In relation to confidentiality, all respondents were reassured that their participation was confidential and that any data they provided would be anonymised when reported. I have changed all respondents' names but chose to use pseudonyms rather than reduce respondents' identities to a number. Information about women respondents' decisions and parity are provided but no other personal information is given to avoid them being identifiable. As breech presentation only affects 3-4% of women I felt that if I provided information about their occupation, number of previous children, marital status etc. they might be identifiable to others. As some professionals might be easily identifiable, particularly when small numbers of people were involved in delivering the breech service, to protect their anonymity I have not identified their gender. Consequently, I refer to all health professionals as women, other than in this chapter when I discuss the implications of gender on the research process. When doing this, I have taken care to ensure the respondents are not identifiable, for example no data are presented. To further protect their anonymity, I have not stated which professionals worked at which unit. I have also removed trust logos and contact numbers from the documents included in Appendices 1-3. All other identifiers (such as place names, children's names and colleagues' names) were removed from the transcripts.

Newcastle University requires that primary research data should be held for 10 years. Storage arrangements for all relevant data materials will be in accordance with the Data Protection Act 1998 and with the University Information Security Guidelines.

All paper based data is stored in a locked cabinet in a locked office within the Institute of Health and Society at Newcastle University. Electronic data is stored on file servers with password access restricted to research team members only. Audio and video recordings were securely deleted from the recording device after files were successfully downloaded to a password protected network.

3.6 Research setting

I recruited respondents in three maternity units in the north east of England. Unit One is a large research-active teaching hospital with 7500 deliveries a year and provides tertiary-level care. Women with a breech presentation are usually managed on the antenatal assessment unit. Community midwives refer women, who they suspect to have a breech baby, for a presentation scan. A specially trained midwife performs this scan and then, if breech presentation is confirmed, counsels women about ECV. Midwife sonographers perform most ECVs and women usually only see an obstetrician if they decline ECV, the procedure is contra-indicated or an attempt at ECV is unsuccessful.

Unit Two is a large research and teaching-active district general hospital with 3500 deliveries a year. Women with a breech presentation are usually managed in antenatal clinics, where they were counselled by consultant obstetricians or specialty training registrars, and on-call consultant obstetricians performed most ECVs on the delivery suite.

Unit Three is a district general hospital with 1000 deliveries a year. Women with a breech presentation are mostly managed on the antenatal assessment unit, where they are counselled by specialty training registrars, and one consultant obstetrician performs all ECVs.

3.6.1 *Negotiating access*

Negotiating access with the maternity units themselves was straightforward and achieved by liaising with the research leads in the units. I had previously worked as an ACF in Units One and Two and knew the research leads in all three units well. I had also conducted background research for this study as an ACF in Units One and Two (Say et al., 2013) and had presented the findings to both teams, so they had some baseline awareness of the study. I made contact with the leads by email or in person and, with their agreement, began seeking the relevant institutional approvals.

Negotiating access was further facilitated by the Northumberland, Tyne and Wear Comprehensive Local Research Network (NTW CLRN), after the NIHR adopted the study to its portfolio. This meant there was an incentive for units to participate. As a portfolio study it was easier to open the study in Unit Three as an additional site and I also benefited from NTW CLRN support with the administrative tasks to gain R&D approvals.

3.6.2 *Research population*

Key health professionals involved in the management of breech presentation at term were identified at each site through discussion with the clinical teams. The eligibility criteria for professionals were broad: any obstetrician or midwife involved in the management of breech presentation at term.

Women with a breech presentation were identified by the clinical teams. Eligibility criteria for women were:

1. Confirmed diagnosis of breech presentation at term
2. Age ≥ 18 or <18 and assessed as Gillick competent by the clinical team
3. Capable of giving informed consent
4. Able to read and converse in English (funding was not available for interpreters)

3.7 *Sampling*

For this qualitative study, I used non-probability sampling as the sample was not intended to be statistically representative. I chose to use purposive sampling,

meaning that I designed the sample to have particular pre-defined characteristics (Ritchie et al., 2003). I intended to use purposive sampling to choose women who made particular decisions including women who chose to attempt ECV, women who declined ECV, women who chose a planned CS and women who chose a vaginal breech birth. I also wanted to include both primiparous and multiparous women. I chose these characteristics to ensure I could explore as widely as possible the context for decision making about breech presentation and women's requirements for decision support.

Due to the difficulties in recruitment for observations at the beginning of the study opportunistic sampling was used initially. This meant taking a flexible, pragmatic approach and, at first, recruiting all women with a breech baby who were keen to take part (Ritchie et al., 2003). As the study progressed, I noted a high uptake of ECV in Units One and Two, where I began recruitment. These observations were supported by audit data and by participating health professionals who themselves reported directly counselling women during interviews (see Chapter 5). I therefore used typical case sampling to recruit women who chose to attempt ECV. Typical case sampling means selecting cases which represent average positions identified by gaining knowledge of the population being studied (Ritchie et al., 2003), in this case women who chose to attempt ECV.

As I was concerned that the high uptake rates of ECV might not be typical of UK practice, I decided to extend recruitment to another local maternity unit and aimed to identify a unit where the uptake of ECV was not so high. However, it proved impossible to select a unit on the basis of ECV uptake as none of the local units were able to provide audit data. Recruitment was extended to Unit Three in the hope that women recruited there would bring a different perspective to the study as the clinical pathway was different, with only one consultant performing ECVs.

Later in the study I was able to purposively sample to seek-out women who declined ECV and also women who chose to attempt a VBB. This was partly by taking a flexible approach, for example accepting I might not be able to both observe a consultation and undertake an antenatal interview (see below). Also, the sampling frame for postnatal interviews and design workshops included procedural logs and electronic records (see below) which meant these women could be more easily

identified. This meant I could focus on disconfirming cases by choosing women who had made less typical choices.

For health professionals I aimed to purposively sample on the basis of job, to include midwives and obstetricians (consultants and specialty training registrars). Sampling of professionals was, by necessity, opportunistic for observations, as it depended on which women also consented, and for design workshops, as that depended on which professionals were able to attend. I was able to purposively sample for interviews.

Ritchie et al. (2003) argue that key features of qualitative sampling are the requirement for diversity and that respondents should have characteristics or occupy a position of relevance to the research question. By using a combination of sampling techniques I was able to meet these requirements, as I succeeded in recruiting women who chose to attempt ECV, declined ECV, were unable to attempt ECV, chose a planned C and chose a VBB. I also recruited a mixture of nulliparous and multiparous women respondents and health professionals with a range of backgrounds.

3.7.1 Sample sizes

As qualitative research seeks to explore experiences and phenomena in-depth by the collection and analysis of “rich, substantial and relevant data”, sample sizes are determined by the likely number of respondents needed to achieve this (Charmaz, 2006 p18). This means that samples are usually small in size (Ritchie et al., 2003).

Proposed sample sizes are given in Table 4. Actual sample sizes are provided in Table 5 and an explanation of why they varied from the original plan are discussed below under the different methods of data collection. I collected data until I was satisfied it was rich and sufficient (Charmaz, 2006 p18-19). Charmaz (2006) p18-19 lists questions for researchers to evaluate the sufficiency of their data, which may be summarised as:

- Have I collected enough background data to understand the context of the study?
- Have I gained detailed descriptions of a range of respondents’ perspectives?

- Do the data expose what is going on beneath the surface?
- Can the data reveal changes over time?
- Have I gained multiple accounts of the possible actions in relation to the research question (in this case decisions made)?
- Can I develop analytical categories?
- Can I make comparisons between my data and how do such comparisons inform my interpretation of the data?

By considering these questions I was able to modify my research plan. For example, as I was concerned that antenatal interview data was limited by being unable to reveal changes over time I added the postnatal interviews (see interview critique below).

3.8 Recruitment

3.8.1 Observed consultations and antenatal interviews

Potential respondents who met the eligibility criteria were initially identified and approached by a member of their clinical team and provided with a respondent information sheet (Appendix 1). Women who were interested in participating were asked to inform clinical staff if they would be willing to have their consultation observed and/or audio-recorded. If they agreed I (or a research midwife in Unit 2) approached the potential respondent to seek consent. At this stage, the voluntary nature of participation was reiterated and it was made clear to invitees that their decision regarding participation would have no influence upon future healthcare decisions. The person seeking consent then confirmed that they had received and understood the respondent information leaflet, answered any questions and determined their willingness to proceed. All potential respondents were advised that if following participation they wanted to withdraw from the study then they could and their data would not be used. Potential respondents were offered a 24 hour period to consider participation in the follow-up interview. However, if the woman preferred and found it less burdensome to be interviewed following the consultation this was arranged.

As women who declined ECV and opted for planned CS proved harder to identify, I recruited most of these women from a pre-operative assessment clinic so it was not possible to observe the consultation when they had been counselled about options. Eligible women were identified by a research midwife or obstetrician who asked them if they would be willing to take part in an antenatal interview. If they agreed the midwife or obstetrician contacted me by telephone or email and I attended the clinic to seek consent as described above.

3.8.2 *Postnatal interviews and design workshops*

Women were recruited via two pathways. Some potential respondents were identified in hospital and were approached by a member of their clinical team and provided with a respondent information sheet (Appendix 1) and expression of interest form (Appendix 2). Women who were interested in participating were asked to advise clinical staff who then asked them to provide contact details and a preferred time to be contacted. With the potential respondent's permission their contact details were relayed to me. Alternatively women could complete the expression of interest form and return it in a pre-paid postage envelope addressed to me. I then contacted the women who provided their contact details in order to establish their willingness to participate and to arrange a suitable time for a workshop or interview.

In addition women who had had a breech presentation in the last six months at each participating unit were identified from unit procedural logs and electronic records and sent a letter inviting them to participate along with the respondent information sheet and expression of interest form with a pre-paid envelope for return (Appendices 1 and 2). I contacted all women who provided their contact details to invite them to participate in the study and, if they were interested, to arrange a suitable time for a workshop or interview. Written consent was sought at the time of the interview as described above.

Many qualitative researchers, including feminist researchers, have recommended the use of repeat interviews to collect data (Oakley, 2005). I had initially anticipated that women would only be recruited to participate in one part of the study in order to reduce the burden of participation for them. However, several respondents expressed

an interest in continuing participation so I submitted an amendment to the REC to allow for repeated participation.

3.8.3 Health professionals

I identified key personnel involved in the management of breech presentation at term at each site through discussion with the clinical teams as well as my prior knowledge of the units. Professionals included consultant obstetricians, specialty training registrars and midwives working in antenatal services. I provided potential respondents with a letter of invitation and respondent information sheet (Appendix 1) either in person or by email and then contacted them subsequently either in person or by email to establish their willingness to participate. If they indicated they did not wish to participate they were not contacted again. If they did not respond to the initial email they were prompted a second time either by email or in person. I emphasised the voluntary nature of participation and that their decision regarding participation would have no impact upon their employment. Written consent was sought as described above. To minimise over-burden I aimed to recruit different health professionals at different stages of the study. However, if a respondent expressed interest in continued participation they were recruited for subsequent stages.

3.8.4 Critique

Identifying eligible women was more challenging than expected. Women who were referred to antenatal day units with a possible breech presentation were seen at unpredictable times. Some women were referred to antenatal clinics but were often not identifiable as having a possible breech baby before they were seen and could be reviewed in any clinic so were often missed. Also, many women who were referred with possible breech presentation on abdominal palpation by their community midwife were found to have a cephalic presentation on ultrasound. This meant I spent a large amount of time attempting to identify eligible respondents. Spending time in the clinical areas was helpful in that it enabled me to raise awareness about the study and to develop relationships with clinical staff facilitating their engagement in the project. It also enabled me to spend time as a researcher in the clinical areas observing them as social worlds, rather than as my work environment.

Due to these practical challenges I had to rely on support from research midwives to assist with recruitment. Generally, this was invaluable and the research midwives were involved in identifying and approaching eligible women, distributing respondent information sheets and recruiting women for observed consultations. Nevertheless, in Unit One the clinical midwives fed back to me that there was some tension between them and the research midwives, as they perceived that the research midwives did not work as hard as them, were paid better than them, had more sociable working hours than they did and that they did not help them with clinical tasks, even when the unit was extremely busy. Hunter (2004) also described conflicting occupational ideologies among different groups of midwives and acknowledged that these differences could be a source of frustration and lead to emotional difficulty. Such conflict did appear to be a barrier to recruitment as some of the clinical midwives were open with me about being deliberately obstructive to the research midwives. In contrast, they advised that they would do “anything” to help me recruit women myself and were extremely helpful and proactive when I was recruiting potential respondents.

A further barrier to recruitment for observed consultations was that initially I had planned a 24 hour cooling off period for women to consider participation which proved to be impracticable. This was because women were usually counselled about management options at the time of diagnosis of breech presentation. Discussion with the clinical teams suggested that a better way to recruit women would be to approach them immediately prior to their consultation and give them time then to consider participation. If they agreed to their consultation being observed they could be offered further time to consider participating in the follow-up interview. However, if they were keen to participate, and it was more convenient to be interviewed at the same appointment, this was offered to reduce the potential burden on respondents. There are no fixed guidelines for the time which should be allowed for potential respondents to decide if they want to take part in the research. Guidance from the NRES suggests this should be flexible and depend on various factors such as the type of research and the views, convenience and welfare of respondents (National Research Ethics Service, 2010).

3.9 Respondents

Thirty nine women were respondents in this study (see Table 6). Some respondents participated in more than one phase of the study. All women respondents were white British and spoke English as their first language. I did not routinely collect demographic data during interviews but I learned that women respondents were all aged in their 20s-40s. They had a range of social backgrounds and occupations. Example occupations included: photographer, civil servant, accountant, stay at home mother and pole dancer. Some were married, some had long-term partners and some were single. As many of these features would make women identifiable, I have not included a summary of them in Table 6. The decisions they made, type of birth they experienced, their parity and the unit they were recruited in are summarised in Table 6.

Table 6 Women respondents in the study

Pseudonym	Phases participated in	Decisions made	Type of birth (if known)	Parity	Unit
Aisha	Antenatal interview	Not to attempt ECV and planned CS	Not known	Primiparous	One
Alison	Postnatal interview	Attempt ECV (successful)	Emergency CS	Multiparous	Two
Carly	Antenatal interview	Unable to attempt ECV due to presence of maternal antibodies and planned CS	Not known	Primiparous	Three
Carol	Observed consultation and antenatal interview	To attempt ECV (unsuccessful) and planned CS	Not known	Multiparous	One
Catherine	Design workshops x 2	To attempt ECV (successful)	Forceps	Primiparous	One
Catriona	Postnatal interview	Breech presentation diagnosed during labour so not eligible for ECV/ planned CS. VBB	VBB	Multiparous	Two

Table 6 Women respondents in the study

Pseudonym	Phases participated in	Decisions made	Type of birth (if known)	Parity	Unit
Danielle	Observed consultation and antenatal interview	Attempt ECV (unsuccessful) and planned CS	Not known	Primiparous	One
Eleanor	Postnatal interview and design workshop	Attempt ECV (successful)	Normal birth	Primiparous	One
Emily	Postnatal interview	Attempt ECV (unsuccessful) and planned CS	Planned CS	Primiparous	Two
Ellen	Recorded consultation	Attempt ECV	Not known	Multiparous	Two
Esther	Recorded consultation	Attempt ECV	Not known	Multiparous	Two
Georgina	Postnatal interview and design workshop	Planned CS	Planned CS	Primiparous	Two

Table 6 Women respondents in the study

Pseudonym	Phases participated in	Decisions made	Type of birth (if known)	Parity	Unit
Grace	Design workshop	Breech presentation diagnosed during labour so not eligible for ECV/ planned CS	Emergency CS	Primiparous	Two
Heather	Observed consultation and antenatal interview	Unable to attempt ECV due to low amniotic fluid index and planned CS	Not known	Primiparous	One
Holly	Antenatal interview	Not to attempt ECV and planned CS	Not known	Primiparous	One
Isobel	Recorded consultation	Attempt ECV	Not known	Multiparous	Two
Jane	Recorded consultation	Attempt ECV	Not known	Multiparous	Two
Katherine	Postnatal interview	Attempt ECV (successful)	Normal birth	Primiparous	One

Table 6 Women respondents in the study

Pseudonym	Phases participated in	Decisions made	Type of birth (if known)	Parity	Unit
Laura	Observed consultation and antenatal interview	Attempt ECV (successful)	Not known	Multiparous	One
Liz	Recorded consultation	Attempt ECV	Not known	Primiparous	Two
Louise	Postnatal interview	Unsuccessful ECV and planned CS	Planned CS	Multiparous	Two
Lynne	Observed consultation, antenatal interview and design workshops x 2	Unable to attempt ECV due to low amniotic fluid index Planned CS	Planned CS	Primiparous	One
Martha	Postnatal interview	Attempt ECV (unsuccessful) and planned CS	Emergency CS	Multiparous	Two

Table 6 Women respondents in the study

Pseudonym	Phases participated in	Decisions made	Type of birth (if known)	Parity	Unit
Mandy	Postnatal interview	Attempt ECV (but laboured before appointment) and VBB	VBB	Multiparous	Two
Melissa	Postnatal interview	Attempt ECV (unsuccessful) and VBB	VBB	Multiparous	Two
Michelle	Antenatal interview	Attempt ECV (unsuccessful) and VBB	Not known	Multiparous	Three
Miriam	Recorded consultation	Decision not made during recorded consultation as left to consider options	Not known	Primiparous	Two
Nina	Observed consultation, antenatal interview and design workshop	Attempt ECV (successful)	Normal birth	Multiparous	One
Pippa	Observed consultation and antenatal interview	Attempt ECV (unsuccessful) and planned CS	Not known	Primiparous	One

Table 6 Women respondents in the study

Pseudonym	Phases participated in	Decisions made	Type of birth (if known)	Parity	Unit
Rose	Recorded consultation	Attempt ECV	Not known	Not known	Two
Samantha	Observed consultation and antenatal interview	Attempt ECV	Not known	Primiparous	One
Sarah	Recorded consultation	Attempt ECV	Not known	Primiparous	Two
Sophie	Design workshop	Not to attempt ECV and planned CS	Planned CS	Primiparous	Three
Tina	Antenatal interview	Not to attempt ECV and planned CS	Not known	Multiparous	One
Yvette	Postnatal interview	Attempt ECV (unsuccessful) and planned CS	Planned CS	Multiparous	Two

Table 6 Women respondents in the study

Thirty health professionals were respondents in the study. Nineteen were obstetricians and 11 were midwives. Seventeen were employed at Unit One; 12 were employed at Unit Two and one respondent worked at Unit Three. Twenty two were women and eight were men. As discussed in Section 3.5.2, all professionals were given a pseudonym to differentiate them when presenting data. Midwives were named after colours and obstetricians after crops and features of the countryside.

3.10 Data collection and analysis

Data were collected during observed and recorded consultations; semi-structured antenatal, postnatal and professional interviews; design workshops with women and professionals; and in field notes. Data collection lasted from December 2011 until December 2013.

3.11 Phase 1: observed consultations

My original research plan was to video consultations, to obtain visual data that would enable me to gain additional insights into the clinical interactions, for example non-verbal communication, which would not be possible with an audio-recording alone. However, I had to adapt this plan as some professionals were unwilling to be videoed (see critique below). Therefore, only woman and one health professional participated in a videoed consultation. I did not realise until later that the woman had already had a scan and some initial counselling by a professional who did not want to be videoed. She had agreed to see Dr Dene for a further videoed consultation, as she herself was happy to participate. This meant that the consultation was not typical as usually a woman would not have seen another professional at this stage. For this reason, and as I had no other video data, I have excluded this consultation from my analysis.

Audio data were collected from 15 further consultations. Seven women and five health professionals participated in audio-recorded consultations which I also observed and eight further women and three health professionals participated in audio-recorded consultations which I did not observe. One midwife (Midwife Black) participated in five observations and one obstetrician (Dr Lake) participated in four recorded consultations. Consultations took place in antenatal day units (Units One and Three) and in the antenatal clinic (Unit Two). Data were digitally audio-recorded.

3.11.1 Critique

My plan to use video was an unexpected barrier to recruitment. I had assumed that it would be acceptable as videoing consultations is now common during training of health professionals and I had envisaged that respondents' familiarity with being videoed in a training context would lead them to accept it as a method of data collection. However, through discussions with midwives – informally while I was waiting to recruit women and more formally when I attended a team meeting - I learned that video is not used routinely in midwifery training. Many of the midwives were familiar with its use in primary care, either from their community placements as student midwives or from experiences of being a patient themselves. Despite its widespread use in the training of health professionals they perceived it as a component of medical training.

Furthermore, there had not been any previous research studies using video to observe consultations in this clinical setting. This unfamiliarity with video as a research tool may have contributed to some professionals' lack of trust in it. For example, despite the respondent information sheet stating how videoed data would be stored securely in accordance with the Data Protection Act, one respondent told me she was concerned she “might end up on YouTube” (extract from field notes).

A disadvantage of me directly observing consultations was that I was frequently engaged in the consultations by participating health professionals. This was particularly common in consultations between midwives and women, when the midwife would refer to me when discussing any obstetric input needed. This was a disadvantage of my being a researcher and also a registrar in obstetrics, particularly as I had also been a colleague of some of the participating health professionals. While I tried to limit any active participation, this may have affected women's willingness to report negative aspects of their experiences during subsequent antenatal interviews, if they perceived that I was part of the clinical team.

Due to difficulties identifying potential respondents (see above), I was not able to directly observe any of the audio-recorded consultations in Unit Two. This meant that, whilst I was unable to consider non-verbal communication, I did have data from consultations which otherwise I would have missed. It also meant I had data from

consultations where I was not involved directly so I could consider potential effects my presence had on the other consultations.

For practical reasons (clinical workload and the women respondents who agreed to take part) two health professionals were involved in nine of the observations. I would have preferred to have included more professionals to explore a wider range of consultation styles but at the time of recruitment these two professionals were seeing the majority of women in Unit One and Unit Two with a breech baby, so their more frequent participation was unavoidable.

3.12 Phase 2: semi-structured interviews

3.12.1 Antenatal interviews

Thirteen women participated in antenatal interviews. Nine of these respondents had also participated in an observed consultation. I had planned that all interviews would follow an observed consultation but, in order to purposively sample women who declined ECV and opted straight for a planned CS, this was not possible as these women could only be identified during their antenatal clinic appointment (see above). Also, none of the women who participated in the audio-recorded consultations in Unit Two chose to participate in antenatal interviews at a later time.

An interview schedule (Appendix 4) was developed but it was used flexibly and adapted in response to the consultation, if observed, and women's responses. The length of interviews varied from 25-35 minutes. Interviews either took place in a private space on the antenatal day unit or in a dedicated counselling room. Interviews were digitally audio-recorded.

3.12.2 Postnatal interviews

I interviewed eleven women after they had given birth. Two of these women chose to be interviewed in Unit Two, one interview took place in a clinical space and the other in an office space, determined by room availability. Two women were interviewed in meeting rooms in the Institute of Health and Society, Newcastle University. Six respondents were interviewed in their own homes and one woman responded by telephone at her request. In the hospital and university I provided refreshments and in

women's homes they all offered me a hot drink. Most respondents were interviewed with their babies present. The length of interviews varied from 35-90 minutes with most lasting around one hour. Interviews were semi-structured and I used an interview schedule but was flexible in my approach responding to the accounts which women gave.

3.12.3 Critique of interviews with women

A number of issues emerged from the process of conducting interviews with women. In relation to antenatal interviews, most women chose to be interviewed immediately following participation in an observed consultation. While this was most convenient for them – which was important for me to reduce the burden of participation for women who were preparing to give birth – it meant they had only a limited time to reflect on the experience of the consultation before taking part in the interview.

Furthermore, several women chose to be interviewed while being monitored immediately following an attempt at ECV. I believe this influenced the interview as they often appeared anxious and preoccupied by the ongoing fetal monitoring; and they appeared keen to justify their decision to have an ECV, even if it had been unsuccessful. These factors may have limited the richness of the data and respondents might have been more sensitive to their own beliefs and concerns in a more relaxed setting more remote from their experiences of ECV. In addition, all the antenatal interviews were conducted in a clinical setting, which is likely to have influenced respondents; they may have been more empowered in a more familiar and less medical setting.

In response to these concerns, I added the postnatal interviews to my research plan to enable a more detailed exploration of women's experiences and what they wanted to support decision making. This was successful and I obtained an abundance of rich data during postnatal interviews, so much so that I met Charmaz (2006) requirements for rich and sufficient data after eleven interviews (see Section 3.7.1).

During all interviews, I was open about my role as a trainee obstetrician undertaking a PhD and answered any clinical questions which respondents asked me. Thus, women's accounts of their experiences may have been affected by them knowing that I had prior knowledge and experience of managing breech presentation. My being a

doctor and a PhD student may also have affected the relationship between me and individual respondents. Richards and Emslie (2000) argue that professional background and personal characteristics impact on interviewing but that these may have varied effects and these effects vary within a particular interview. This seemed to be the case as my roles as doctor and researcher seemed to have different effects on different respondents. One respondent, who was herself a doctor, aligned us as fellow doctors and shared clinical anecdotes. Several respondents focused more on my role as a PhD student and shared their experiences of completing projects for undergraduate and postgraduate degrees, sympathising with me about the challenges of doing a research project. For example, a respondent who had completed doctoral research gave me advice about recruitment. Other women appeared more deferential referring to my 'knowledge' and two remarked that the fact that I was able to perform a caesarean section was 'amazing'. That I was a woman of childbearing age (although not pregnant during interviews) may have also affected the interviews as I was a similar age to respondents and they may have been more open with me because of this.

Respondents often chose to be interviewed with their partner or mother present. One postnatal respondent chose to be interviewed at a time when her hairdresser was styling her hair at home, which seemed particularly pertinent as several women told me their hairdresser had offered them advice about breech presentation (see Chapter 6). I did not have ethical approval to use data from these other people but they did contribute to the interviews.

3.12.4 Interviews with health professionals

Eight professionals agreed to take part in semi-structured interviews. Two of them had not participated in observed consultations but were identified as key informants by the clinical teams. Interviews took part in their offices, if they had them, or in private spaces in clinical areas such as counselling rooms or empty consulting rooms. Interviews lasted between 15 and 35 minutes. I used an interview schedule (Appendix 4) but was flexible depending on my observations and what emerged during the interview. Interviews were digitally audio-recorded.

3.12.5 Critique of professional interviews

All except one professional respondent were known to me before the study, so I was aware that I was interviewing colleagues and that my past identity as a specialty training registrar was likely to influence the content of the interview (Charmaz, 2006). As with women, participating professionals responded to me in a variety of ways. Mindful of the traditional power relationships between obstetricians and midwives criticised in the feminist literature (Oakley, 1980; Oakley, 1984), I considered the effect my role as a trainee obstetrician might have on midwife colleagues. However, the difficulties I experienced recruiting professionals for videoed consultations, and the conversations I had with colleagues exploring them, reassured me that potential respondents did not feel under pressure to participate and that they were able to voice their concerns with me.

I did experience more negative responses from a minority of obstetricians. One male consultant told me he thought my PhD was 'boring'. On a second occasion, when I was on the assessment unit recruiting, he asked me what I was doing and when I advised I was 'doing fieldwork' he told me it 'sounds like you're on a Geography school trip'. I felt that these comments were deliberately undermining. Another male obstetrician who participated asked me to undertake the interview with him in his office in the presence of another consultant colleague. I felt quite intimidated by this dynamic, particularly as he made it clear he was trying to patronise me at times.

Qualitative researchers have noted challenges in interviewing health professionals, such as difficulty accessing their underlying beliefs due to them being experienced in presenting themselves in public (Pope and Mays, 2009). This may have been an example of this or it might have reflected the imbalance of power between him as the powerful male consultant and me as the less powerful female trainee.

Most professional respondents made it clear that they were very busy and most of these interviews were interrupted by other colleagues or by them responding to their telephone or on-call bleep. This made interviews disjointed and I sometimes felt pressured to finish them sooner than I might have liked. Respondents also took it for granted that I understood clinical pathways or departmental politics so I had to

consciously ask more questions to explore these issues and this was occasionally challenging, particularly if a respondent was critical of other colleagues.

3.13 Phase 3: design workshops

During the course of the project I developed a new collaboration with Dr Madeline Balaam, Lecturer in the School of Computer Sciences, Newcastle University. This meant that the design team I will refer to below consisted of Dr Balaam (MB); Mr Dan Nesbitt (DN), PhD student School of Computer Sciences, Newcastle University; my supervisors Prof Exley (CE), Prof Robson (SCR) and Prof Thomson (RT); and me (RS).

Dr Balaam provided guidance on adopting a user-centred design process, which meant revising my original research plan. At the beginning of the design process it was unclear how technology could best support women. Consequently we designed a series of different design activities to further explore women's experiences and how technology might best support the decision making process, based on the British Standard 'Ergonomics of human-system interaction – part 210: Human-centred design for interactive systems ISO 9241-210:210' (British Standards Institution, 2010). This guideline sets out six principles of human-centred design summarised in Figure 2:

- The design is based upon an explicit understanding of users, tasks and environments
- Users are involved throughout design and development
- The design is driven by and refined by user-centred evaluation
- The process is iterative
- The design addresses the whole user experience
- The design team includes multi-disciplinary skills and perspectives

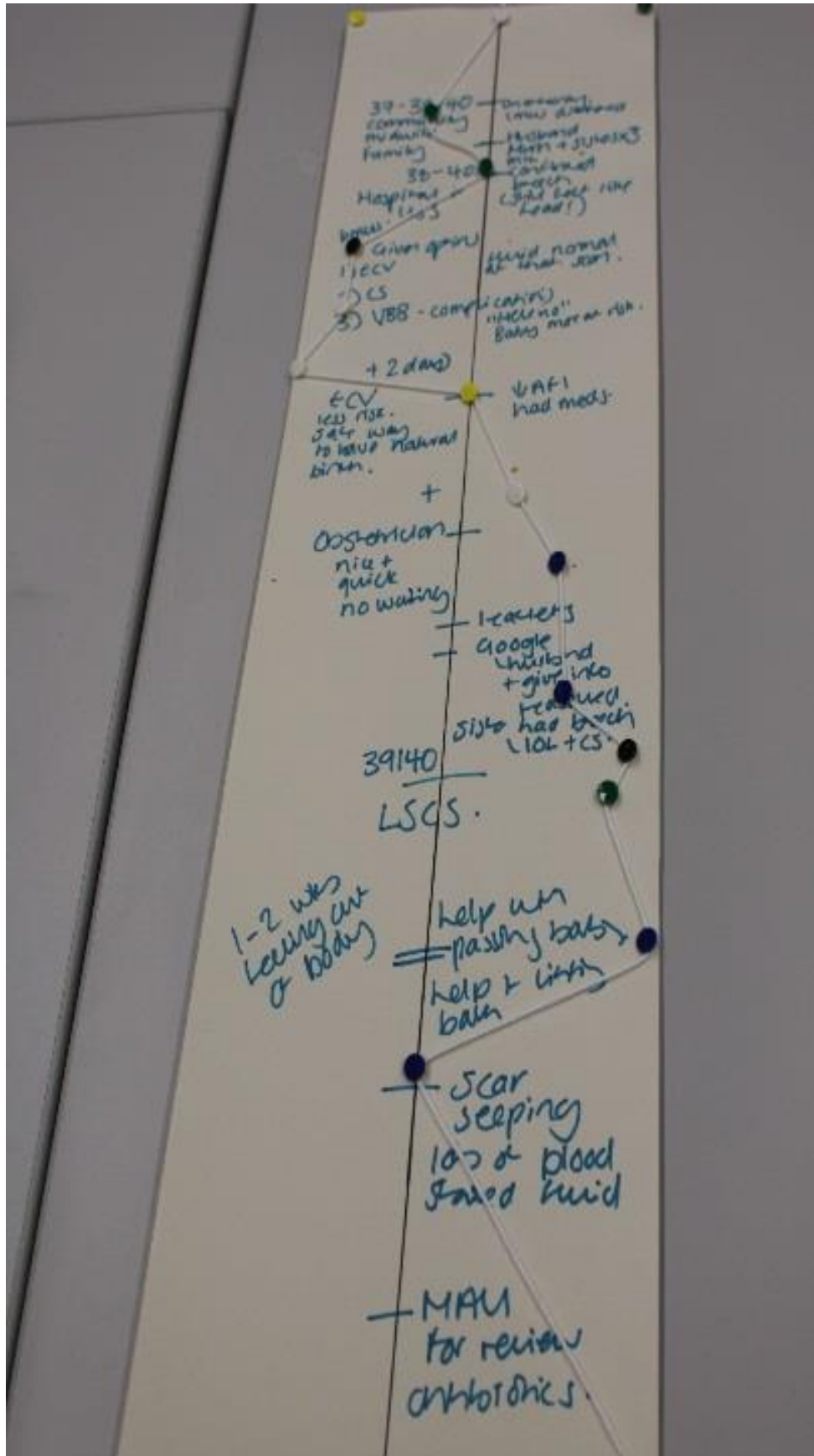
Figure 2 Principles of human-centred design (British Standards Institution, 2010)

Hence, the aim of the design workshops were to ensure that women's needs were correctly understood before any software development began and also to enable a richer exploration of how technology might be useful by not restricting respondents to particular design ideas.

Design workshops were informal small group or one-to-one sessions which used creative activities to stimulate discussion about women's experiences of breech and needs to support decision making, as opposed to a list of questions such as the interview schedules used in Phase 2. These sessions addressed the possible forms of PDA, the content of the PDA, the level of complexity of information women seek, and how and where a PDA should be delivered. Photographs of examples of the outputs from the workshops are shown below. The design activities included:

1. **Creating a timeline of events during pregnancy (Photograph 1).** Women were asked to share key events at every stage of their pregnancy and talk in-depth about these experiences. The aim of this activity was to gain a richer understanding of respondents' experiences of pregnancy and to explore how these experiences later impacted on decision making about breech presentation.
2. **Mapping the emotions experienced along this timeline (Photograph 1).** Respondents were asked to use a piece of string or a written line to demonstrate, and talk about, the emotional ups and downs they had felt throughout their pregnancy and during the birth.
3. **Identifying the key people who were involved in supporting decision making (Photograph 2).** Respondents were asked to consider who had supported them or provided them with information during decision making and write the names of these people or resources on paper leaves to stick on to a decision tree. As they named them, women were asked to explain how that particular person or resource had helped them.
4. **Identifying key information which influenced decision making and adding that to the pregnancy timelines (Photograph 1).** Respondents were asked to recall key information which had helped them make a decision, explain where and when they had found that information and discuss how they had used it to help them to make a decision.
5. **Using a "magic ball" to explore how technology could best help women at various point of the decision making process (Photograph 3).** Respondents were presented with four scenarios and asked how technology might help them at each point. They were given a glass paperweight to use as a magic ball to encourage them to think creatively and not be constrained by existing

technologies, or what they thought was possible, whilst they were discussing each scenario. Thus, the magic ball was meant to represent the ideal technology for them. As well as being a physical prompt, using a representation of a magic ball also helped break the ice in workshops as women usually responded to it with humour and enthusiasm. The first of the four scenarios respondents were presented with was performing an Internet search about breech. Women were asked how a magic ball could help them work through all the information they had found, for example, how it might help them choose what to look at. The second scenario was evaluating and using information they had found. Respondents were asked to consider how a magic ball would help them decide whether or not to use the information they had found, for example how it could help them decide how trustworthy a particular source was. The third scenario was preparing for a consultation. Women were asked to consider how a magic ball could assist them in preparing for an appointment with a doctor or midwife, for example, how it could provide them with other information or support they would have liked to have had at that stage. The final scenario was sharing information with a health professional. Respondents were asked to consider how a magic ball could help them share and discuss the information they had found with a doctor or midwife, for example, identifying what technologies might be needed in a clinic to achieve this.



Photograph 1 Example of a timeline with emotional mapping (writing is mine to protect anonymity)



Photograph 2 Example of a decision tree (writing is mine to protect anonymity)



Photograph 3 The magic ball

Seven women participated in design workshops summarised in Table 7. Lynne and Catherine both participated in two rounds of workshops. Nina, Lynne, Georgina and Eleanor had previously participated in the study (see Table 6). Workshops varied in length from 45 minutes to 115 minutes. As the design team was satisfied by the quantity and quality of data obtained, it was decided that these were sufficient to design a prototype of the PDA and so no further workshops with women were needed.

Workshop	Respondents	Facilitators	Design activities
1	Catherine, Nina	RS, MB, DN	Timeline, tree
2	Sophie	RS, DN	Timeline, tree
3	Grace, Lynne	RS, MB	Emotional mapping
4	Georgina	RS, MB	Magic ball
5	Catherine	RS	Magic ball
6	Eleanor	RS, MB	Magic ball
7	Lynne	RS, MB	Magic ball

Table 7 Summary of design workshops with women

Twenty professionals participated in two design workshops, one held at Unit One and the other at Unit Two, both facilitated by me. Professionals from Unit 3 were invited to either session, as so few individuals were involved in managing breech presentation in that unit, but none chose to attend. During these sessions I used a storyboard, a form of low-fidelity prototype, to stimulate discussion and evaluation of working practices and how these practices might be impacted by the digital tool (see Picture 1). Discussion focused on: the form of decision support, the timing and place for delivery, facilitators and barriers for using the resources within existing care pathways, the appropriateness and feasibility of decision support and potential benefits and problems with using the tool. Professionals were also asked to appraise a list of facts and values about breech presentation developed from a review of the literature and from observations and interviews. The workshops lasted 40 and 110

minutes. Again the design team was satisfied by the quantity and quality of data obtained and agreed that no further workshops were needed.



Picture 1 Example picture taken from storyboard

3.13.1 Critique of design workshops

As potential women respondents were all new mothers, some who had older children as well, and some women had returned to work, it proved impossible to arrange workshops with more than two respondents present. For the first workshop I was able to recruit five women but unfortunately one woman later telephoned to withdraw from the study and two women did not attend. Recognising the practical issues involved in participating in workshops for mothers, I tried to arrange workshops flexibly and responsively to respondents' needs and encouraged women to bring their children.

However, having small numbers of respondents in each session may have limited the ability of the data to explore the social context and for women to discuss differences in their views between themselves (Lewis, 2003). However, it did mean that women gave rich and detailed accounts of their experiences during workshops. I felt the creative design activities facilitated exploring their perspectives and that these might be useful tools even outside of a design setting.

Whilst facilitating workshops, both MB and I were pregnant. This may have impacted on workshops as, although neither of us had breech babies, respondents may have identified with us and viewed us as potentially similar to them.

Professional workshops were well attended but, as during interviews with professionals, some obstetricians spoke condescendingly towards me during the sessions, for example, when expressing their cynicism about SDM. After the interviews I was prepared for this, but as I was myself pregnant at the time I felt undermined by such behaviours and concerned at how reluctant some professionals were to recognise the expertise women have about their own bodies. I noted that trainee obstetricians and midwives were much more supportive.

Unfortunately, no one else from the design team was able to co-facilitate the professional design workshops as there was little flexibility with the dates for these. They had to coincide with audit events when clinical sessions were cancelled to enable professionals to take part as potential respondents advised they would not want to participate in their own time. Having another facilitator who was not an obstetrician may have altered these dynamics.

Nevertheless, being aware of these attitudes and considering how they might prove challenging when implementing the PDA was useful.

3.14 Practicalities of data analysis

I analysed data using the constant comparative method, which is a detailed and systematic approach which aims to generate theoretical principles which are ‘integrated, consistent, plausible and close to the data’ (Glaser, 1965 p436-445). The constant comparative method involves data collection and analysis occurring concurrently as an iterative process (Charmaz, 2006). This enabled me to explore unanticipated topics or issues raised in early data collection in further detail in subsequent fieldwork and analysis. For example, I became interested in exploring how women reconciled different sources of information about breech presentation which they have reported seeking-out. Thus, I continued to explore new themes brought up by respondents in a flexible way.

Observations, interviews and workshops were transcribed verbatim as soon as possible by either a clerical colleague in the Institute of Health and Society, Newcastle University or by a professional transcription company. I checked the accuracy of all transcripts and corrected any errors. I then rechecked the transcripts against the audio-recordings. Preliminary analysis began during the checking of the transcripts as I highlighted parts of the transcripts and made notes.

I then undertook further analysis as soon as possible. This involved familiarisation with the data through reading and re-reading the transcripts and, initially, coding the data into as many themes as possible. I coded the transcripts line-by-line, categorising each line with a short

name which summarised the data. Initial codes were: ‘provisional, comparative and grounded in the data’ (Charmaz, 2006 p48). Following Charmaz (2006), I initially coded using gerunds focusing on actions and processes, and staying close to the data using respondents’ words when possible (see Figure 3 for an example).

In the next stage of coding, I further organised the data by identifying the most significant codes, integrating similar codes and rewording codes when appropriate. I compared data to identify similarities and differences, both within individual respondents’ accounts and between different respondents. As data collection and analysis continued early themes were integrated into categories to organise the data, using respondents own words as codes when possible (see Figure 4 for an example). I focused on actively seeking out respondents to refute the emerging analysis, in order to ensure the validity of my conclusions. As well as this detailed analysis, for the purposes of developing the PDA and, in particular when writing the film script, a more pragmatic thematic analysis was undertaken concurrently to identify key recommendations respondents made.

35	B	Yes, so it's changed your plans a little bit, but you seem to	
36		coping with it very well. What did you know about breech	
37		presentation, before you came to the hospital?	
38	D	Well, what I <u>heard</u> about breech presentation was probably	
39		based on like Dickens' novels where it is a terrible thing and the	Being a terrible with)
40		woman dies in labour (laughs) because in the past I think if	
41		someone went into labour and <u>was breech</u> it was really bad,	being really bad
42		because they were <u>unprepared</u> for and they didn't know and it	being unprepared Not making bawgwa, bawea.
43		tends to be quite bad. Today, I don't think it's such a big deal,	Contrasting + pa &
44		but it is still <u>not something I really want to go through</u> and it's	Being something she doesn't want to go through
45		probably all the <u>connotations</u> attached to breech from the past.	connotations of breech
46		You know you hear people saying it was a breech birth, it was	hearing people say)
47		<u>horrendous</u> , it resulted in a caesarean in the end anyway, so	horrendous requiring CS anyway (concs).
48		things like that kind of <u>make me very cautious</u> .	making me cautious (being wary)

Figure 3 Line by line coding using gerunds

53 And they wanted to admit us at one point, and I let them [Yeah], for like *let them*

54 about three hours and I was like, "Right, I want to go home now." [Yeah]

55 But the doctor came that night, and one of the doctors said that she *directing*

56 thought it would be best if I'd let them turn him [Yeah], like I tried to. But *concerns*

57 I was worried that if I did let them try and I ended up having an *worried about*

58 emergency section [Yeah], and I think with my history as well, I know *hx*

59 what emergency sections are like. I've seen one in theatre [Yeah] and it's *experience*

60 kind of like a bit more dramatic than the planned section was [Yeah]. *Not dramatic*

61 So all of these things put together made us just think I'm, I didn't have *didn't have*

62 any other kids at home [Yeah]. I knew I would have help for the first six *knew would*

63 weeks [Yeah], I knew I wouldn't have to lift a finger, do anything other *have help*

64 than look after the baby [Yeah]. So that just pointed us more in the *Rational*

65 direction of a section [Yeah] than anything else. *for decision.*

doctor said ECV

had support

Figure 4 Coding using emerging themes

3.15 Developing the decision support

Based on the qualitative data collected a PDA was developed consisting of a website and animated film.

3.16 Website

Following the completion of the design workshops, MB produced a series of prototypes which were reviewed and refined by the research team. As per the British Standard ISO 9241 (British Standards Institution, 2010), this enabled MB to make her design ideas more explicit and explore several possible ideas. Unfortunately, due to time constraints, we were not able to share these early prototypes with respondents but refined them on the basis of my emerging analysis. This means that a user-centred evaluation is still required (see Chapter 8) as this could not be carried out in the timeframe of my doctoral research. The research team discussed these prototypes in the context of my analysis and chose one which was developed into the website (breech-decisions.ncl.ac.uk). Please see subsequent four chapters for discussion of the content of the website.

3.17 Animated film

The script for the animated film was developed in collaboration with Ellie Land, the film director; Siobhan Fenton, film producer; and Bridget Deane, script consultant. The role of the script consultant was to ensure that, while the script was grounded in data from this study, it also had a believable conversational tone. The design team was able to provide feedback at various stages including: the script; the animatic (a series of images and early animation displayed in sequence with the script read by one voice); early versions of the film with the script acted but the images not fully animated; and the fully animated film. Most of this work was undertaken whilst I was on maternity leave so, although it took several months, there was insufficient time after my return to work to seek feedback from respondents on the early stages.

3.18 Chapter summary

In this chapter, I have described my theoretical standpoint and discussed the methods which I used. I have presented a reflexive, critical account of data collection and analysis. In the next four results chapters, I will include representative excerpts of data to allow readers to scrutinise my interpretation of the data.

Chapter 4. Breech: diagnosis, searching for information and seeking support

In this chapter, I explore the diagnosis of breech presentation and how women search for information and support, at home and in hospital. These are the first parts of the process of decision making which is explored in Chapters 4-6. Following the chapter conclusions, I also explain how these data informed the development of the PDA, consisting of the website and the animated film.

4.1 Diagnosis

Breech presentation may be suspected by a healthcare professional when she examines a pregnant woman's abdomen. Assessing presentation is part of all routine third trimester examinations, when professionals also assess fetal growth and listen to the fetal heart. The results of such examinations are discussed with women and are also recorded in women's handheld maternity notes, so this information is freely available to them. Presentation is also noted at the 18-20 week anomaly scan and any subsequent ultrasound examinations a woman may undergo, reports of which are also included in their notes. This means that some women are aware their baby is, or could be, breech for a number of weeks.

I had one of those 3D scans, and she was still in the head down position then, that was at 28 weeks. But then just after that I'd gone for me midwife appointment and she'd had a feel and she [baby] had turned round and she was like that for the rest of the pregnancy... every midwife appointment I went to she was breech constantly. (Louise, failed ECV and planned CS, postnatal interview)

I actually had more scans than a straightforward pregnancy... So, I think it was... 28 weeks when I came in, I had a scan with regards to the fibroids... but then he was breech... I knew mine was breech at 28 weeks and he had really stayed breech. I could actually feel his head. (Catherine, successful ECV, design workshop)

Breech is common at 28 weeks gestation, affecting 20% of babies, but most babies will spontaneously turn, leaving only 3-4% breech after 37 weeks (RCOG, 2006b). Hence, breech presentation, suspected or diagnosed before 36 weeks of pregnancy, is of low concern to health professionals. During interviews and workshops, professionals suggested they were reluctant to provide information earlier than 36 weeks because of the likelihood of spontaneous version.

I think the problem with breech, specifically breech, is that about a third of babies are breech prior to 37 weeks, so... you're telling... one in ten women erroneously that they've got a problem, which they haven't. Their baby will be cephalic [head

down]... I don't see a tremendous downside to giving the information close to the point at which the diagnosis is made, because people do still have a little bit of time to make a decision and they come to no harm in the interim. So I'm not sure that providing the information well up front is valid in this group. (Dr Corn, professional workshop 2)

Such views are paternalistic and underestimate both the work women do to find information themselves as well as the anxiety they may have about breech presentation, which is discussed below.

After 36 weeks, if breech presentation is suspected, routine practice is to refer women for an ultrasound examination to confirm the diagnosis. This is because abdominal palpation is unreliable. Research shows that the sensitivity of abdominal palpation to diagnose non-cephalic presentation at term is 70% (Nassar et al., 2006a) and a midwife reported to me that an audit undertaken in Unit One had shown that 80% of women referred for a presentation scan were found to have a cephalic presentation (recorded in my field notes). Although no women respondents reported being told explicitly about the limitations of abdominal examination as a method of diagnosing breech presentation, many were aware that community midwives were uncertain about the presentation of their baby and that the role of an ultrasound scan was to give a definitive diagnosis.

I went to see my midwife and... she felt again and still thought it felt cephalic. But because my movements hadn't changed position she just wanted to be cautious so said, "We'll send you for a scan at 36 weeks." (Aisha, planned CS, antenatal interview)

Several respondents described how their community midwives had explained they were being cautious. During a design workshop, midwives who worked both in the community and in hospital reflected this might be because undiagnosed breech presentation was a risk management issue and would always be investigated:

It's certainly audited when it's an undiagnosed breech. So, and looked into. So, you know, that can influence that decision to send somebody for a scan. (Midwife Blue, workshop 1)

Sometimes respondents had disagreed with their midwife about their baby's presentation. Some women interviewed knew their baby was breech because of symptoms they had experienced, such as the location of fetal movements or a sensation of pressure from the head under their ribs. Danielle, for example, had requested an additional review as she was convinced her baby was breech when her midwife thought it was cephalic:

In previous appointments the midwife thought he was head down but I didn't think he was because I could feel that he wasn't. So I booked another appointment... and I said, "Can you check...?" So she checked and she said, "OK, I can't feel the head so we will refer you." (Danielle, unsuccessful ECV and planned CS, antenatal interview)

Other respondents reported that the diagnosis had explained symptoms that they had experienced. This was particularly true of parous respondents, like Melissa, who had previously had cephalic babies.

The pregnancy just felt different... I kept saying to my husband: "I think he's going to come early." Because he felt low down. But now I understand it was his legs pushing down. (Melissa, unsuccessful ECV and VBB, postnatal interview)

However, for other women, the diagnosis of breech was a surprise and caused considerable anxiety for some of them.

They [the community midwives] were all sort of saying, "Oh, your head's down,"... so I was under the impression normal birth, everything's the way it should be. And it was when she [community midwife] came back off her holidays that she was like, "Ah, I don't think so."... so I had to go to hospital... I was told by the first person in the hospital that they thought as well that the head was down and I was like, "Oh yeah, me too... I think she [community midwife] is wrong"... when they scanned me they were like, "Um, no she's breech."... That's when the panic set in I suppose. (Lynne, planned CS following decision not to attempt ECV due to low AFI, antenatal interview)

I went home that afternoon and started looking at breech births and what have you. And I was scared. I thought, "This is not something I expected to happen". (Sophie, planned CS, workshop)

Health professionals reflected that breech presentation was often an unexpected complication for women:

I think quite a few, it's never occurred to them that it might happen. I had one [woman] recently that was 39 weeks... and had come in for presentation scan and he [the baby] was breech. And it had never occurred to her that she would have to make any decisions about the delivery, it would just happen... (Midwife Indigo, professional workshop 1)

Respondents whose pregnancies had previously been low-risk reported that having a breech baby had disrupted their plans for birth. For example, some were disappointed that they would not be able to use a midwifery led unit or birth in water if their baby remained breech.

It has put a bit of a spanner in the works because I had planned to go to the birthing centre. You run it through in your head, it does a certain way, but it is

not a big problem, in the scale of things that can go wrong with a pregnancy, this is relatively minor, so you've got to roll with the punches a bit. (Danielle, planned CS following unsuccessful ECV, antenatal interview)

However, whilst disappointed, accounts such as Danielle's suggest that women perceived breech presentation was less serious than other possible complications. For example, some respondents were aware of other women who had experienced tragedy during pregnancy and birth, and suggested this gave them a sense of perspective about breech presentation:

The important thing is she got here safe and the day after she was born, my cousin lost a baby at about 25 weeks. (Martha, unsuccessful ECV and emergency CS, postnatal interview)

A few women appeared to normalise breech presentation by attributing it instead to their baby's personality, describing their babies as awkward, naughty or lazy. Other women perceived that their baby had chosen to be breech and was comfortable in that position.

I feel it's one of those things. She's breech, she's going to be awkward. So be it. (Heather, unable to attempt ECV due to low AFI and planned CS, antenatal interview)

I think she's been this way always... She just seems snug. (Tina, planned CS, antenatal interview)

Further analysis suggests that respondents believed that their babies' personalities or preference to be breech might even account for the success of ECV.

I think if you've got an active baby that's moving all the time, you give them a nudge and they'll move anyway. If you've got a baby that's quite lazy that has been stuck in a breech position for a long time, then you kind of think well that baby might not want to turn. (Nina, successful ECV, workshop)

Some women were anxious about the implications of breech presentation. For example, Aisha gave an account of her concerns about something being wrong with her baby:

I am just like: "Why is the baby breech? He [her partner] is like: "Just because he wants to be." I am like: "It might not be because he wants to be... what if there is something wrong with him?" (Aisha, planned CS, antenatal interview)

Some respondents reported that they had some knowledge about breech presentation prior to their own experience. This was usually because they had known someone else who had a breech baby:

I've got a close friend who lives nearby... And she had one that was breech and they tried to turn it, and then they disturbed the placenta so she had an immediate caesarean. I suppose that's when I probably first checked up on it. (Catriona, unplanned VBB, postnatal interview)

As discussed in Chapter 2, little previous research has explored women's attitudes to breech presentation. Founds (2007) reported that some women in her study were anxious about the diagnosis but that other women appeared not to be concerned about it. Disruption of birth plans was not a theme in her work but this may reflect the differences in expectations for birth between women in a low-resource setting, rural Jamaica, and women in the UK.

4.2 Gathering information

My data suggest that, for pregnant women, gathering information about breech presentation is a process which begins at the time the possibility is raised and continues until women have made decisions about ECV and how to give birth. During interviews and workshops, women gave accounts of how they had searched for information. They reported using a variety of resources, including both lay and professional sources (Table 8). Although diverse, this list is unlikely to be exhaustive.

Information source	Examples named in interviews
Internet sites	<p>NHS Choices (www.nhs.uk/pages/home.aspx)</p> <p>YouTube (www.youtube.com)</p> <p>Babycentre (www.babycentre.co.uk)</p> <p>Bounty (www.bounty.com)</p> <p>Babyworld (www.babyworld.co.uk)</p> <p>Facebook (www.facebook.com)</p> <p>Mumsnet (www.mumsnet.com)</p> <p>Netmums (www.netmums.com)</p> <p>Hospital websites (individual trusts)</p> <p>You and Your Baby (www.youandyourbaby.co.uk)</p> <p>Emma's diary (www.emmasdiary.co.uk)</p>
Books	<p>The Pregnancy Book (Department of Health, 2009)</p> <p>Conception, Pregnancy, and Birth (Stoppard, 2008)</p>
Television programmes	One Born Every Minute, Call the Midwife
Voluntary sector	National Childbirth Trust classes
Magazines and newspapers	Pregnancy and Birth, The Sun
Other women's accounts	Friends and relatives, more remote acquaintances, on-line forums
Health professionals	Community midwife, hospital midwife, obstetrician, friends or relatives who were doctors or midwives

Table 8 Sources of information about breech presentation

Many respondents had been given some initial information by their community midwife.

I remember she [midwife] said that the breech delivery wasn't recommended, because it could be dangerous... She said the... when they try to turn them... there was about a 50% chance of it working, but they couldn't guarantee the baby would stay that way... or he might not turn at all. And she said that the third option would be to choose a C-section which... was the safest method of delivery. (Holly, planned CS, antenatal interview)

Such information appeared to direct women towards ECV or a planned CS and some women found this directive approach unsupportive (see Chapter 5). As lots of women who are referred for a presentation scan are found to have a cephalic baby, many professionals thought information about options should not be provided until the diagnosis was confirmed, to avoid causing unnecessary anxiety for women who actually had a cephalic baby.

I think my comment on that scenario [in the workshop] means that the lady has been given potentially a large amount of information on an app before a diagnosis has been reached. That would be my biggest concern. I would usually confirm the presentation before I had the conversation with the patient about what the options are. (Dr Meadow, professional workshop 2)

Dr Meadow's account of her practice suggests that she prefers to decide when to give information to "the patient" rather than finding out what the woman would prefer, her use of language emphasising the power dynamic. This would appear to contrast with women's preference for information as most respondents reported seeking information as soon as the possibility of breech presentation was raised (see below).

A few professional respondents reported they did, or would support, giving women information earlier, partly so they could direct them to sources of information which they themselves perceived were reliable. They also suggested it should be made clear to women that abdominal palpation might be wrong.

You can really point out the number of time that it's actually cephalic when it's thought to be breech and it's obviously something you want to check out. (Midwife Blue, professional workshop 1)

Well at least you know [if you provide information], you're going to know what information they're going to get. 'Cause if they just go on Google it could be anything, couldn't it?... And somebody like her [Samantha in the scenario] would be anxious anyway so she'd want to look, wouldn't she? So she'd probably look at the wrong stuff. So it's probably just as well [to provide information]. (Midwife Violet, professional workshop 1)

In contrast to most professionals' preference to provide information after the diagnosis is confirmed, most respondents reported that they had started looking for information themselves as soon as a professional had first queried breech presentation, to find out what the implications were. Some had been frustrated that health professionals had been reluctant to provide them with information before the diagnosis was confirmed.

Well this is the funny thing. No one will actually, from a health professional side of things, no one wants to talk about it until really late on... So I think some information earlier on might have just helped, maybe even put us at ease... I know I just Googled 'breech baby after 35 weeks'. (Yvette, planned CS following unsuccessful ECV, postnatal interview)

Only a minority of respondents had not searched for information before they were referred to hospital. No one reported this was because they hadn't wanted to, rather they explained they had not had time because the referral was quick and they led busy lives. Some respondents were still working:

I'm an [profession] so I haven't had a lot of time to sit as well to look stuff up. (Heather, planned CS following decision not to attempt ECV due to low AFI, antenatal interview)

Women in this study reported that they used the internet most commonly when seeking information about breech presentation. This is consistent with previous international research, which suggested over 83% of pregnant women were using the internet to influence their decision making (Lagan et al., 2010). Respondents gave accounts of typing general terms such as "breech baby" and "ECV" into search engines, most often Google. With the breadth of information sources available to them, women had to decide how much information to search for and use, and how trustworthy it was.

'Googling' was suggested by some women to be risky as the quality of information which could be found was variable and women needed to evaluate many different sources. When exploring how they selected which sites to look at from a Google search, I discovered respondents used a number of different approaches. Some simply selected the first in the list:

I'm terrible for Googling everything really. I mean it's not always a good thing... I think sometimes you can make yourself worry more than what's needed. But again, at the same time I think it's a fantastic tool, the internet, for getting information on everything... I had looked up quite a bit... I would have just typed in "ECV" and whatever's come up, I probably would have just clicked on and had a look... from the first few. (Louise, unsuccessful ECV and planned CS, postnatal interview)

However, many respondents explained how they were keen to avoid “horror stories” (see Chapter 6) and wanted balanced and accurate information.

I think it was an American forum and it said this baby’s cord can be ripped and you know it [ECV] leads to death... And I was like: “Well what is the percentage?”... But there’s a lot of horror stories on, as well as decent information. And I think it’s just a click away if you Google it. (Melissa, unsuccessful ECV and VBB, postnatal interview)

Some respondents were also concerned that they might find complex medical information that might mislead or frighten them. It seemed that Yvette felt that doing her own research had made her feel more anxious and so she decided not to continue.

It’s the worst thing you can do, Google medical things, I think, when you’re not a medical professional. Because I was getting things back... why is a baby breech? Are they going to have these brain things, and they can have, the head’s wrong... I stopped doing it because I was probably making myself worse by looking for information myself when what I was getting back was not what I wanted to know really. (Yvette, planned CS following unsuccessful ECV postnatal interview)

She tried to discuss the information she had found about the association between congenital abnormalities and breech presentation with a junior doctor but had found her concerns were dismissed as the doctor was not aware of the link:

I can remember mentioning it to one of the doctors who we saw at the hospital and I can remember, she just said: “Oh, no. I’ve never heard of that.”... maybe I might have talked it through with the wrong person... it was pretty frightening really, just what you stumble across. So as I say, I stopped myself. (Yvette, planned CS following unsuccessful ECV, postnatal interview)

This example shows how difficult it may be for women if, by researching on-line, they come across information they are concerned about, or want more information about, but find they are better informed than the professionals they are referred to.

Several respondents stated that searching for information about breech presentation had made them worried. Even regular users of the internet reflected on anxiety they had experienced in relation to searching for information about breech options. Emily had stopped searching for information because of this. After an unsuccessful ECV, she had accepted her baby would be born by planned CS, but she suggested she had not wanted to consider the risks of the operation. Other women also gave accounts of both searching for information and making an instinctive choice.

I think as well I'd got to a point in my pregnancy where... I was reading everything... and I think I'd got to a point where I realised that sometimes reading too much can actually make you feel quite nervous. So I stopped... I was like thinking, "God this could go wrong, this could go wrong"... But when I spoke to the surgeon the day before there was a form that I filled in. They did go through it... but I think I was... just, "I just want my baby; I'm blocking it all out. I don't want to know"... I did know that there were risks... We didn't realise... even when you have a planned caesarean section things can go wrong. (Emily, unsuccessful ECV and planned CS, postnatal interview)

As respondents like Emily were aware of the potential disadvantages of using the internet to search for information, they gave accounts of the strategies they used to evaluate information and try to avoid problems. Many reported that they frequently used NHS websites, as they trusted them and valued seeing the NHS logo:

I did look on the NHS site. I tend to use that one quite a bit. That, I feel that that's a bit safe. But sometimes I would just Google and just go for it and see. And sometimes that's the worst thing to do I know. (Emily, unsuccessful ECV and planned CS, postnatal interview)

Generally, respondents were more confident in using information if they recognised and respected the source. Similarly, several respondents said they had particular sites they would actively avoid as they perceived them to be unreliable. Many respondents also reported a preference for UK sites rather than American ones.

I always avoid Yahoo answers because I think that's like teenage kids... if it ends in .gov.uk or if it ends in .org.uk it's more reliable. (Eleanor, successful ECV, postnatal interview)

Anything that looks a bit more organised and legitimate, if that makes sense? Something which is from a proper body I would always go to. I tended not to look at things which are American and stuff because I thought well they probably haven't got the same sort of stuff as what we've got in this country. What's the point of looking at that? (Martha, planned CS following unsuccessful ECV, postnatal interview)

As well as relying on the internet, many respondents also sought out information from lay people such as family and friends. They seemed used to discussing or sharing experiences of pregnancy and childbirth with female relatives and friends. Other women's experiential knowledge had been valuable to respondents throughout their pregnancies:

I'm very open with friends and family. All the gory details with me friends and me cousins and things like that. I mean, I've seen me Mam's little girl born. I was 16 and seen me sister come into the world. (Mandy, VBB, postnatal interview)

A lot of my friends have already got children so I'm one of the last ones to have them... Like I remember for the first time in my life being constipated and texting my friend and saying: "Is this normal?" Or getting piles and being like: "Do you get [them]?"... Things are more socially acceptable to talk about, like cracked nipples and toilet troubles, you just talk about it openly with your friends. (Eleanor, successful ECV, postnatal interview)

Eleanor's account suggests that, by sharing embodied experiences of pregnancy and birth, women transgress previous social norms and are able to discuss personal problems. It may be easier for women to both access and ask one another about potentially embarrassing symptoms, rather than approaching health professionals.

Some respondents had relatives and friends with first-hand experience of breech presentation. A few also discovered that they too had presented breech.

As soon as we got home... I told my Mum 'cause I didn't know that had happened with me, and then she said and I was like "Oh that's really strange that I was the same way." (Lynne, planned CS following decision not to attempt ECV due to low AFI, antenatal interview)

I spoke to me friend... about when she'd let them turn him [her baby] and there was another... someone else that I knew that had an unsuccessful ECV... a friend of a friend... she had an unsuccessful [ECV] and ended up having to have an emergency section. (Sophie, declined ECV and planned CS, workshop)

Sometimes the experiences of other women did not relate directly to breech presentation but respondents still seemed to view them as relevant, particularly their experiences of CS in general:

I have got a few friends who had babies last year. One had placenta praevia [low lying placenta] so she had an elective section. She said she had found it a positive experience, and she actually said she felt relieved, because she was so frightened of a normal delivery... I have had friends with emergency sections which didn't find it such a pleasant experience. And then the people who have obviously had normal deliveries who have said that it is positive. (Aisha, planned CS, antenatal interview)

If they did not have relatives or close friends with experience of breech presentation, many respondents tried to find other women with first-hand experiences through their existing social networks:

You go and ask other mothers how they've dealed [sic] with it... Obviously reading a leaflet you're not getting no emotion, no nothing. It's just: "This is what we'll do. You come in and they put this in you." So I really needed to ask how someone felt. (Tina, planned CS, antenatal interview)

Respondents valued the insight other women's accounts gave them into the emotional implications of the different options, and thus such accounts complemented or enhanced the factual information they also used.

Many women had also looked online for other women's accounts. They explained that they had used internet forums throughout their pregnancy as a source of reassurance and trusted advice.

I am on forums like the Babycentre and Bounty. And there is another one I use: babyworld is it? They are quite useful... I like to just chip in and type in key words, like indigestion or whatever, and see what people are saying so I think they are really good. (Danielle, planned CS following unsuccessful ECV, antenatal interview)

Some respondents acknowledged that internet forums were not always reliable sources of information (see next chapter for discussion of horror stories). Respondents acknowledged that some women using them could be unsupportive, that posts could be aggressive, and that some women could be actively trying to persuade them to choose particular options.

I was just quite surprised at the mix of responses to be honest. Some people get so angry which is what quite surprised me. Rather than being supportive of different women's choices, people were quite vicious about things actually. Things like: "Don't let them bully you into an elective section, you need to think about having a vaginal breech delivery." Things like that, and I thought well it's someone's personal decision. (Aisha, planned CS, antenatal interview)

Some respondents reported spending considerable amounts of time researching their options before they were seen at hospital. They suggested this enabled them to make decisions at home, apparently independent of interactions with health professionals. For Pippa, seeing an obstetrician in the antenatal clinic seemed to be more about enacting rather than making a decision:

I think it's really just a case of getting booked in [for a CS] now... I have done a lot of research before I came here... I have had the information prior to making a decision and it's all been fine with the research I've done myself. (Pippa, planned CS following unsuccessful ECV, antenatal interview)

Some women who had made up their minds before the consultation described being worried that they would have to convince their doctor or midwife to enable them to enact their choice. Georgina described rehearsing what she was going to say in the car on the way to the hospital:

- B Did you go into the ultrasound then knowing what you were going to do?
- G Yeah, I think I'd pre-empted and I knew I was going to get a pep talk. So I was kind of like, "Right, I'm going to say this, I'm going to say that." So I'd kind of done me homework and, and went armed... I was like... "I don't want them to think that we just want the section for the sake of wanting a section"... we'd done our homework... we'd done our War and Peace and this was the summary in the car. (Georgina, planned CS, workshop)

Georgina's use of language suggests she had anticipated conflict with staff about her decision to opt for a planned CS. This wasn't realised, rather she was surprised how accepting the consultant was of her decision (see Section 4.3).

Professionals knew that some women make their decisions outside of consultations.

A lot of women have made the decision already even before we talk to them and then we just kind of enable their decision without actually having a conversation with them about pluses and minuses... 90% of the people that I have met have already made the decision (Dr Rice, professional workshop 2)

Another obstetrician suggested that sometimes it was a case of going through the motions of providing information during a consultation.

... you'll find that a lot of people will come to that point for consultation having decided what they want done anyway, and they're really coming along for rubber stamping. And so you give them information because you should, without any expectation that it's actually going to influence the outcome of the consultation. (Dr Hill, interview)

During my observations, professionals never asked whether women had made a decision prior to the consultation nor did they explore sources of information women had accessed or women's values (see Chapter 6). Dr Rice's comments above suggest that it is not routine practice to explore whether a woman's decision is well informed or consistent with her values. Similarly, during observations women did not disclose that they had already made a decision nor discuss any of the information they had gathered with professionals. In this way, it appeared that the work women do researching and evaluating information at home, and in the community, goes on in parallel to counselling in the hospital, rather than them being complementary processes.

Once the community midwife had queried breech presentation, women were usually referred for an ultrasound scan within a few days, some even the next day. Clinical pathways varied between units. In Unit One a presentation scan and initial counselling was undertaken by a

midwife on the maternity assessment unit. In Unit Two, women were referred to the antenatal clinic, where some were scanned by a midwife sonographer immediately prior to their appointment and given some initial information about their options, before being reviewed by an obstetrician. Others were seen straight away by an obstetrician. In Unit Three, women were scanned by a midwife sonographer in the pregnancy assessment unit and were then reviewed by an obstetric registrar.

Most respondents reported that health professionals had provided them with some written information about breech presentation at this stage. Unit Two used standard RCOG leaflets 'Turning a breech baby in the womb (external cephalic version): information for you' (RCOG, 2008b) and 'A breech baby at the end of pregnancy: information for you' (RCOG, 2008a). Units One and Three provided leaflets which were based on the same information but presented in their own format. For example, they included the hospital name and local information about where ECV would be provided. Unit One also provided a separate locally produced leaflet about planned CS but nothing additional about VBB.

Respondents' attitudes towards these leaflets varied, emphasising the variation in women's preferences for information. Some women explained they had not met their needs for detailed information and others also criticised them for being poor quality

She did give us a leaflet. It was very black and white... I don't think it was very detailed... there's not a lot there. (Emily, unsuccessful ECV and planned CS, postnatal interview)

What I got from [name of unit] was like a mismatched kind of photocopy that was a bit wonky so the writing went off the page a little bit. (Georgina, declined ECV and planned CS, workshop)

Other women were satisfied with them and had not needed to look for any more information after the consultation:

Just literally from the last session... they verbally informed we and they gave we literature... everything we needed to know... we felt really informed. (Lynne, planned CS following decision not to attempt ECV due to low AFI, antenatal interview)

Only one respondent, Martha, had not received any written information:

The midwife told us, she said: "Oh, don't worry. They'll give you loads of literature, loads of information." And it wasn't like that... No, I didn't get any literature and I'm the sort of person that needs that. (Martha, unsuccessful ECV and planned CS, postnatal interview)

During observations, women were usually required to make a decision about whether to arrange an appointment to return for ECV immediately. During interviews, these respondents reflected on how they had little time to make the decision because of the short time between diagnosis and the optimal time to attempt ECV.

So it's all happened in a week, so it has been quite quick, so it's been a lot to take in. (Heather, unable to attempt ECV due to low AFI and planned CS, antenatal interview)

Some women had not made a final decision at the time of the initial consultation as they went on to search for further information at home after these consultations.

At that point I wasn't really sure, I went home and discussed it with my husband, because I wasn't really sure if I wanted to have him turned or not. Then, after reading the information on the website, and I can't remember if she gave us a hand-out... I decided I didn't think it was a good idea. (Holly, planned CS, antenatal interview)

Other respondents explicitly stated that, they had not made a decision at the initial consultation and explained how, despite this, they were given a provisional appointment to return for ECV, but were advised they could change their mind.

...they discuss the ECV option with you and give you the information... the thing that frightened me a bit was... I hadn't had time to think about it... like on the Friday I was given the information and they provisionally booked me in [for ECV] on the Monday with the idea that if I changed my mind after thinking about it over the weekend, I could just ring up and cancel... had it not been for her [the midwife performing the scan] I would have probably not bothered. (Catherine, successful ECV, workshop)

Accounts like Catherine's suggested that some professionals may influence women to choose ECV by using clinical pathways to steer their choices. Potter et al. (2008) also describe how the structure of antenatal care can make acceptance of a particular option the default position. Professionals' strong preference for attempting ECV is discussed in Chapter 6. Interestingly no respondents reported changing their mind after 'provisionally' booking in for an ECV. This may reflect that it was the right choice for them but it is possible that they found it difficult to decline ECV once an appointment had been made.

Following the initial discussion about options, the next contact respondents had with health professionals was usually when they attended for ECV. If women declined ECV, or it was unsuccessful, they were usually referred back to an antenatal clinic to discuss birth options, although sometimes a doctor would discuss their options immediately.

If they chose to attempt ECV, the clinical pathways varied in the three units. In Unit One, women were then referred to a team of midwife sonographers who were trained to perform ECVs. Immediately prior to ECV, women underwent a more detailed ultrasound scan to measure fetal growth and wellbeing. A final decision to attempt ECV was made following this scan and usually it was performed immediately, but occasionally women returned another day, depending on the sonographer's schedule. In Unit Two, women were referred to the on-call consultant on the delivery suite, the presentation of the baby was rechecked prior to ECV and a cardiotocograph (CTG) was used to assess fetal wellbeing prior to the procedure. In Unit Three, women were referred to a particular consultant who performed all the ECVs. ECV was attempted in a day unit, the presentation of the baby was rechecked prior to ECV by ultrasound examination and a CTG was used to assess fetal wellbeing. Most health professionals asked women to sign a consent form prior to ECV, necessitating a recap of the risks. Only one obstetrician preferred to take verbal consent.

I just take verbal consent. I have thought about using a consent form. But... I think it's reasonable to take verbal consent for it. And I also think that actually it just lowers the anxiety rate a little bit. Because I know when you take consents pre-operatively... you give them information about risks in minutiae and actually I think sometimes, for some women, it just makes them so nervous you wonder whether it's really worth doing... I mean they have had an information leaflet so they've had the chance to look. They know there are some pros and cons. And I think just a recap of that verbally; I personally think that's alright. (Dr Bird, interview)

Whilst this obstetrician seemed confident that women would read the information leaflet provided about ECV, during an observed consultation she did not check that the woman had read this information. However I did note that the woman was under the care of a specialist midwife whom Dr Bird seemed to trust would have already provided her with accurate information. While this may be an example of poor practice in consent, it may also demonstrate how professionals share the responsibility for supporting women's decision making about breech presentation. In all three units, a number of different professionals were involved and provided women with information at the different stages discussed above. Goodwin (2014) argues that while professional and medico-legal discourses about decision making frame it as an autonomous action, emphasising individual clinician's responsibilities, when clinical decision making is actually observed it is often more collaborative between professionals and distributed over time. The implications of such a collaborative approach on patients are not known. In this context, it is unclear how teams ensure that all the relevant information is provided consistently or how different relational dynamics between different

clinicians and the patient may impact on how the information provided is understood and used.

4.3 Seeking support

As well as sharing their experiences of gathering information, women respondents also described seeking support during the process of decision making. Consistent with previous research that demonstrates the importance of partners in antenatal decision making (Jaques et al., 2004), women in my study spoke about the significance of their partners. Respondents frequently gave accounts of how their partners had helped them search for information, deliberate and make a decision.

He [name of partner] read the literature that we were given, you know, from the hospital? He'd spoken to my cousin and he'd watched the videos on YouTube... we'd both just come to the decision that the C-section was the safest thing. (Georgina, declined ECV and planned CS, workshop)

At that point [having just been given information about ECV, CS and VBB by a midwife in hospital] I wasn't really sure. I went home and discussed it with my husband, because I wasn't really sure if I wanted to have him turned or not. (Holly, planned CS, antenatal interview)

Some professionals acknowledged the important role partners play as they occasionally offered to delay decision making to enable women to involve their partner. This delay in decision making varied from only a few minutes to much longer:

So, I think the best thing for you two to do is have a chat, I'm going to leave you to it, and I'm going to come back in a few minutes... I'm going to leave you to talk, tell me what you want and I'll organise it. Back in a few minutes. (Dr Lake, consultation 10)

You don't have to decide anything today. You might want to go home and discuss it with your partner. You might want to make an appointment [for ECV], we'll see. We'll just go with the flow and don't feel like you've got to do anything. (Midwife Black, consultation 2)

Wider family and friends were also important sources of support for women.

Obviously I talked to me mam about it as well [as her partner] because she's me best friend... It's like, tell her everything. And me sisters, the same, we're really quite close... they just said, "whatever you think's safest for you and the baby... I spoke to obviously people at work and I spoke to me friend (Sophie, declined ECV and planned CS, workshop)

Me gran and me husband's mam as well. Yeah, they were all very supportive... I don't think they could have done anymore really could they? (Holly, planned CS, antenatal interview)

Respondents also sought support in on-line forums. This sort of support was perceived as particularly useful for women who did not know anyone personally with first-hand experience of breech presentation:

And there's lots of women that have conversations [on-line] about how far they are and they want someone to talk to that's in the same position... there might be some people who haven't got no one to talk to at the school, like I have. Or like even other people around them that's had kids. They might be totally on their own and it might be nice to go on-line and then be able to click something that says: "...I'm having this tomorrow, I just need someone to talk to, who else has had this?" (Tina, planned CS antenatal interview)

Nevertheless, some respondents still felt unable to connect with other women with similar experiences to their own and so were unable to obtain the reassurance they were seeking:

I was trying to put questions on [Mumsnet] and some people would go: "My friend had that." And I'd think: "Well, I don't want to know what your friend had. If you've been through it, it would be nice to get your opinion."... I don't know anybody personally who's actually gone through the same... I posted questions on there... "I've been told I've got a breech baby and it's not going to turn in time for delivery, so I've got to have either A, B or C... Has anybody else been through this? Just so I'm not going through it alone."... but there was nobody really that was in the same predicament that I was in... I don't know if some people just didn't want to talk about it or they just happened to not be online that day. (Mandy, VBB following unsuccessful ECV, postnatal interview)

One respondent, Michelle, explained she had no support from her partner, who was in prison, or from her family. She emphasised the vulnerable situation she and her children were in when she described how she had prepared her oldest child to call for help in case of an emergency during her pregnancy:

Well, I've went through it with me little boy... let him hold the phone and I've held the other phone and said, "Right, you're on the phone to the hospital, [name of first child], what number do you dial?" He says, "999." So I'm the lady on the end of the phone, "Hello, what would you like, ambulance or a fire?" "An ambulance, please, me mam's having a baby." "How old's your mam?" And he knows. "Where do you live?" You know, obviously he knows. "When's the baby due?" He knows that. Then he says, "Can you just hurry up, because the time you're talking, you could be on your way?" Bless him. (Michelle, unsuccessful ECV and planned VBB, antenatal interview)

Michelle had been supported instead by a specialist midwife who had also been involved in her care during her first pregnancy. In order to avoid making Michelle identifiable, I have chosen not to disclose the role of this midwife but she clearly valued her a lot:

[name of specialist midwife] is great... she [looked after me] with me little boy as well... Me little boy knows her. (Michelle, unsuccessful ECV and planned VBB, antenatal interview)

Some other respondents also reported feeling supported by midwives and obstetricians during the decision making process.

I can't stress enough how fab [name of midwife] is... I would have stayed here a month waiting for her if I had to. Her mannerisms, how friendly she is, how she explains it... she really put my mind at ease. (Nina, successful ECV, workshop)

However others suggested they would have valued more support. Georgina, despite making a decision before attending the antenatal clinic (see Section 4.2), described how she would have liked more support from the obstetrician and how her experience had felt impersonal because the doctor appeared so detached and had not explored her decision nor her values (see Section 4.2):

You're just kind of an NHS number, at the end of the day. She didn't sit down, it was all, like a conveyor belt... I do wonder, did she accept my decision because she had a load of patients and perhaps she knew I wasn't going to change me mind so was I worth wasting another 10 minutes when she could get on with her next patient... it would have just been nice if she's sat down and said, "Yeah, you've made the right decision," or words to that affect, "I respect your decision (Georgina, planned CS, workshop)

Accounts such as Georgina's again suggest that the decision making processes women experience at home, and in the community, are detached from the processes in the hospital. It is unclear why professionals do not explore women's decisions (see Chapter 8). Nevertheless, these data demonstrate that decision making about breech is a process involving a number of consultations with different health professionals and encounters with various other key informants.

4.4 Conclusions

In this chapter, I have presented data relating to the experiences of diagnosis and decision making about breech presentation. For many women, the diagnosis of breech presentation comes late in pregnancy, around 36 weeks, and begins with uncertainty, either because the community midwife is unsure about the findings of an abdominal palpation or because the

woman is interpreting her own symptoms. For other women the process begins earlier in pregnancy, following a routine examination or an ultrasound performed for another reason, but there is still uncertainty about whether or not the baby will remain in a breech presentation. Women are usually not provided with information about options until breech presentation is confirmed, usually at 36 weeks of pregnancy. This is because health professionals believe they would be providing unnecessary information to women whose babies turn spontaneously or who are found to be cephalic on scan. They are concerned this would cause unnecessary anxiety. This approach fails to take account of women's clear preference for information as soon as the possibility of breech presentation is raised.

When the diagnosis is confirmed by ultrasound examination, around 36-37 weeks, women are required to make decisions about whether or not to attempt ECV and how to give birth in a short time period. The late timing of the diagnosis in pregnancy means that women are often shocked at the diagnosis and some are disappointed that they may be required to change their plans for birth. Some also feel pressure due to the short time between diagnosis and needing to act, particularly if they want to attempt ECV.

Gathering information about breech presentation is distributed across a number of clinical and lay interactions involving a variety of key people. Women seek information themselves, usually from the internet, and some spend considerable amounts of time researching their options. They also value lay experiential information highly. Key lay supporters and informants include: partners, female relatives, close friends, internet contacts and more remote acquaintances. Women also receive information from a range of different health professionals and some clinical pathways are organised so that professionals collaborate to provide information and counselling. Women report varied attitudes to the way information is provided in hospital but many are dissatisfied with it. Some professionals themselves report providing information in a perfunctory way, which contrasted with other observations and accounts, given by professionals and women, of coercive and directive counselling, discussed further in Chapter 5. As professionals do not routinely explore the information that women have found themselves prior to consultations, and women do not usually discuss it with professionals, it appears that these processes are independent. Having presented and discussed these data, in Sections 4.5-4.7 I show how they were used to inform the design of the PDA, consisting of the website (breech-decisions.ncl.ac.uk) and animated film.

4.5 PDA development

Perhaps unsurprisingly, as they had volunteered for the study, all the respondents were positive about the aim of developing a PDA for women with breech presentation. They preferred a freely available internet resource to complement information provided by health professionals. This would have the advantage of being readily accessible to them, whenever and wherever they wanted to use it, and enable them to involve key supporters such as their partners. Being able to access information at home was seen as empowering, in contrast with the hospital environment:

The clinical environment was a bit of a put off... Maybe sitting in your own home, or sitting, I don't know, somewhere else out of this hospital environment, you relax a little bit more, and you're maybe open to more discussion and open to consider things a little bit more but... when you're in the hospital, you're in your doctor's environment, and that's their territory and you will do as they say... It's like when you walk into hospital, you just lose a bit of your own sense of who you are... you're like overcome by this whole building and the clever people that occupy it. (Georgina, declined ECV and planned CS, workshop)

Another advantage was being able to return to it later as some women acknowledged that they felt unable to take everything in during consultations:

The biggest thing that we learned was sometimes... I wouldn't take it all on board and [name of husband] would take other bits of information on board... And I think sometimes that's why it's really important to have a good leaflet or a pamphlet or a website to go to afterwards... you take bits of it in; but you don't take all of it. (Emily, unsuccessful ECV and planned CS, postnatal interview)

Although they wanted a resource that would be freely available, some women explained that they would prefer professionals to direct them to it:

Definitely I think if you came to a hospital and they gave you the same information that you get but then say on the leaflet, or something like it, it will say you can go onto the website and have a look as well... you definitely would. (Lynne, planned CS following decision not to attempt ECV due to low AFI, antenatal interview)

Some respondents perceived that providing an internet link rather than a leaflet could save the NHS money:

...then people could look at the information... maybe the evening before. And it would save the hospital paper as well because they wouldn't need to give them the information sheet. (Alison, emergency CS in labour following successful ECV, postnatal interview)

Professionals were generally positive about an internet resource, particularly if the quality of the information could be assured. However, some felt that an internet resource would be inferior to a consultation.

I'm still not quite sure what this [the resource] does that a piece of paper... wouldn't do.... It's a bit of a false god. It's a bit of a worship: "It must be right because it's on the web."... in some ways we're reinforcing this idea that if it's on the web, it must be true... I suspect it's actually better to sit down with a trained professional and talk it through (Dr Corn, workshop)

Such views did not take account of the fact that many respondents reported that decision making occurred outside of consultations nor that a PDA would be envisaged to complement rather than replace a discussion with a health professional.

A few professionals were concerned that not all women would be able to access an internet resource. An obstetrician from Unit One, had been particularly critical during a design workshop:

We've got a lot of deprivation in [name of city], as I'm sure you know. But not everyone has a smartphone or an iPad. How are you going to deliver it to the women that don't?... A lot of my patients don't. (Dr Wheat, professional workshop 2)

Unfortunately, I did not have the opportunity to explore why she believed so many of her patients would not be able to access an on-line resource. However, internet access was not a concern for most professionals; those from Unit Two, which is in a more deprived area than Unit One, were positive about putting the resource on the internet or making it available as an app:

Probably an app's more accessible to people, you know everyone carries a mobile phone, a mobile phone is something you always have that you can access. And with a leaflet you're going to put it down and you're going to, if you're like me, write a note on it and then it goes in the bin or something... It's easy to misplace... whereas an app's on your phone, you can access, you can maybe have a read of it and then something comes up, you can go back to it later. (Midwife Azure, professional workshop 1)

All the women in this study reported they had access to the internet and overall they believed this would be the most useful and useable format. However, it is important to consider that this type of resource may not be accessible to all women (see Chapter 8).

As well as preferring a freely available internet resource, as I will show in the next chapter, women valued experiential knowledge highly. Reflecting this, many respondents suggested case studies, including women's accounts of their experiences, should be included in a PDA.

Having the women sort of explaining how each of the decisions were made or just sort of like what they experienced during them and things like that. That would be good because then you would totally be able to relate straight away I think. (Lynne, planned CS following decision not to attempt ECV due to low AFI, workshop)

Respondents perceived that combining experiential information with factual information would have the advantage of legitimising women's accounts which might otherwise be seen as subjective:

It's important to hear women's experiences absolutely but backed up with professional knowledge as well. (Samantha, planned ECV, antenatal interview)

To provide representative experiential information, a nine minute animated film was developed about two fictional women's experiences, Polly and Rachel. The script was developed from interviews and workshops. This depicts the decision making process; the characters' reasons for making their decisions (see Chapter 7), their birth experiences (see Chapter 8), and ends with the characters' reflections on the process.

Respondents recognised that, with all the information available to pregnant women on-line, it might be challenging to make a new resource stand out.

So I think personally you need to make your information stand out. Have it, maybe something eye catching or something. (Melissa, unsuccessful ECV and VBB, postnatal interview)

It is hoped that combining factual information with women's accounts will be seen as novel, and useful, and that the animation and website design will be striking and attractive to women searching for information. In response to the accounts women gave of searching, and to ensure appropriate acknowledgments are made, the Newcastle University logo and NIHR logo (which includes the NHS logo), are included.

4.6 Website content relating to the themes in this chapter

Acknowledging that the decision making process for breech presentation is complex, several respondents suggested that a flow chart outlining the process and the different treatment options would be helpful.

Just what to expect, what the options... what might happen, like a – like a flow chart, like, “If you do this, then this will happen,” sort of thing. That would be helpful I think, definitely. (Eleanor, successful ECV, postnatal interview)

In response to this, a flowchart is provided on the website. Information is also presented along a timeline, explaining how breech presentation is diagnosed and then providing information on all the options. As the website will be freely available for women to access whenever they choose during pregnancy, the likelihood of a breech baby spontaneously turning by 36 weeks and also the possibility of the baby being found to actually be cephalic on ultrasound is discussed.

Reflecting the variable amount of time respondents reported spending doing research, the information is presented in three layers of increasing complexity. Users can decide how much detail they want to read. This approach of providing basic information to all but making further, more-complex information to people who want it has been advocated as a novel approach to supporting shared decision making which respects patient autonomy but also recognises that different people will have different preferences for the amount of information they need (Entwistle et al., 2008).

In order to attempt to encourage women to discuss the information they have found on the website with health professionals a “sticky note” feature is included to enable them to write a list of questions as they work through the information.

4.7 Film content relating to these themes

The animation begins with Polly undergoing an ultrasound examination which confirms her baby is breech. She represents respondents as she describes how shocked she was to find her baby was breech and how it has disrupted her plans for a water birth. The significant role of women’s partners is reflected by the support her husband David gives her. In scene six, she reflects that the decision was left up to them, representing women who felt they made the decision with their partner alone (rather than with health professionals). To ensure the film also represents women who do not have a partner, Rachel, in contrast, is a single mother. Later in the film, she sends a text message to her mother, to share the news that the ECV had been successful, to represent the importance of respondents’ mothers to them.

In the fourth scene, we see Polly and David being counselled by a female health professional. The exact role of the professional is ambiguous so she could be a doctor or a midwife. This was so the film was applicable whatever the clinical pathway in a viewer’s unit. A leaflet is

visible representing the written material usually given to respondents. The research women do into breech presentation themselves is represented by Rachel reading a pregnancy magazine (see Chapter 5 for discussion of the content of this magazine).

Chapter 5. Content of information given to women by healthcare professionals and lay people

In this chapter, I focus on the content of information about breech presentation given to women by health professionals and lay people and describe how this contributed to decision making. I then explain how the themes discussed have informed the development of the PDA, consisting of the website (breech-decisions.ncl.ac.uk) and animated film.

5.1 Information provided by health professionals

To identify the key information provided to women by health professionals, I analysed data from the 15 observed consultations and compared these to accounts women and professionals gave during interviews. During the consultations there was wide variation in the amount and level of information given, reflected in the varied length of consultations: between five minutes 42 seconds and 35 minutes.

5.1.1 ECV

I frequently observed health professionals encouraging women to choose ECV, presenting it as the norm and a better option compared with CS or VBB.

Normally what we're trying to do in this unit, we try to turn the baby's head-down. (Dr Field, observation 15)

I think you've got a good chance [of a successful ECV], okay? If you don't try at all it will be worse, okay? (Dr Forest, observation 8)

During interviews, some professionals acknowledged that they directly counselled women about ECV and defended such an approach.

I do think you try and encourage them towards ECV, and I think you are doing that for all the right reasons, so you're facilitating a vaginal delivery and not wanting a scar on the uterus. I think you are doing all that for the right reasons. I think the clinicians need to have a positive attitude [towards ECV]... (Midwife Green, interview)

In most of the observed consultations professionals provided more information about ECV than CS or VBB. They were also more consistent in the information they gave about ECV, both individually, when a single professional was observed more than once, and comparing between professionals. These practices also suggested a bias towards ECV. The professionals consistently discussed what an ECV was; advised that a tocolytic drug would be

used; explained that ECV might be uncomfortable; and indicated the success rate and also potential risks. They described ECV in different ways. Most professionals gave short but positive descriptions, some with no detail of what would be involved physically:

It will be a gentle manipulation round to get the head where it should be.
(Midwife Green, consultation 5)

Others were observed, or gave accounts during interviews of, providing, more detailed descriptions:

I describe it by getting baby to do a summersault, because people can see that motion in their head when you say what a summersault is and effectively it is moving the baby in their forward summersault to try and bring baby's head down. I think I would maybe normally say that the first part would get baby's bottom out of the pelvis and then bring baby's head down and that will either... be in one movement or it might take a couple of movements to bring baby down. (Dr Dene, interview)

In most consultations professionals advised women that they would be given a tocolytic drug prior to ECV. Tocolysis is recommended to increase the chance of success (RCOG, 2006a), but professionals were often not explicit about this. Most advised women it would relax their womb without informing them why this was desirable. It was occasionally presented to women as a method of pain relief, which it is not.

Usually we give you something to relax your womb, so that you don't have much pain. (Dr Wood, consultation 14)

The potential side effects of tocolysis were only covered in one consultation. In fact, when some women asked about them, other professionals advised that there were no side effects:

No, there's not thought to be any side effects to it [terbutaline] (Midwife Green, consultation 5)

This contradicts the RCOG Guideline 20a, which states women should be advised of the adverse effects of tocolysis² (RCOG, 2006a), and if correct information is not given it is potentially misleading to women. In fact, I recorded in my field notes that following

² Most commonly tachycardia.

observed consultation 5 the woman Carol felt so unwell after tocolysis was administered, she required a medical review.

Professionals acknowledged that ECV might be uncomfortable, but when encouraging women to consider ECV they did reassure them that they could ask for the procedure to be stopped at any time if they found it too painful.

If you are in too much pain, then we stop it, okay, so you are in control (Dr Wood, consultation 14)

Some professionals distinguished between discomfort and pain, suggesting that ECV would not be painful. This contrasted with women's accounts of ECV (see Chapter 7).

So I literally try and scoop the bum up and encourage the head to go around so it's like sort of pushing and pushing, here and here and it will be uncomfortable it should not be painful and if it's painful at all I want you to tell me to stop (Midwife Black, consultation 4).

As per RCOG Guideline 20a (RCOG, 2006a), the success rate of ECV was usually quoted as being 50%, frequently this was presented to women in a positive way to encourage them to attempt ECV:

You can try and turn this baby round, okay? The advantage in doing that is in 50% of cases it does go round... At least we've tried which means half the women we would successfully turn round, they could go on and have an attempt at a vaginal delivery. (Dr Forest, consultation 9)

While in interviews and workshops, respondents suggested they would value being told local success rates, only Dr Bird told women his own success rate. Midwife Black and Midwife Green estimated their unit's data but over-estimated the local success rate at 80% (an audit conducted during the study found the success rate was 60%). Only one professional was observed discussing factors that might affect the success rate of ECV:

Now with regard to the fluid, I have a little bit of concern... it is measuring just below 5cm... Just to put that in perspective for you, I have been turning babies now for [number] years, give or take, and in all that time what I have found is that where there is less than 5cm of fluid I have never been able to turn a baby... Between 5cm and 8cm I have managed to turn probably two or three babies. Over 8cm seems to be when... you tend to get the success. So that is my track record. Now the thing that I think is going to stop me with you, turning the baby, isn't the fluid, it's the fact that the baby is really low with extended legs and the bum is really low in the pelvis. (Midwife Black, consultation 8)

In my observations health professionals were generally consistent in relation to their advice on the potential complications of ECV, advising women that these included changes in the fetal heart rate which usually resolved without intervention but occasionally required an immediate emergency CS.

... it's a safe thing to do... it doesn't seem to cause major problems. You will find if you look on the Internet under ECV... you will find information about bleeding behind the afterbirth or the cord getting tangled up. And it is true that that can happen but it's a rare occurrence. Of course, if it did happen you're starved and it would just be a caesarean section then wouldn't it? In this hospital we turn babies actually on the labour ward, so you'd be set up for immediate delivery of the baby if there was a problem... But we're not expecting a problem, it's a small percentage of babies that have a problem during the turn. (Dr Lake, consultation 9)

Like Dr Lake, many professionals reassured women that they would monitor their baby closely to watch for signs of a problem and that ECV would be performed in a safe environment with an operating theatre available. All women seemed to be advised they needed to not eat for a number of hours before the ECV in case emergency surgery was needed, which the RCOG advises is unnecessary due to the low risk of complications (RCOG, 2006a).

Some professionals also gave information about potential risks based on local experience.

...if the baby's heart slows and the baby doesn't like what we're doing we stop... I would stop manipulating your abdomen and then what we usually would find is that the heart rate would come back to normal... If the baby's heart rate didn't come back to normal... that's when we would send you for an emergency caesarean section. Now that sounds really dramatic. In the [number] years that I've been turning babies we've had to do that four times. We've taken five women to theatre. One woman's baby was fine when we got there so she didn't end up having a caesarean section. Two women had a caesarean section because they were over their dates and it [ECV] didn't work so... it was called an emergency but it could have waited. Two babies didn't like the fact we'd turned them, their heart rates slowed down and they both needed delivery. Mums weren't put to sleep to have that, so it wasn't that kind of speed, but both babies and both mums were absolutely fine. (Midwife Black, consultation 2)

By giving some details about the individual women she had known go to theatre Midwife Black may have made the risk appear less serious than if she had just given an incidence.

In many consultations, professionals either did not share, or appeared not to know, the absolute risks of complications from ECV, often describing them as "very small". The RCOG advise that the risk of needing an emergency CS is 0.5% but that there is no excess

perinatal morbidity or mortality (RCOG, 2006a). However, most professionals if they did provide an absolute risk of emergency CS estimated it as 1%. Some admitted that they didn't know the exact figures.

A I think the source of information we saw said it was 0.5% risk of emergency caesarean section?

Dr Yeah, it's going to be in the right ballpark... I don't know the figures... it's a very small number. (Anna and Dr Lake, consultation 16)

Nevertheless, some women indicated that they valued statistical information about options. Catherine suggested she made her decision based on her interpretation of the numerical risks she was given:

...to me the important things were things like statistics... the percentage of it [ECV] working... was there any danger to the baby by doing it and the fact that it may, potentially bring on labour, because that percentage was quite small, that was a significant thing for me in making that decision. If that had been a higher percentage I would've probably been less willing to do it. I thought it was a fairly low risk. (Catherine, successful ECV, workshop)

Risk communication is discussed further in Chapter 8.

5.1.2 VBB

If an attempt at ECV was unsuccessful, or if women declined it, professionals tended to counsel women towards CS. VBB was generally presented as abnormal, problematic and risky. Women were consistently informed that there were risks to their baby but sometimes professionals were not explicit about these risks. For example, Dr Wood advised:

Because it's the soft part of the baby which is coming out first, and there's that hard bit, which is the biggest part of the baby coming out at the end, there is an anxiety there... immediate complications might be a little bit higher for the baby. (Dr Wood, consultation 15)

During the consultation, she did not explain what she meant by the soft or hard bits of the baby; why this situation might cause anxiety; what the immediate complications might be; or what "a little bit higher" meant. Women were also commonly informed that a doctor would be present for the birth; that they might end up needing an emergency CS; that an episiotomy might be required; and that forceps might be used during the birth. In most consultations, professionals did not explain why these interventions might be necessary and many appeared not to know the absolute risks:

During the birth itself... sometimes it [the baby] needs some manipulation during the birth to help the baby come. Sometimes forceps for the head when the bottom's out. Usually during the birth you'd be lying on your back with your legs in stirrups and the doctor, obstetrician, would be sitting in between helping the baby to come... and the heartbeat is monitored continuously. For people who try for a vaginal birth with a breech baby, the success rate is about 50%. About 50% of the other people end up with a caesarean anyway maybe because labour is slow, maybe because the cord falls out by mistake, prolapses, maybe because the heartbeat gives a concern. They are approximate figures but they're about right. (Dr Lake, consultation 12)

Several professionals appeared not to understand the findings of the Term Breech Trial (Hannah et al., 2000) or certainly struggled to communicate the evidence during consultations. For example, Dr Forest suggested that differences had been found between the outcomes of planned and unplanned VBB, which the trial did not investigate:

Now about 10 years ago there was a big study that was done which compared outcome for baby with the event of an elective caesarean section or a breech vaginal delivery and it came out quite clearly that it was safer to go for an elective caesarean section... if you came in in labour the story was slightly different depending on how far you were on in labour and things like that. (Dr Forest, consultation 9)

Dr Hill attempted to discuss the long-term follow up data from the Term Breech Trial, which showed planned CS was not associated with a reduction in risk of death or neurodevelopmental delay in children at 2 years of age (Whyte et al., 2004), but her explanation was unclear and suggested that there was uncertainty about the results, which there was not:

...we are not 100% sure if that [improved short-term outcomes with CS demonstrated in Term Breech Trial] really translates into long-term benefits. You would think it would be obvious that it would, but it is not quite so clear as that and I think the benefits of the immediate days after the birth are more clear than the longer term benefits (Dr Hill, consultation 6)

No professionals discussed the PREMODA study (Goffinet et al., 2006) or other observational data (see Chapter 2), either during consultations or in interviews.

A few professionals provided women with erroneous information. For example, Dr Field suggested to a woman that the risks associated with breech birth were a modern problem:

If I look about 20 years ago, women delivered bum-down babies easily. No problem, because the way we used to work, like scrubbing floors and everything, they had pelvic strength and they delivered nicely. (Dr Field, consultation 15)

Few professionals presented any potential benefits of VBB for either mothers or babies. Dr Wood explained that it was “physiological” and that recovery would be “better” without explaining what these terms meant:

From the vaginal breech point of view... you’re delivering vaginally which is physiological so the recovery is much better (Dr Wood, consultation 14)

In interviews many professionals reflected on their bias against VBB.

I’m very poor at selling a breech birth... I don’t seem very positive but I can’t make that sound any better... (Midwife Black, interview)

Only Dr Hill informed me that he had a more positive view of VBB, believing that it was a reasonable alternative to a CS. He suggested his approach to counselling women was unusual.

Well I suppose I am unusual in that I routinely do talk about the Term Breech Trial. And the reason I do it is to make sure they’ve genuinely considered the option of vaginal birth because... the decision to have a caesarean section... is quite a big one. There are potential risks for [sic] it and they should genuinely consider the alternative of not having a caesarean section. (Dr Hill, interview)

Professionals’ views of VBB appeared to have been influenced by research, in particular the Term Breech Trial (Hannah et al., 2000), but some also suggested that their subsequent lack of experience with VBB might have also contributed.

I think I certainly would mention that, a lack of expertise in delivering breech because I have only ever done a breech delivery as part of a caesarean section³. I have never done a vaginal breech. (Dr Dene, interview)

This negative image of VBB appeared to be presented to women throughout the process of diagnosis and decision making, beginning when the community midwife queried breech presentation. Pippa explained to her obstetrician:

I didn’t think there would be much discussion about the other options to be honest... It’s not like anyone has said “You will have to have to have a caesarean,”

³ Obstetricians use the same set of manoeuvres to deliver breech babies at CS as they do during VBB.

but so far it's been the midwives... they've just mainly said [it's the] safest option (Pippa, observation 6)

During interviews and workshops, it appeared that women accepted that breech presentation was potentially dangerous for babies (see next chapter for women's values relating to VBB). For example, Nina described her perception of the risk of cord prolapse:

The umbilical cord just naturally drops and it hangs above your cervix, so you're walking around with your cord basically hanging between your legs...and if at any point you get a pain your waters break, the cord falls out you see... and it has contact with air, nine times out of ten your baby dies. (Nina, successful ECV, workshop)

This is an over-estimation of the mortality from cord prolapse (which is 91 per 1000 (RCOG, 2014)) which may reflect the way professionals had counselled her as she explained to me how she felt they had pressured her to be admitted to hospital by emphasising the risk of death (noted in field notes). Health professionals may thus perpetuate a discourse of risk and abnormality relating to breech presentation, which also seemed to be embedded in lay accounts of breech presentation (see below).

Whilst few women in any of the units during the study appeared to choose to attempt VBB, purposive sampling enabled me to recruit three women who did. Mandy explained how she had felt constantly pressured by professionals to review her decision:

Every time I went to the hospital [professionals said] "Are you sure? Think about a caesarean" ... I think it would have made their life a little bit easier... whip her in, open up, baby out, done you know? But it just wasn't in my ideas. It just wasn't going to happen... I fought them all the way to say, "I don't want one, I don't really need one!" (Mandy, VBB, postnatal interview)

By referring to herself in the third person "whip her in", Mandy suggests she felt depersonalised during some encounters with professionals and the use of "fought" suggested she had to struggle to implement her decision to attempt VBB.

5.1.3 Planned CS

In contrast to the detailed information given about ECV (see above), the information professionals gave about CS was much more concise. If women had already made the initial decision to attempt ECV themselves prior to the consultation (see previous chapter), professionals appeared to provide only basic information about birth options:

We'll just give it a go. If it works it works, if it doesn't it doesn't. We'll go to 'Plan B' and we can discuss 'Plan B' which will either be a caesarean section or vaginal breech delivery if we need to. There's no point in going into that now because if the baby turns then hopefully you'll go on and have a nice normal head first delivery. (Midwife Black, consultation 3)

This seemed to be because most professionals had a preference for ECV so they accepted the woman's decision to attempt ECV readily. In this circumstance, they appeared to function more as ECV providers than facilitators of SDM. This sometimes reflected the different roles professionals had or how clinical pathways were organised. For example, in Unit One the midwife sonographers providing ECV perceived that counselling women about CS or VBB was not part of their role, rather they would refer women on to discuss these with an obstetrician if an attempt at ECV was unsuccessful.

I suppose... my main aim is... to try and see if they want to do the ECV, and hopefully we can get them on board for that. (Midwife Brown, interview)

Whoever does your operation will go through a consent form with you and they will tell you about things which Dr Say [the researcher] would know more about. Occasionally they might nick your bladder when they are actually physically doing the operation but I don't think that happens very often... That's something the doctors are more au fait with obviously because we don't do that. (Midwife Black, consultation 8)

However, some obstetricians provided little or no information about the benefits and risks of CS or VBB. For example, Dr Forest only provided this short summary of the Term Breech Trial (Hannah et al., 2000) and did not discuss risks and benefits further during the consultation.

Now about 10 years ago there was a big study... which compared outcome for baby with the event of an elective caesarean section or a vaginal breech delivery and it came out quite clearly that it was safer to go for an elective caesarean section, OK? (Dr Forest, consultation 9)

Some professionals provided more detailed information covering risks of CS; implications for future pregnancies; potential benefits; and practical information about the surgery and recovery period. Practical information given was not consistent between consultations but included: the need to not eat anything prior to surgery; the recommendation to take prescribed antacids prior to the surgery; the need for a urinary catheter; and what would happen if labour began before the planned CS.

Like every operation you'll need to be starved for it. And we're also going to give you two tablets today... called ranitidine, it settles your tummy from any

acid... That is your breakfast. If you have any more than that when you turn up we will know and the anaesthetist will cancel you and send you home. (Dr Hill, consultation 6)

Most professionals provided little practical information about recovery following a CS. Some did not discuss recovery at all; others touched briefly on the potential length of recovery and dealing with post-operative complications:

It's major abdominal surgery, by no means a walk in the park, you will have a scar... Any post-operative complications like chest infection, wound infection, clots in your legs and clots in your lungs can all apply... You may be in bed 24 hours and then you are up. In the olden days... we used to keep women in bed for 10 days, I don't know what we were thinking! Nowadays you're up and a lot of ladies go home on day three... so complications hopefully would be less, but you need to be aware of them. (Midwife Black, consultation 7)

A few professionals discussed the benefits of CS. Only Dr Lake provided numerical information from the Term Breech Trial (Hannah et al., 2000) including absolute and relative risks to explain the benefits of CS (see Chapter 8 for further discussion of risk communication):

If you made a plan for a vaginal birth, then your chance of a poor outcome in the labour is about 5%, about one in 20, and when I say a poor outcome I mean the baby being sick on special care, having seizures or even dying. But 19 out of 20 chances your baby would be pristine no problems... Your second option is to just have a caesarean section... From the baby's point of view, a caesarean is probably safer than going for a vaginal birth. The chance of your baby being poorly after the birth is about 1.5% instead of 5%. So in a sense you could say they're both small risks. On the other hand, you could say it's three times safer for the baby to have a caesarean section planned. (Dr Lake, consultation 16)

Other potential benefits of CS, unrelated to breech presentation, discussed by professionals included the convenience of knowing the date the baby was likely to be born and avoiding an emergency CS.

The things I would tell them was: you will be given a date to have that procedure [CS] done, I would tell them about the actual atmosphere of having an elective caesarean section, 'cos it's very laid back... you would meet the team... there are not normally any problems and then baby can come straight back to you. (Dr Dene, interview)

As well as discussing potential benefits of CS, professionals also discussed the risks, commonly: bleeding (including the possible need for transfusion); post-operative infection; venous thromboembolism; damage to other organs; cutting the baby; and the risk of respiratory morbidity for the baby. The chance of cutting the baby was the only risk which

professionals consistently provided a numerical estimate of, all quoting one in 50 operations. Occasionally professionals provided other numerical estimates of risk some of which were incorrect. For example Midwife Black estimated the risk of transient tachypnoea of the newborn wrongly (the risk is 12% (NICE, 2013)).

Very occasionally babies can get a bit of fluid on their lungs as they come through the sunroof, so to speak... I'm not sure of the exact statistics for that but it's probably about 1%. (Midwife Black, consultation 1)

Although professionals appeared unsure about numerical risks, these data are readily available as the RCOG has produced advice for clinicians obtaining consent from women undergoing CS (RCOG, 2009). Observations suggested that professionals did not routinely use this guidance as many of the risks were not discussed and they did not make use of the absolute risks provided in the guideline.

Occasionally, health professionals did advise women about the implications of having a CS for future pregnancies including the option of vaginal birth after CS (VBAC) and the increased risk in subsequent pregnancies of stillbirth, uterine rupture, low lying and morbidly adherent placenta.

If you get pregnant again when you've had a caesarean section... there's a very very small increase in a bad outcome... We're talking about rare things like stillbirth being slightly more common... Labour can be more difficult... the placenta can get stuck low in the womb on the old caesarean scar... I don't want to overstate the potential complications but it does make you a slightly higher risk category automatically... And that I think is one of the reasons why some people go for trying to turn the baby (Dr Lake, consultation 9)

These types of information seemed to be used to persuade women not to opt for CS.

The main things that I try and get across to them is the limitations or the potential limitations on the size of your family from having a caesarean section. Also, the danger of repeated caesarean sections... I don't think it is a tangible risk to people when they are just about to have their first section. I don't think they consider, "if I have a section now, I am going to be worried about my scar two or three pregnancies down"... I do try and tell them about that... but I don't know how effective that is about changing people's views. (Dr Dene, interview)

In a workshop, Sophie gave an account of how she had perceived a consultant obstetrician had tried to persuade her to opt for ECV rather than CS:

When I said I didn't want an ECV and she [obstetrician] asked us why, I said because I was scared and she went, "Well are you not scared about having a section?"... I went, "But I've had three previous miscarriages... So I'm quite

protective and I just want everything to be safer for the baby.” And she went, “Well, having a section increases your risk of having a miscarriage.”... That annoyed us more than anything... it wasn’t a very nice thing for anyone to hear that at all, especially when I was in tears... It felt like I was totally pushed for ECV from the minute that they said the baby was breech... I felt like everyone was pushing us towards that and... I don’t know why or whether that’s normal or what... I think after that I just went, “I’m having a section, that’s it.” (Sophie, planned CS, workshop)

This moving account emphasised how vulnerable women may be during the decision making process and how some professionals may take a confrontational approach, framing risks in a particular way, to encourage women to choose the option they think is best.

Some professionals had apparently cited the cost of a caesarean section to the NHS to persuade women to attempt ECV:

... the not so nice midwife said, “Well, you know, they don’t routinely like to do caesarean sections ‘cause they cost a hell of a lot of money than it would if they tried the turn. We would explore all avenues, i.e. the turn, before we would even offer you the caesarean section.”... as if I was paying her wages, and by me having a c-section I was depriving her family of a meal. (Georgina, planned CS, workshop)

As well as being more costly, Georgina’s account suggests that she felt the midwife had implied a CS would only be an option after an attempt at ECV. The use of “even offer” suggests that Georgina felt the midwife was emphasising that professionals had all the power.

Whilst professionals were open about directive counselling, none were observed coercing women in the way some women respondents described during interviews and workshops. They did reflect in interviews on situations when women had not followed their advice and how they wished they could insist women attempted ECV first:

...some people come in with fixed ideas... sometimes... I feel a bit cross because you’ll have somebody come in who, say they’ve got a breech that’s free [not engaged in the pelvis], they’re a para two [had given birth twice before] and you know you’ll be able to turn the baby. And they’ll say: “No, I’m having a caesarean section”... and I’ll say to the woman, “I think that’s such a shame because... I can nearly guarantee your baby will turn round”... So sometimes... I wish we could just say, “You have to have an ECV.” (Midwife Black, interview)

5.2 Key information provided by lay people

These data are taken from reports of information given to them by lay contacts that women shared during interviews and design workshops.

5.2.1 ECV

In contrast to the positive information provided by professionals, women reported that their family, friends and acquaintances mostly gave them negative accounts of ECV:

The only thing that worried me was what everybody else tells you... other people who have had it done or people that know people that have had it done... Well my sister's a hairdresser. She does an anaesthetist's hair and [she said] different things, "Oh don't do it because it distresses the baby and the cord could get wrapped round its neck. You know, they'd have to deliver it early and then you'll end up having a section anyway..." so it's kind of a bit like scaremongering. (Laura, successful ECV, antenatal interview)

As well as being told that ECV was dangerous, most respondents had been told by family and friends that ECV was painful, some that it was extremely painful:

I've had family friends telling other family members about what it was like and that it was quite horrendous... like the pain and the tugging. (Carly, planned CS, antenatal interview)

I don't know anybody and I've never heard of it being done. I've never heard of it before. But everyone seems to think it's excruciating, it really hurts. (Nina, successful ECV, antenatal interview)

All of these quotes illustrate how many people appeared to have shared accounts of ECV with respondents without having actually had any experience of it themselves.

Some respondents were accompanied by their mothers who did have personal experience of breech presentation and ECV. Sometimes, their mothers shared accounts of ECV which were quite brutal and reflected antenatal care in the 1970s and 1980s. For example, I recorded in my field notes that one respondent's mother told me she had an ECV performed in an antenatal appointment, which was uncomfortable as they used considerable force. Such accounts gave me insight into the sorts of stories respondents may have heard about ECV which were off-putting but might not reflect current obstetric care. Professionals also told me about historic practices which corroborated such accounts:

You know for my first registrar job over in [name of unit], the consultant I was working for came in to see one of my patients I thought had a breech baby at 36 weeks... the lady was lying on the couch, and he started prodding her tummy shall we say a little harder than average and he said: "Hang on a minute dear, just wait a second, I think this baby's moving." And he performed in front of me an ECV without any counselling, without any drugs, tocolytics, nothing like that... that I think is potentially dangerous, and I think some of the bad press for ECV came from practice like that. (Dr Hill, interview)

5.2.2 VBB

Many respondents were advised against considering a VBB by relatives and friends. VBB was perceived to be potentially dangerous for mother and baby, and likely to be more painful and to require unpleasant interventions, such as the use of forceps:

A lot of people were saying, “Oh, it’ll be horrendous and it’ll hurt so much more and you might need this done, you might need that done.” (Mandy, VBB, postnatal interview)

Negative accounts of VBB appeared to be embedded in the community, and even in popular culture, despite few respondents knowing any women who had actually had a VBB:

You know you hear people saying “It was a breech birth, it was horrendous, it resulted in a caesarean in the end anyway, so things like that make me very cautious... It’s based on nothing but hearsay, because I don’t actually know anyone that has had a breech birth but... you just hear and you think: “Oh breech. Oh God, know it wouldn’t have gone well... I think a lot of it’s from novels and stuff, when you read books and things when they die in labour... based on absolute nonsense probably when you think about it. I don’t know anything about the statistics or anything but my instincts were if it is a breech birth, keep well away. (Danielle, planned CS following unsuccessful ECV, antenatal interview)

When I reflected back to her that it was interesting that, despite so few women knowing anyone who had had a VBB, there appeared to be many negative stories in the community she replied: “No one knows from where [they come]” suggesting that there is some mystery surrounding VBB.

5.2.3 Planned CS

In contrast, it appeared that women were generally given much more positive accounts of CS. Respondents frequently reported that other women saw CS as an easier option than vaginal birth, even when breech presentation was not an issue and that the perceived endorsement of it by some high profile celebrities influenced women’s perceptions of CS:

One of my very good friends has had two... she, I think, probably just didn’t cope so well in her first labour, so chose, and ended up with a section... and she was one of these people who kind of bounced back quite easily from it. She didn’t have any problems with her wound. She was driving after three weeks. So she was like, “It’s easy, just have your section. It’s great.”... But I think most people see it as an easier route... they’re too posh to push. And you hear that a lot: “Oh God, it’s great. Just get it done... you’ll be booked in. You won’t have to worry

about calling someone to come and look for [name of daughter] and, you'll know exactly when you're going in."... And I do think the celebrity side of it as well. (Yvette, planned CS following unsuccessful ECV, postnatal interview)

Nevertheless, some respondents reported that family and friends told them about potential disadvantages of CS: commonly a prolonged recovery and postoperative pain.

I've heard you can't lift anything... You can't drive. (Carly, planned CS, antenatal interview)

A few women told me they had been warned about unexpected and rare problems:

And so the lady that looks after my little girl, she's in a nursery, she said... "Oh well you want to avoid a section, my sister went psychotic after she had one." (Laura, successful ECV, antenatal interview)

This suggested that, although less of an issue than for ECV or VBB, women were told horror stories about CS as well.

5.2.4 Horror stories and conflicting accounts

The horror stories women were told about options for breech could be described as atrocity stories, defined by Dingwall (1977) as critical stories about dramatic events told within groups of friends or acquaintances focusing on issues of mutual interest. They do not necessarily involve a disastrous climax, rather Dingwall (1977) explains that the dramatic term reflects how everyday experiences are transformed into powerful narratives to illustrate the complaint the storyteller has, inviting the audience to side with them against other actors in the story. Nearly all respondents in this study reported being told horror stories by their families, friends and acquaintances. Many were frustrated that other women had constantly shared these with them during pregnancy, and reported that they would have preferred reassurance:

Everybody, do you know, I've found everybody wants to tell a pregnant woman the worst thing ever...you know you just think. I just said to my Mam: "Why does everybody have to say awful things? You should be saying to people: "Oh don't worry, it'll be fine."... I would say my experience with the whole thing is it's not what the hospital are or aren't saying, I think they're doing everything right, it's what everybody else wants to tell you and...I don't know how you would overcome that. (Laura, successful ECV, antenatal interview)

Laura's account suggests she was unsure what the purpose of such stories was and believed she would not share such accounts. When asked about decision support, she identified that

overcoming the provision of conflicting and potentially undermining advice about ECV, CS and VBB would be a significant challenge.

As found previously (Say et al., 2013), health professionals are also frustrated by the potential for such accounts to negatively impact on decision making:

I don't know where all these horror stories come from... because we're nothing but nice to the women...but the horror stories, it beggars belief... but... [they] will dissuade them [from choosing ECV] or give them the impression it's an awful thing to have done. (Midwife Black, interview)

Although Midwife Black was unsure where such stories originate, other professionals reflected they might have been informed by more brutal old-fashioned styles of care (see quote from Dr Hill above).

When considering the purpose of sharing atrocity stories, academics have argued that they can be used to initiate new members into a group; create social cohesion amongst people with shared experiences; create boundaries between insiders and outsiders and define social control (Dingwall, 1977; Hafferty, 1988). Thus, by telling atrocity stories, women create a shared culture of motherhood and birth. Respondents reflected that there may also be a crass and competitive element to these stories.

I think everybody just scares you... horror stories at work... People talk about it in the [communal area at place of work]... as soon as you're pregnant, people start telling you about giving birth and how it feels... I think they just like to boast about the fact that they've done it... the more graphic the better... how many stitches they had afterwards and even what degree tear they had, and you're like, "I really don't need to know this, stop it." It's not personal... they don't give a shit...they build it up... as if they're better than you. (Sophie, planned CS, workshop)

By constructing social norms about pregnancy and birth, groups may influence women's decision making about breech presentation, such as presenting CS as safe (see below) but VBB and ECV as risky. For example, one respondent described how a friend had tried to persuade her to choose a planned CS:

She was sort of like: "Yeah, just do it, join us too posh to push ones." (Eleanor, planned CS, postnatal interview)

This may be problematic for women who are making decisions themselves which do not match the values or preferences of the social groups they belong to. In this situation women may feel pressured into making particular choices.

In a way I felt like I was a bit on me own because everyone's different and a lot of people are trying to say, "Are you scared man? Like is it the pain? Like toughen up, just get it [ECV] done." And it's like no, it's not about that. It's me, it's something in me that I don't want, want done... There was a woman at the school, she said someone had said that to her so she'd had it done, but then she suffered for it. Because someone had told her how to be. (Tina, chose planned CS, antenatal interview)

As well as enabling women to interpret their experiences of childbirth and contributing to social cohesion, atrocity stories may also serve a micro-political purpose (Allen, 2001).

Telling atrocity stories may enable patients to safely criticise medical behaviours, when overt criticism would be constrained, and redefine the roles of professional and patient by publicly reinterpreting past encounters (Dingwall, 1977).

While it was very common for women to be told accounts of ECV, VBB and CS which were atrocity stories, they also reported being given more positive accounts of the different options. Sometimes the conflicting accounts were all from sources women perceived as trustworthy which required them to reconcile the different perspectives.

...my sister had told me that the chances were that it [ECV] probably wouldn't work...The lady who ran the NCT... she was very pro-natural... it was quite good. Because she was very much like, "Oh go with it [ECV]... have a try and see how it goes." You know? She was very much kind of like: "Even if it doesn't work you can still have that natural childbirth [VBB]." Whereas my sister... she kind of felt that it, it probably would have been better to have a C-section... my sister had said that it [ECV] would be quite... discomfoting, a bit painful (Emily, planned CS following unsuccessful ECV, postnatal interview)

Dingwall (1977) argues that in any social encounter people use common sense knowledge to typify one another and make sense of the other's perspective. Thus, Emily interpreted the conflicting advice she was been given by viewing her NCT antenatal teacher as idealistic in her 'pro-natural' approach and her sister, who was a midwife, as 'more practical'.

Sometimes women valued hearing conflicting accounts as it enabled them to explore a range of women's attitudes and experiences to help them to anticipate how things might unfold for them during decision making.

I think it's quite interesting in a way just to compare people's stories... It makes you think: "Oh, I wonder what will happen for me? I wonder what my pregnancy story will be and I wonder if I will... need stitches or I wonder if I'll have to have a caesarean?" (Katherine, successful ECV, postnatal interview)

Some women also reported deliberately seeking out positive accounts of ECV, VBB or CS on-line to actively counterbalance the negative accounts which they had been given by their friends and relatives:

We went on the Internet and we looked up different forums... I'd already made the decision at this point though, I was definitely having it [ECV], there was nothing going to change my mind about it, but I was just, because my friends had said it was so horrendous... I wanted to see someone say positively... (Eleanor, successful ECV, antenatal interview)

5.3 Conclusions

In this chapter, I have presented data relating to what women were told about ECV, VBB and CS by professionals and lay people. Three important themes have emerged: directive counselling by health professionals; professionals having a poor understanding or difficulty communicating the evidence base; and horror stories and conflicting lay accounts of breech. During observed consultations, interviews and workshops, it became apparent that most professionals encouraged women to attempt ECV in the first instance. If ECV was unsuccessful then professionals advised women to choose a planned CS rather than a VBB.

As part of directive counselling, ECV was usually portrayed to women as a safe way to avoid a CS. However, professionals appeared to be unfamiliar with the numerical risks associated with ECV. Similarly, whilst most professionals were aware of the Term Breech Trial (Hannah et al., 2000), few demonstrated a detailed understanding of its findings (or limitations) either during observations or interviews. No professionals referred to observational studies, in particular the PREMODA study (Goffinet et al., 2006), and it appeared these important data were not routinely used to counsel women.

The final key theme of this chapter was horror stories and conflicting accounts. Women were commonly given multiple and often contradictory accounts of ECV, VBB and CS which could be problematic for them, particularly when people shared horror stories. Such stories may be anxiety provoking and women can feel pressured by others to make a particular decision. Despite this, some women valued being able to compare different accounts and some sought out particular perspectives to reassure themselves about the decisions which they had made. Having presented and discussed these data, in Sections 5.4-5.5 I show how they were used to inform the design of the PDA, consisting of the website (breech-decisions.ncl.ac.uk) and animated film.

5.4 Website content relating to the themes in this chapter

As observational work suggested that women are provided with inconsistent and, at times, inaccurate information about breech presentation by health professionals and lay people, it appeared that a resource providing balanced, high quality, evidence-based information would be helpful to support SDM about breech presentation. In response to this, the website component of the PDA was developed to summarise the evidence base for the management of breech.

The website was designed to begin with an explanation of what breech presentation is, how common it is and a list of potential reasons why babies are breech (which some women reported searching for). The process of diagnosis and decision making is then described (with the flow chart explained in Chapter 4). For each option there is a description of what is involved and the benefits and risks are summarised. These data are structured around the values women shared during interviews and workshops (Chapter 6).

Evidence from the Cochrane Reviews, RCOG and NICE guidelines is summarised and numerical risks are framed both positively and negatively to avoid. Success rates are also given. As this resource is aimed at women from all over the UK (and beyond) local success rates were not included as they might have been misleading, rather the international average is given.

The types of birth experienced by women who choose to attempt ECV, VBB or planned CS are provided in Table 1 of the website alongside those of women with a cephalic baby for comparison. As the use of forceps was a theme in accounts of VBB the rates of forceps (and ventouse) use are also included in this table.

Data from the Term Breech Trial (Hannah et al., 2000) is shown alongside data from the PREMODA study (Goffinet et al., 2006) so women can compare the risks of VBB and planned CS. A simple summary of this research is also provided, describing the limitations of the evidence base discussed in Chapter 2.

5.5 Film content relating to these themes

The film addresses the key themes in this chapter of horror stories and directive counselling. Rachel is seen reading a magazine featuring “Amazing Birth Stories”. The aim of this scene was to acknowledge and explore visually the negative images, particularly of VBB, with which women are bombarded, and the impact they may have. There are pictures in the

magazine of a medicalised breech birth. A woman is seen isolated, in lithotomy and obviously in pain. The next image is of a health professional delivering a breech baby. This is contrasted with a happy image of the mother cuddling her newborn baby as Rachel reflects that her own midwife has reassured her that complications are rare. She summarises the dilemma women face in having to evaluate contrasting accounts by saying, “It gets to the point where I don’t know what to believe.” Horror stories about ECV may also be confronted by the provision of two examples of attempts at ECV which are more realistic, grounded in the accounts women gave in interviews and workshops (see next two chapters for further discussion of these examples).

The issue of directive counselling is addressed more subtly by showing parts of a model consultation in the film. Throughout the film, it is explained that women have three options and the decision process is summarised visually, initially as a simple flow chart on the clinic wall and then using signposts on a motorway. It is hoped that this will emphasise or remind users that women have three choices available to them which they can discuss with professionals.

In addition to addressing these two key themes, the film is also used to show some key information about options relating to themes in this chapter. For example, the purpose of tocolysis prior to ECV is explained; that women are monitored after ECV is shown; and it is explained that you can’t drive immediately following a CS.

Chapter 6. Women's values about breech presentation

Choosing between different treatment options based on one's own values is a central component of SDM (see Chapter 1 and Coulter and Collins, 2011). In this chapter, I explore women's values that underpin decision making about breech presentation. Within this discussion, I consider women's attitudes towards ECV, VBB and CS and how these relate to the values they describe. I then examine respondents' accounts of how they made decisions before explaining how all these themes informed the development of the PDA, consisting of the website (breech-decisions.ncl.ac.uk) and animated film.

6.1 Women's values

6.1.1 *Wanting to keep their baby safe*

Most respondents explained that keeping their baby safe was their main priority.

I'm more concerned about the baby than anything else. (Heather, unable to attempt ECV due to low AFI and planned CS, antenatal interview)

I think the main information that I took into account was: was there any risk to the baby... or is there any risk it could jeopardise your pregnancy by doing it [ECV]? So I think that was important. (Catherine, successful ECV, design workshop)

It is possible that social pressures mean women feel required to say this as the protection and nurture of children, beginning in pregnancy, remains central to normative constructs of motherhood (Oakley, 1981; Ruddick, 1990; Miller, 2005). However, respondents shared more details about what this value meant to them, which suggested it was fundamental to them. For example, many respondents explained they would do anything to protect their baby, including accepting risks to themselves. Tina explained that she opted straight for a planned CS, rather than attempt ECV, because she perceived it would be safer for her baby but had accepted that a CS might not be the safest option for her:

I had to go on my gut and it's: "No" [to ECV]...everyone else had said they've either had it done and they've been in pain or it's triggered something. But I just didn't want that to happen to me and you always think you're the one it's going to happen to. So I just couldn't do it. So I'd rather opt for the c-section than try and turn her... They can do what they want to me as long as they get her out and that's fine. (Tina, planned CS, antenatal interview)

The embodied experiences of pregnancy, such as feeling fetal movements, may give women a sense of their baby being a person in their own right. Eleanor's account of the differences

between her husband's and her own attitudes towards their baby and decision making suggested this:

I think he was more worried about me, 'cause to him I was the only person that was important at that point in time. That's what he kept saying that, "You've felt the baby and you know that the baby's there, but to me you're the person that has to make the decision as, as it's going to happen to you. And at the moment the baby's just, it's something that's moved in your stomach... I don't know it [the baby]." He felt like he didn't have a connection to her until she was born. (Eleanor, successful ECV, workshop)

Laura's account of decision making also suggested that women see their unborn babies as separate beings and feel responsible for the decisions they make on their baby's behalf:

If you're making a decision about yourself that's fine... but it's not just me it's my baby and that's where I found it hard... If... something bad happens I'll have to live with that for the rest of my life... especially when it's this close to being born, you've went that long protecting your baby and doing everything you can. (Laura, successful ECV, antenatal interview)

She suggests that the desire to protect one's baby is instinctive throughout pregnancy. Other women's accounts also supported this view. For example, Sophie described how she disliked other people touching her pregnant abdomen:

I didn't even like letting the [sic], when they were palpating me stomach to be honest. And I was quite protective about who touched me bump... I didn't like it, you know, random people in the supermarket, "Ee, how many weeks are you?" I would go, take a step back. So maybes that had something to do with it [decision not to attempt ECV]... I was really protective of me bump. (Sophie, planned CS, workshop)

Keeping their baby safe may feel particularly important to women with a breech baby as they are constantly being told about the risks to their baby, including the risk of death (see Chapter 6). For example, Grace explained that was why she had chosen to have a CS rather than attempt a VBB when diagnosed with breech presentation in the second stage of labour:

I thought it... was a no-brainer, if there's danger to the baby... I think in my own brain I just magnified them [the risks] as they [the baby] would get stuck, that it would just be harder and they'd be stuck in the birth canal and all of those situations. And the last thing you do when you go in to have a baby is to not to take, you want to take your baby home. You know, you don't want to have that [the baby die]. (Grace, emergency CS, workshop)

Grace's account suggests that the risk of stillbirth is a real concern to women with a breech baby and that they desperately want to avoid this. This explained why many women did not

want to consider a VBB as this sort of birth was generally perceived as risky for babies. Specific risks women were concerned about included: injury to their baby; cord prolapse; fetal distress; labour not progressing; the need for forceps to assist with delivery; and the likelihood of needing an emergency CS.

I was very dismissive of that idea... if you've got a small pelvis it could be very difficult for you and obviously the cord... can come out first and the baby can get distressed which I would want to avoid at any costs... and I said to her [the midwife] straight away I wouldn't consider it because it's too risky. (Laura, successful ECV, antenatal interview)

Many women described the mechanics of a VBB as problematic because the smaller legs and buttocks of the baby would be born before the larger head:

There could be a little bit of bumps coming out and obviously the birth, the fluid and things coming out and breathing and with the head coming out last, the bum coming out first and it can be a bit of a strain on the head and they might have to use forceps or to try and help... it just didn't sound appealing at all. (Lynne, unable to attempt ECV due to low AFI and planned CS, antenatal interview)

Several respondents believed that a VBB would be stressful for them as they would be anxious about a poor outcome, and to avoid this opted for either ECV or planned CS:

I just don't like the idea of it... I think I would feel quite panicked... that the baby would get hurt... I would just be worried about the baby's safety and that's kind of paramount really... it just feels risky I think, so why if you can avoid the risk then avoid it really. (Samantha, planned ECV, antenatal interview)

As well as the specific risks associated with breech birth, for some respondents, previous negative experiences in pregnancy heightened their desire to protect their baby. Several respondents disclosed previous pregnancy loss, and suggested that these experiences had influenced their decision making about breech presentation by making them more cautious about potential risks to the baby. Emily shared the anxieties which she and her husband had had:

I think as well with my husband he was – because we've had so many miscarriages – he was very nervous about the idea of me having a natural childbirth. (Emily, unsuccessful ECV and planned CS)

Georgina, who had also experienced multiple pregnancy losses, declined ECV and chose a planned CS because she perceived this was the safest option for her baby. She had accepted

'missing out' on the experience of natural childbirth (see below) at the time in order to have a healthy baby.

I was told the options with regards to the manual turn... But obviously I didn't want to take that risk, given my history... In the end, I decided to go for the caesarean section. The reason being really because of the background. You know, the two years that we've took to have [name of baby]. And I was disappointed, I really, really wanted a natural birth, but I knew...that going into labour with a breech baby, wouldn't really be good for me or her. (Georgina, planned CS, postnatal interview)

As well as past experiences of pregnancy loss, respondents described how other experiences of pregnancy complications also contributed to the importance of wanting to keep their baby safe. Tina had given birth to her first son at 34 weeks and he had required admission to the Neonatal Intensive Care Unit (NICU). Her experiences of this and of tube feeding her son on the postnatal ward had influenced her decision to have a planned CS, which she believed would be safer for her baby than an ECV.

I want to do this as safely for her as possible. Because I spent a lot of time in with me son in hospital, and I just didn't like it... I don't want to have another baby with tubes. (Tina, planned CS, antenatal interview)

A planned CS was generally perceived as safe for babies but riskier for mothers (see below):

I think probably from the baby's point of view it's less risky but obviously from the mother's point of view, it's more risky. (Alison, successful ECV and emergency CS, postnatal interview)

However, some women, like Laura, were concerned about possible risks to their babies from a planned CS:

...it [the baby] has not decided it wants to come so you're bringing a baby out before it's time... they can be a bit more mucousy and sometimes have a bit more breathing difficulties. They have to give them oxygen because they haven't been through the birth canal. (Laura, successful ECV, antenatal interview)

6.1.2 Wanting to experience a natural birth and to breastfeed

As well as wanting to keep their baby safe, many respondents also explained that wanting to experience a natural birth was also important to them. Most women reflected that they had planned a natural birth prior to the diagnosis of breech presentation. Many respondents told

me they had planned to birth in water. Using water was seen as an attractive method of pain relief, but a water birth also appeared to symbolise an intervention-free birth:

I think... the birthing experience, it's an amazing thing to be able to do so I'd like it to be natural... I've got an idea in my head of possibly using water and I want to go with what I know, I think, is going to work for me and be comfortable and help me feel kind of calm and reassured. (Samantha, planned ECV, antenatal interview)

During interviews and workshops I explored what natural birth meant to respondents. Lynne explained she had chosen to attempt ECV to be able to aim for a low-intervention birth in a pleasant environment:

It's [the reason she chose to attempt ECV] the idea of having a perfect birth. The ideal birth that you've planned and thought about, and know is the more natural, the way of doing things... no pain relief or anything... a total dream, everything just happens within a few minutes... you have your nice little soothing baths... lovely nice, airy, modern looking room... the baby wasn't affected by any drugs or anything like that. You know, that would be lovely, that's the perfect ideal... obviously... every single sort of pain relief on backup... But that was just straight out the window, I was like, "Oh crap! Oh no." Now [she was unable to attempt ECV]... that's all out of my hands... It was all in their, the doctors' hands and I haven't got anything to do with it now, it's taken away from us. (Lynne, planned CS as unable to attempt ECV due to low AFI, workshop)

Like Lynne, many respondents chose to attempt ECV to enable them to have a natural birth and avoid a CS. Eleanor explained some of the reasons why a natural birth was important to her:

I just wanted everything about my pregnancy and my birth to be natural... I was quite optimistic that it [ECV] was going to be successful and that I was going to have a natural birth... I just have beliefs that the human body of a woman is supposed to give birth... we've done it for years beforehand, so why not now?... My body's supposed to do this... why do I need medical intervention? (Eleanor, successful ECV, workshop)

Many respondents explained they had wanted their partner to be able to participate in the birth and had wanted to ensure he (there were no lesbian respondents) would also have a positive experience. Natural childbirth was seen as enhancing bonding within a partnership, whereas a caesarean section was presented as excluding men from participating in the birth process:

I think probably for my husband as well I think he would be more involved in a natural birth than a caesarean... I want it to be equally a special occasion for him as well. So I think just the event and the whole experience of us doing it together, the pair of us. (Samantha, planned ECV, antenatal interview)

Aiming for a natural birth was important throughout pregnancy and many respondents had made a birth plan. Some respondents reported that they had attempted to prepare their bodies for birth by sitting on a birthing ball or by doing exercises they thought could make birthing easier. Some women had also attempted alternative strategies to try and turn their babies themselves, before or after attempting ECV.

I do a lot of yoga and things like that and looking at preparation for labour... I had read all these different techniques about how to turn the baby yourself, different positions and acupuncture and reflexology and all sorts of things... The yoga I am doing as well, there were some positions in there that they recommend for breech as well which I have been doing all the time... We tried the torch and the baby did move around a lot more if you shine a torch, low down... I didn't try the frozen peas because that seemed a bit odd. (Pippa, unsuccessful ECV and planned CS, antenatal interview)

Although research has shown such methods are not effective (Hofmeyr and Kulier, 2000a; Coyle et al., 2012) trying alternative approaches may offer women a way to take an active role in the management of breech presentation.

Previous positive experiences of birth were also given as an explanation of this value. Several respondents had experienced natural births in previous pregnancies and described the sense of achievement they had gained:

I've done that and I've laboured. I've pushed that baby into the world! (Mandy, VBB, postnatal interview)

Nina, describing the birth of her first son, explained how birth had felt instinctive to her:

You can feel your body pushing the baby out and you know when you're pushing if you are moving them or not... You just feel like a sudden drop and you can feel your body pushing them out even when you don't push, you can feel your body moving it a little... further and further. (Nina, successful ECV, workshop)

Thus, these respondents chose to have an ECV (or less commonly a VBB) to try to achieve a natural birth.

Even if a previous birth had required some intervention, women often expressed a preference for another vaginal birth. For example, Laura preferred to have an ECV and aim for a vaginal birth, rather than consider a CS or VBB which were unknown to her.

It's maybes a bit of better the devil you do know than the devil you don't... I know what it's like to have a baby so well. (Laura, successful ECV, antenatal interview)

This was despite difficult experiences of preterm birth, augmentation of labour and episiotomy.

Some respondents did express anxiety about natural childbirth. For example, Catherine described her fear about birth and her ambivalence towards ECV during a workshop:

I was maybe a little bit reluctant to have it [ECV] just because it was my first child and I was scared of giving birth... so in my mind actually not having the procedure done and going for a planned caesarean was actually something that I was kind of quite keen on... if it avoided all the concerns as to what might happen... I kind of thought I would give it one go and fate would take [sic]. And if it worked it worked, and then I would have to go through with the labour. It was a bit, when it was successful it was a bit of a "Oh!" disappointment, which I know is not supposed to be the thing... I think I kind of went in to it, well if it works then that's ... probably better for the baby... and probably ultimately better for me if everything goes alright at the birth. (Catherine, successful ECV, workshop)

Only three women, all of whom had had normal deliveries before, planned to attempt a VBB. These women believed a CS was unnecessary just because their baby was presenting breech and believed that having a VBB had the advantages of: avoiding the risks of surgery (see below), avoiding a scar, enabling a faster recovery, thus making it easier to care for other children (see below), and facilitating bonding with their baby:

I don't need one [CS], it's unnecessary really. You know, I've had my other two at home with no pain relief, I can do it again. (Mandy, VBB, postnatal interview)

For me it was a lifestyle choice. Because I've already got a daughter and I don't want to be inactive for up to six weeks if I could help it. Because I think I wouldn't have been able to bond with him... I don't think I would have enjoyed the experience of being a mum to a new baby if I'd had a section. (Melissa, unsuccessful ECV and VBB, postnatal interview)

Nevertheless, they both reported experiencing anxiety relating to VBB:

I felt glad there is a chance for him to come this way. But then I thought: "Well have you been silly enough to go this far? The waters have broke, what happens if the cord's wrapped round his neck? Or he gets stuck and then you need a caesarean anyway and then he's like stressed?" (Mandy, VBB, postnatal interview)

Most respondents did not perceive VBB as a natural option, rather they saw it as abnormal. Despite many reporting a preference to give birth vaginally, most explained that they had not wanted to attempt a VBB.

So that was my main concern, just to avoid it [CS] at all costs so we were trying everything before that apart from the breech vaginal birth. I didn't want to do that one... it just didn't sound appealing at all. (Lynne, unable to undergo ECV due to low AFI and planned CS, antenatal interview)

Several respondents recognised that VBBs were rare and were concerned that health professionals might lack the necessary skills:

There isn't many midwives who have got experience with that because they just don't happen as much now, so a lot of people were saying you have to, if you really want to, look for an independent midwife who might go along that route with you. (Pippa, unsuccessful ECV and planned CS, antenatal interview)

As well as wanting to have a natural birth, wanting to breastfeed was a common theme during interviews and workshops. Respondents were aware of proven benefits of breastfeeding such as improved infant immune function and also saw breastfeeding as a facilitator of mother-infant bonding. Wanting to breastfeed appeared to directly impact on decision making as some respondents were concerned about the implications of a CS for being able to have skin-to-skin contact with their baby which they knew would facilitate breastfeeding:

The c-section recovery bit put me off as well, like with the skin to skin and not being able to lift the baby and would it... hinder breastfeeding and things... I really wanted to breastfeed and even though ... it was so difficult at first, I was so desperate to get it right so that I could do it because it was important and I had to do it because that was going to help her develop, and that was going to give her antibodies, and it was... that sort of belief that I would have a really good bond... 'Cause my mum breastfed me, but she couldn't breastfeed my sister... they're not close at all and... we do have a special bond. (Eleanor, successful ECV, workshop)

6.1.3 *Wanting to avoid surgery*

Many of the women who decided not to have a planned CS were concerned about the risks of surgery for themselves. In this group of otherwise fit and healthy women, few women had any experience of having surgery and were frightened at the prospect.

Just the thought of someone coming at you with a knife, it's awful being awake. I know they say you are behind a screen, a thing, but I don't like the thought of my stomach being cut open. (Nina, successful ECV, antenatal interview)

I am not a big fan of operations as well, you know catheters and all that kind of thing. (Laura, successful ECV, antenatal interview)

In contrast to their positive views of natural birth, some respondents viewed CS as an abnormal way for a baby to be born:

So a caesarean just feels a bit more clinical... well it's surgery isn't it so just that side of it as well, I just want to embrace the experience I guess, of a birth.
(Samantha, planned ECV, antenatal interview)

I felt at the time, there were less risks involved to me and to the baby generally and that surgery seemed unnecessary for a normal, healthy pregnancy. (Carol, successful ECV, antenatal interview)

Many women were aware of the specific risks of CS including: bleeding; infection; pain; damage to other organs; blood clots; the baby having breathing problems; and the baby being cut. Many respondents were concerned about the recovery time following a CS, in particular being less mobile, being unable to drive and being unable to care for the baby or other children independently (see below).

I don't like being stuck, not being able to get up and move around... driving. It's hard when you've had any stomach surgery, just moving, bending and lifting and it affects everything, so I don't want any type of surgery... There is a risk to your bladder; some people have damage to their stomachs; and afterwards the healing, infections and bleeding. Some people bleed a lot and need blood transfusions.
Nina, successful ECV, antenatal interview)

Even women who chose a planned CS were concerned about the implications on their lives of having surgery. For example, Aisha was also disappointed that having a CS would interrupt her usual exercise routine:

I do loads of exercise normally, and I love running, and I realised these kind of things are going to be put on hold for a while. So that is a bit gutting for me.
(Aisha, planned CS, antenatal interview)

6.1.4 *Wanting to be able to care for other children*

All women with older children had considered the implications of the decisions on their children, who they understandably wanted to still be able to care for. These respondents wanted to minimise the risk of any harm to themselves and also avoid being incapacitated after the birth. Carol was concerned about attempting ECV and then vaginal birth after caesarean section (VBAC) in case anything went wrong. However she opted to attempt ECV as she wanted to be able to care for her son:

I am getting more concerned about the risks of rupture and the catastrophic events that could occur from that... I've had the healthy pregnancy so far and now... I just want to get to the other side of it and still be a mum to [name of son]... because I've got one child already you want to make sure you are fine for them as well... I kind of think it is in the back of my mind about how my decisions will affect my family. If I elected for a section and... can't lift [name of son] I have got responsibilities already and you need to try and make a decision that works with them as well. (Carol, successful ECV, antenatal interview)

Like Carol, many mothers were concerned about the impact of recovering from a CS on caring for their other children.

A caesarean... I'm really against that, 'cause I think when I go home, I've got a little boy to get to school. (Michelle, unsuccessful ECV and planned VBB, antenatal interview)

Michelle's partner was in prison and, although he was due to be released soon, would miss the birth. Whilst she seemed ambivalent about this she was concerned about the lack of support she had from her family. This influenced her decision to attempt VBB after an unsuccessful ECV as she was concerned about how she would manage at home recovering from a CS with a baby and a young child:

I've got nine brothers and sisters... I mean, when I come in before [for ECV] and they said: "Are you on your own?" Well, I was on me own. For having such a big family... one of them could've offered to come... I'll be in four days or five maybes with the [other medical reason]... But it's not just that, it's getting home and if it's just me there. (Michelle, unsuccessful ECV and planned VBB, antenatal interview)

This contrasted with accounts such as Tina's discussed below (see Section 6.1.5) when she explained she would have good support from her husband during the recovery period.

6.1.5 *Wanting to have control*

Being able to have some control during pregnancy and childbirth seemed important to many respondents but this meant different things to different women. Some women described how experiences in pregnancy had made them feel out of control of their bodies. Some women had experienced unpleasant physical symptoms including nausea and vomiting, vaginal bleeding, ankle swelling and musculoskeletal pain. It is possible that such experiences may influence decision making about breech presentation. For example, Aisha's account suggests her experience of nausea and vomiting during pregnancy may have impacted on her values about birth.

At the start of the pregnancy I was very happy to be pregnant, it was very wanted and planned. But I had really, really bad sickness... I was just very unwell and I was quite miserable being pregnant... I think it just knocked my confidence and I just thought: "Am I just being a wuss, can I not deal with this like other people can?"... I never made a birth plan, I just couldn't think about delivery. So I kind of think that is probably why... I wasn't gutted at the thought of losing a normal delivery. Because I had never got to the point where I was getting excited about it, or planning it or thinking: "This is important to me." (Aisha, planned CS, antenatal interview)

Eleanor's description of decision making also suggests that feeling out of control of her body had impacted on her decisions. She recounted a negative experience when an obstetrician confronted her about her weight at the time she discovered her baby was breech:

In my mind I was like: "Oh, I'll lose a bit of weight before I fall pregnant" and then I fell pregnant straight away... I've always had problems with my weight... I've always struggled and I've always gone from one extreme to the other... she [the obstetric registrar] came in... and said: "You're going to be here [antenatal clinic] ages because you need a scan because basically you've put on so much weight that your baby could be in danger." And I was like: "What?" I was absolutely shocked... So I got really upset. (Eleanor, successful ECV, postnatal interview)

She went on to explain how this had contributed to a loss of faith in health professionals. She described various examples of when she had been given contradictory advice, not only about the implications of weight gain in pregnancy, but also in relation to the options for breech presentation:

I'm massively in favour of the whole skin-to-skin contact and I think that... wasn't consistent in the hospital... When the doctor suggested I have a caesarean, I said: "Oh I don't want a caesarean because I want skin-to-skin contact. And she went: "It's not that important." I was kind of like: "I've just been to four workshops at your hospital where you've told me it's categorically the main thing to do and they were like: "I know but at the end of the day, the birth of the baby is more important." So I was like: "Be consistent!"... "I want an ECV." (Eleanor, successful ECV, postnatal interview)

Thus, it appears that recognising inconsistency in the advice she was given made her more confident to ignore their recommendation to opt for CS and choose to attempt ECV. In this way, despite feeling undermined by the obstetrician, she appears able to take back control of the situation.

For other respondents, having control meant making a decision which would avoid unnecessary pain. Whilst many accepted that some pain during childbirth was unavoidable,

they were keen to choose the option they perceived would be least painful. For example, Nina was clear that for her, pain was the most significant influence on her decision making:

I don't care what people say... the only thing a woman worries about when you're pregnant is the pain. What is it going to be like if I have this? What is it going to be like if I have that? And some people say: "Ah well, I'll just do what's best for me baby." But at the end of the day, you do want to do what's best for you baby but at the same time, pain. The fear of pain takes over your decisions really... I feel like I have quite a low pain threshold... other people like me mam, who had three kids, said: "You should never have got pregnant if you didn't want to have the pain. Stop being a baby... At some point in your pregnancy you're going to have some kind of pain. Either you have a caesarean or you have natural childbirth. At some point you've got to expect a bit of pain so just get on with it..." I know I don't like pain, so it was a major issue for me. (Nina, successful ECV, workshop)

Women were particularly concerned about attempting a VBB which they anticipated would be more painful than labouring with a cephalic baby.

I would never choose to do it the other way [VBB]. Partly because I remember my mam being breech herself and my nanna had had a terrible time and had to go to hospital, because all her other babies had been born at home. So I thought there'd be a great deal of pain associated with me delivering [breech] and I was exhausted. (Grace, emergency CS, workshop)

For other women, having control meant avoiding the uncertainty about the outcome of an attempt at ECV or labouring vaginally. For example, for Sophie choosing a planned CS gave her control over the sort of birth she wanted as well as avoiding the risks she associated with ECV:

I just kept looking at the fact that I can [sic] have a planned section with, obviously the risks associated with section, or I can have them turn him unsuccessfully. I don't know why, I just kept thinking something would go wrong... if I let them turn him... that to me seemed more invasive than having them cut us open... I didn't want to have an emergency section... but if the ECV goes wrong I have to have a section anyway... I know planned surgery... I know it's calm. (Sophie, planned CS, workshop)

Like Sophie, most respondents wanted to avoid an emergency CS which they perceived as more frightening and stressful than a planned CS:

You know a c-section fair enough it's got its advantages. I think it's got its pros and cons. But an emergency one I think would stress us. It feels it would be more stressful for everybody... Because it would happen so quick... it would be a case of it's got to happen now and the reason it's got to happen now is because

something's gone wrong. (Heather, unable to attempt ECV due to low AFI and planned CS, antenatal interview)

For some women control meant being able to choose when their baby would be born, usually by planning a CS.

This is just the best for me and obviously the best for the family... Maybe if he [her partner] hadn't the time off, I would have thought maybe a little bit differently about being on my own with my son... But this is just best, so everything can be organised. I've got a date, I've got someone to watch me son, he can go to school and everything can go back to normal... I just feel safer knowing I'll go in on a morning. I don't have to go into labour... It's nice to know when you're baby's coming as well and when your baby's birthday is. (Tina, planned CS, antenatal interview)

Although most women with children wanted to avoid a CS (see above), Tina recognised the benefit of being able to schedule childcare around a planned CS.

Occasionally, women described exceptional circumstances which meant that being able to plan the timing of the birth was desirable. For example, Aisha's mother had a terminal illness, and her health had deteriorated during Aisha's pregnancy. Aisha had therefore chosen to have a planned CS to bring forward the birth of her baby (compared with potentially having to wait several more weeks for labour after a successful ECV) to increase the likelihood of her mother being able to meet her baby:

So my Mum's illness has been such a stressful factor in the past six months that I didn't think she would be here now. So when I thought about a section, and the fact that it would be at 39 weeks rather than maybe I might go over and need to be induced. I just thought: "My Mum will see my baby!" Because she is so excited about it. I know it has given her a lot of strength and purpose... I appreciate it is not a typical reason, because logically I do think ECV would be a sensible route. But just with everything that has gone on... I just want to have my baby. (Aisha, planned CS, antenatal interview)

6.2 Eliciting values

During observed consultations, health professionals did not routinely elicit women's values. Most professionals simply asked women what their preferred final option was without exploring what underpinned their preferences. Sometimes women did volunteer their values spontaneously to professionals. For example, Esther was concerned about the possibility of spontaneous version after ECV so explained she was considering a planned CS, particularly as she perceived she would be more likely to ensure her husband, who was working away, could be present:

I'm torn between the turning and the caesarean, a friend of mine also had the same and the baby turned nicely and then the next day turned back... I've also got the added thing with the turning, I'd like my husband to be here and he's over in the Netherlands right now... I just want... what's best for my baby and my husband not being in the country is an added complication. (Esther, observation 11)

After her obstetrician reassured her she could arrange an appointment for ECV at a time when her husband could attend she opted to attempt it. Other women reported during interviews that they had felt unable to discuss their values with health professionals. For example, Aisha explained she had felt unable to discuss her mother's terminal illness and how this had influenced her decision with her obstetrician because she perceived he was too busy:

A So when I thought about a section, and the fact that it would be at 39 weeks rather than maybe I might go over and need to be induced. I just thought: "My Mum will see my baby!"...

B Did you talk to [obstetrician] about that when you were in clinic?

A I just thought, "It is an antenatal clinic, he is busy. I have made my decision." (Aisha, planned CS, antenatal interview)

Georgina reflected that she wished professionals had encouraged her to consider what was important to her during decision making. She had chosen a planned CS as she had thought keeping her baby safe was the most important thing but later regretted not attempting an ECV as she felt she had missed out by not having a natural birth:

I think if someone had sat us down and said: "Right we're going to have a good chat about this... I've read through your notes... you wanted an active birth. You've changed your mind, you're going for this [CS], why are you doing that?" I think I would have been like, "Hmm you're right, what am I thinking of?" That was never pointed out... I disconnected from me core values. (Georgina, planned CS, workshop)

Previous research in other clinical contexts has shown that patients may not have clear preferences and that their preferences, like Georgina's, may change over time (Fagerlin et al., 2013). Therefore, professionals can have a key role helping patients to clarify and develop informed preferences, by providing them with the information most relevant to them (Elwyn et al., 2012). The reasons why professionals did not routinely explore women's preferences are not clear from my data (see Chapter 8). Nevertheless, Georgina's account suggests that she recognised the importance of values in decision making about breech presentation.

During interviews and workshops, most women were able to explain their values and how these had influenced their decision making. It appeared that many could see that their values had affected the decisions which they made. Some respondents reflected that different women would have different values about breech presentation. Sometimes they presented this as being due to various characteristics such as age or personality.

I think older mothers like me want to plan things and want everything to be perfect... It's a control thing. (Martha unsuccessful ECV and planned CS, postnatal interview)

However, a few women described a more instinctive, emotional approach to decision making. For example, Tina described a visceral “gut” reaction to the idea of ECV:

I says to her [midwife]: “Me gut says no.”... At first I had like a sickly feeling in me belly thinking about it. But then it was straight up, “Na.” There was just something about it that I just didn't want. (Tina, planned CS, antenatal interview)

For women like Tina, decision making may be more of an intuitive rather than a rational process.

6.3 Chapter conclusions

In this chapter, I have identified five key values from interviews and workshops. Respondents described wanting to keep their baby safe, to experience a natural birth and to breastfeed, to avoid surgery, to be able to care for other children and to have control.

Wanting to keep their babies safe was the most common reason that women gave as underpinning their decisions. Feminists argue that maternal and infant mortality and morbidity data are not always the most appropriate outcomes to judge the standard of maternity care, suggesting that more emphasis should be placed on women's experiences of childbirth (Oakley, 1984; Trevathan, 1997; Schiller, 2015). However, it appears that for most women in this study, having a healthy baby was genuinely the most important outcome to them and many respondents were prepared to compromise on their aspirations for childbirth in order to achieve this.

Nevertheless, many women explained that they wanted to experience a natural birth. For some women this is because they wanted to avoid medical interventions and to have a birth in a pleasant environment. Previous research has found that women have varied attitudes towards medical interventions during pregnancy and birth. Davis-Floyd (2003a) describes a spectrum of attitudes amongst American women. At one end were women who fully

embraced a “technocratic model” of birth, defined as male-centred, with women’s bodies seen as defective and requiring a doctor and technology to overcome problems and to prioritise the safety of the fetus (Davis-Floyd, 2003a p154-161). At the other end were women who rejected such an approach in favour of an “holistic model” defined as woman-centred, with female reproductive processes viewed as normal and healthy, and experiential and emotional knowledge valued as highly as technical knowledge, with the health of the baby protected by attending to the physical and emotional needs of the mother (Davis-Floyd, 2003a p154-161). Like some respondents, women who preferred the holistic model believed that birth was a natural part of womanhood and that they should trust their bodies (Davis-Floyd, 2003a). Other respondents favoured natural birth because they believed this would facilitate their partner’s involvement in the birth or because they had previous, usually positive, experiences of childbirth.

Respondents generally did not see vaginal breech birth as a natural option, rather they perceived it to be abnormal, risky and were concerned that professionals would not have the appropriate skills to manage such a birth. However, as professionals did not seem to discuss the absolute risks with them (see Chapter 5) nor explore these values during consultations, possibly as they matched professionals’ own values (see Chapter 5), it was difficult to assess how informed these perceptions were. There were three women who took a different view, choosing to attempt VBB because they believed a CS was unnecessary and that a VBB would enable them to recover more quickly and bond with their baby.

Many respondents reported that they had wanted to breastfeed their babies. For some of them, this was because they were aware of the advantages of breastfeeding, but for others they saw it as a way of making up for not having a natural birth. These respondents had considered the implications of the different options on their likelihood of establishing breastfeeding.

As well as wanting to experience natural childbirth, many respondents also wanted to avoid surgery. Some women described being generally frightened of it and perceiving CS as abnormal. Others had specific concerns such as potential complications or the implications of recovering on their independence. This was particularly important for women who had older children to care for. These mothers wanted to make decisions which would ensure they would be safe and also that they would be able to care for other children as quickly as possible.

As in previous research (Lally et al., 2014), being able to have some control during pregnancy and childbirth was an important value but this meant different things to different women. Some respondents considered how feeling out of control of their bodies during pregnancy might have affected their decision making. Earle (1998) argues that lived experiences of the body during pregnancy and birth are a threat to the maintenance of self-identity, but little is known about the effects such experiences may have on decision making. Respondents gave examples of when unpleasant physical symptoms, such as nausea and vomiting, or body changes may have affected the decisions they made, either because they were more accepting of medical intervention or because they rejected medical advice in order to take back control.

For other women having control meant avoiding unnecessary pain or uncertainty relating to particular options. For example, for some, the outcome of ECV was too uncertain and many wanted to avoid needing to have an emergency CS. My previous research shows that other women have similar concerns about ECV to respondents in this study (Say et al., 2013). Some respondents valued the relative certainty associated with planning a CS, particularly having a date to make arrangements around. Some women described circumstances when this was particularly valuable, for example if they had little social support. More exceptionally, one woman explained how choosing a planned CS increased the likelihood of her mother, who was terminally ill, meeting her baby. These examples emphasise the importance of recognising that pregnant women all have different social circumstances and needs, and that these will likely impact on their decisions about breech presentation.

While many women shared similar values, holding a particular value did not necessarily predict the decision a woman would make. For example, three women might all explain that keeping their baby safe was the most important thing to them, but one might choose to attempt ECV, another CS and the third VBB. In this way such values may not be discriminatory in relation to decision making. Some respondents gave accounts of how they had reconciled different values suggesting some were more important to them than others. Therefore, their relative strength and the trade-offs between them may vary between women. Alternatively, such values may not always be important in decision making (Fagerlin et al., 2013), particularly for women who adopt a more intuitive approach. In fact, Gigerenzer (2007) demonstrates that deliberately considering reasons during decision making can lead to people making choices they are less satisfied with.

In general, the positivist emphasis on evidence-based medicine means that instinct and intuition are not viewed as legitimate knowledge (Cioffi, 1997). Intuition - defined by

Gigerenzer (2007 p16) as “a judgment that appears quickly in consciousness, whose underlying reasons we are not fully aware of and is strong enough to act on” - is valued in contexts outside of healthcare, for example, in a business setting the use of intuition has been seen as a critical component when differentiating between successful and dysfunctional boards (Dane and Pratt, 2007). Furthermore, other research outside of healthcare has suggested that a focus on deliberative reasoning about options may result in too much emphasis being placed on attributes which are easy to identify and articulate rather than those which are actually more important to the person making the decision (Fagerlin et al., 2013). Within healthcare, some experts in decision making are concerned about the potential for intuition to bias decision making, by limiting the information used by patients to make the decision and making decisions harder to explain (de Vries et al., 2013). However, Gigerenzer (2007) argues that good choices need not be based on complex trade-offs between the pros and cons of all options. Rather he argues that gut feelings enable humans to use their evolved intelligence to dismiss unnecessary information and make fast and effective decisions by using rules of thumb (heuristics) (Gigerenzer, 2007). Hence, using intuition may help women to make better decisions and also to better integrate their emotions into decision making (de Vries et al., 2013). Certainly, feminists and advocates of natural childbirth suggest that intuition should be held in higher regard in relation to pregnancy and birth than it often is (Davis-Floyd and Davis, 1997; Davis-Floyd, 2003b).

Whilst most respondents were able to clearly articulate their values during interviews and workshops, during observations, professionals did not attempt to elicit women’s values and rarely discussed them, even when women volunteered them. Some respondents also reported feeling unable to discuss their values with health professionals during appointments. This suggests that training about the importance of values elicitation in shared decision making is needed to help professionals develop these skills. Having presented and discussed these data, in Sections 6.4-6.5 I show how they were used to inform the design of the PDA, consisting of the website (breech-decisions.ncl.ac.uk) and animated film.

6.4 Website content relating to these themes

Where possible, I identified research relating to women’s values to provide them with relevant evidence-based information and laid this out under headings which relate to the values discussed above. Headings used include:

- Is it safe?
- Will it hurt?
- Will it work?

There are also specific sections on recovery and breastfeeding. During workshops, respondents described how categorising information in this way would help them identify the information they wanted:

I suppose maybe just something... that had the values... a statement followed by the information underneath (Eleanor, successful ECV, workshop)

In the sections “Polly’s story” and “Rachel’s story”, the characters’ values (see below) and how they affected their decisions are described. This is to complement the animation by further highlighting the importance of values in decision making about breech presentation. It is envisaged that reading about the characters’ values will prompt women to consider their own.

6.5 Film content relating to these themes

One of the key purposes of the film was to explore the values which underpin decision making by using the two characters’ stories to explain their values. As with reading the website content, it is hoped that hearing these accounts will prompt viewers to consider what is most important to them. Polly explains that she had wanted to experience a natural birth so had opted to attempt ECV, despite concerns about pain, as natural birth was most important to her. When ECV is unsuccessful she explains that she chose a planned CS as she had also been nervous about labour. She reflects that choosing a planned CS gave her more certainty about when the birth would happen; enabled her to plan for the birth more easily; and helped her feel calmer. In contrast, Rachel explains that, as a single mother, being able to care for her other children was extremely important and that was why she chose to attempt ECV and desperately wanted to avoid a CS.

Women’s concerns about recovering from a CS are represented in the animation both in the script and visually in the driving scene, as being unable to drive following surgery was a common concern for respondents (see quote from Nina in Section 6.1.3 above). Throughout the animation, the script is used to remind women that there is no right decision, rather they should make a decision which is best for them. For example, Polly says about a planned CS “It just felt like the best option for me.”

Respondents' desire to breastfeed is reflected in the final scene where both characters are seen breastfeeding. This symbolises research which shows that mode of delivery for breech presentation does not impact on breastfeeding rates (Hannah et al., 2002). In this scene Polly contemplates that:

“At the end of the day, it really doesn't matter how your baby has come into the world, as long as they are safe. All that's important is that you've made the right choice for you.”

This acknowledges respondents' key concern to keep their baby safe but also emphasises that decision making is personal and that a woman's values are important in making the best decision for her.

Chapter 7. Women's experiences of ECV, VBB and planned CS

In the last three chapters, I have examined the process of decision making about breech presentation. I have considered the diagnostic process; examined how women search for information to support decision making; compared and contrasted the content and impact of information given to women by health professionals and lay people; explored women's values relevant to the different options; and reported that professionals did not routinely elicit women's values during consultations. Whilst I have demonstrated the importance of experiential information to respondents (Chapters 4 and 5), in Chapter 2, I showed that there is only a small body of qualitative research about women's experiences of ECV, VBB and planned CS, and that some of this research has important limitations. Therefore, in this chapter, I explore respondents' actual experiences of ECV, VBB and planned CS for breech presentation. Although not directly related to decision making, these data were important for development of the PDA so that future women can access experiential information. I describe how information about women's experiences was used to develop the website and animated film in the final part of this chapter.

7.1 Experiences of ECV

Key themes which emerged from the data were anxiety, pain during ECV and uncertainty relating to the success rate and not being able to attempt ECV. Many respondents reported that they had been concerned about their baby's safety:

And you're thinking [during the attempt at ECV], "God, don't hurt the baby."
(Louise, unsuccessful ECV and planned CS, postnatal interview)

The physical experience of ECV was counter-intuitive to some women as they were so used to protecting their pregnant abdomen.

You know why it is, as well, that area is what you want to protect so if anything comes near you, like if my little toddler is having a fit and she stomps back or something, I'll just get out the way... it's what you want to protect your baby. So they're doing exactly what you don't want anybody to do, if that makes sense? So... emotionally it's a bit horrible. (Laura, successful ECV, antenatal interview)

Only one respondent, Martha, believed that she had experienced a complication following an unsuccessful attempt at ECV. She perceived the attempt at ECV had started her labour, which then required her to have an emergency CS. In fact, ECV is not thought to precipitate labour

(RCOG, 2006a) so she may have laboured anyway. She described how anxious she had been at the prospect of an unplanned vaginal breech birth:

I firmly believe that they started my labour off... I really think they disturbed her a bit. Then I ended up having an emergency section... I woke up and the waters had broken and I had no pain yet... I thought: "This is going into a proper like birth here so we need to get her out." Because I was terrified of having breech labour... Absolutely terrified... Because I had read the statistics that the baby can die. (Martha, unsuccessful ECV and emergency CS, postnatal interview)

Most respondents found ECV painful, but not all women did:

I was thinking how it was really painful... I can remember them saying, telling me to relax and I was thinking, "I can't relax." Because I think they could see my hands tightening and they were going, "You're not relaxed," and I was going, "I know I'm not relaxing," I was like, "Have you seen what you're doing?" ... (Katherine, successful ECV, postnatal interview)

To be honest I don't know what the fuss was about... I was fine. I'd heard a lot of people say it was really uncomfortable... And I don't really get scared of pain or anything so I just went in like sort of relaxed and it was fine... I would definitely recommend it (Eleanor, successful ECV, postnatal interview)

These contrasting accounts of successful ECVs illustrate how the level of pain respondents described seemed to be unrelated to whether or not the ECV was successful.

It seemed most respondents hadn't known what level of pain to expect from ECV. Different women reported experiencing more or less pain than anticipated. Respondents' expectations seemed to be affected by their attitudes towards their own ability to cope with pain:

I think it was more uncomfortable than I thought it was going to be, because I thought I had a high pain threshold, but obviously not as high as I thought. (Pippa, unsuccessful ECV and planned CS, antenatal interview)

They were also affected by accounts of ECV they had been given by people beforehand.

However, it seemed that anticipating pain did not necessarily result in a painful experience.

I didn't find it bad at all, because a few people, when you talk to mums at toddler groups and stuff, had said, "Oh my God I wouldn't get that done... It's supposed to really hurt." And it wasn't. And I think there's a lot of misconception about that. (Yvette, unsuccessful ECV and planned CS, postnatal interview)

Most parous respondents compared the pain from attempts at ECV to their experiences of childbirth. Katherine described it as a different sort of pain to birth:

...it was really painful, and but I mean it was completely different to childbirth painful, like a different kind of pain. (Katherine, successful ECV and vaginal birth, postnatal interview)

Catherine's account is an example of respondents who perceived ECV was less painful than birth:

I suppose in hindsight, after giving birth, it was nothing... it did hurt and I would say it's more than uncomfortable... it was painful. But it was very short, sharp pain, so it wasn't a prolonged pain... compared to the birth it was nothing. (Catherine, successful ECV, workshop)

Other respondents reported that they had found it more painful than birth. Martha felt that attempting ECV had been worse than having a planned CS, even though she had experienced significant post-operative pain and a haematoma. She suggested she would avoid it, if faced with the decision again:

M ... if I had another breech baby I wouldn't do it...I had a difficult experience after the section but I coped and I think I would just say: "No way," for me personally.

B So for you the ECV was worse than the section overall?

M Definitely, yeah. (Martha, unsuccessful ECV and emergency CS, postnatal interview)

Respondents gave detailed descriptions of the physical sensations they had experienced. Their descriptions of ECV, as well as their perceptions of the level of pain they experienced, varied strikingly. Respondents commonly described it as a sensation of pressure but some also provided vivid images to explain their experiences:

It's just a lot of pressure and like as if somebody's putting a lot of weight and pressure on, especially down below, like on your sort of pelvic area and then like a twisty feeling up at this part [indicates upper abdomen]... a lot of pressure with a lot of twisting. (Laura, successful ECV, antenatal interview)

Like literally fists, fists in like kneading bread, you know? (Louise, unsuccessful ECV and planned CS postnatal interview)

It felt as if me tummy was getting a Chinese burn... (Melissa, unsuccessful ECV and VBB, postnatal interview)

Most women, like Catherine above, had only experienced pain for the short time while ECV was being attempted but a few respondents described having pain afterwards, or even seeing some bruising.

... it didn't last ages and like as soon as they stopped the pain went, it wasn't like it kind of stayed afterwards or anything. (Katherine, successful ECV and vaginal birth, postnatal interview)

...the worst pain was on the night time... I think I must've got like bruised. You know like if you do too many sit ups and your like abs burn? It felt like that. (Melissa, unsuccessful ECV and VBB, postnatal interview)

Several respondents explained that their partners had found watching attempts at ECV difficult and distressing. This was because the men were worried about their partners' and babies' safety and had perceived that ECV was extremely painful, sometimes even when the women themselves had felt able to cope:

I mean my husband was with me and he was in more of a state than I was because he saw me breathing through this pain, to me which was manageable, but obviously to him, he had no idea. (Eleanor, successful ECV, postnatal interview)

A minority of respondents reported using some form of pain relief during ECV. Alison felt she would not have been able to tolerate the ECV without nitrous oxide:

[Obstetrician] told me that it would be quite painful, so I asked if I could have gas and air with it and I don't think I would have managed it without the gas and air. Although I have heard that people do but it was painful so I did need it. (Alison, successful ECV and emergency CS, postnatal interview)

Louise was the only respondent to experience a second attempt at ECV under regional analgesia. Interestingly, she did not view the absence of pain during this unsuccessful attempt positively. Rather, she was concerned that this could have worsened her pain after the CS as she thought that pain during an ECV could be a means of protecting her and her baby from harm.

...obviously the good thing about that is you can't feel anything but then I'm thinking: "Is it though?"... the only thing I worry about with them trying to turn the baby when you've had an epidural is, because you can't feel anything, I don't know how rough they had been. So maybe that added to me pain after me section because... when they tried without the pain relief they were rough enough... not only did I have the pain of the section scar, where they'd operated and stuff but, maybe on top of that, that's why I was in so much pain as well because of how, how rough they had been trying to turn her... maybe I was a bit sore and tender inside (Louise, unsuccessful ECV and planned CS, postnatal interview)

The attitudes and approach of healthcare professionals seemed to have impacted significantly on respondents' attitudes towards ECV. For example, Nina shared a negative account of ECV but explained she had still opted for a further attempt by a midwife sonographer who had previously successfully turned her baby. She had been admitted to hospital because her baby had an unstable lie (when the presentation of the baby changes frequently and reversion following ECV is more likely):

It was a surgeon, like a consultant... and it was like something out of a horror film. Honestly, her and this student [identified to be an obstetric specialty training registrar]. The student one tried... she just started grabbing at me stomach and I could feel like she was grabbing his head and so there was no movement with her hand. It was just like grabbing and like doing this [indicates on abdomen] and it was absolutely horrendous, I was screaming and everything, it was horrendous...to be fair, I could tell she [the registrar] had never done it before and she kept saying to the consultant... "It's not moving, it's not moving, I don't feel like it's moving." And she [the consultant] kept telling her to carry on like "Ah, you're fine." But it was horrendous and I had to tell her to stop...I knew if I was left in their hands they couldn't turn a baby... So I asked for [midwife]... I knew if there was any chance of us having him turned it would be by [midwife] the same way I'd had him turned before. (Nina, successful ECV, workshop)

Despite clearly being a bad experience, her account suggests she was able to take control by asking the obstetricians to stop and requesting the midwife take over her care. Both Nina and Catherine described how the communication skills of the midwives they had seen had given them confidence. During a design workshop, we explored what aspects of the interactions they had found particularly helpful:

N I can't stress enough how fab [name of midwife] is.

C It's just her manner.

N I would have stayed here a month waiting for her if I had to! Her mannerisms, how, how friendly she is, how she explains it... I was so worried about the pain... the way she explains it: "Don't worry it'll be fine and I do it all the time... To put it this way, the chances of me not being able to turn your baby, if I don't turn your baby I'll show my bum in [department store]'s window." So she really, really put me mind at ease and I suppose if someone puts that much confidence in themselves you think they'll do it. Even if she didn't do it, the way just by putting it me head she would do it made us feel much better. (Nina, successful ECV, and Catherine, successful ECV, workshop)

Respondents also experienced disappointment about ECV if they were not able to attempt it or if it was unsuccessful. Two women were advised not to attempt ECV because there was not enough amniotic fluid around the baby (both had an amniotic fluid index (AFI) <5cm).

This is not an absolute contraindication to ECV, and AFI was not routinely measured in Units Two and Three, but these women appeared happy to accept the professional's advice that an attempt was unlikely to be successful.

I knew I had a lot of things going against me with it [the amniotic fluid] being low. I think the position with it being in a 'u' shape rather than being tucked with its legs up by its head... I knew that it was not going to potentially happen anyway so I was prepared for it not even going ahead...it is a bit gutting (Lynne, unable to attempt ECV due to low AFI and planned CS, antenatal interview)

Lynne's interpretation of the information she had been given about ECV prior to the procedure had enabled her to develop an explanation of how her baby's position, as well as the quantity of amniotic fluid, might limit the procedure. Nevertheless, she had felt disappointed that ECV had not been possible. Several respondents experienced unsuccessful attempts at ECV. Not surprisingly, women who were more optimistic that ECV would work appeared to have been more disappointed when it was unsuccessful than respondents with lower expectations.

So they couldn't spin him round. And then after I says like: "Can I have another go like next week?" And they says: "Well like in a nutshell, there's no point because the chances of him turning are very slim... I just felt gutted. (Melissa, unsuccessful ECV and VBB)

Menakaya and Trivedi (2013) also found that women who experienced unsuccessful ECVs were disappointed. However, my study does not support their finding that women perceived that they lacked support afterwards (Menakaya and Trivedi, 2013), perhaps reflecting differences in clinical pathways as all respondents in my study had further appointments with health professionals following an unsuccessful ECV.

Some respondents in this study accepted the uncertainty about the outcome of ECV as they perceived it was worth trying in order to have a cephalic birth:

I knew it was a fifty-fifty chance of it working and probably more likely to work if it wasn't a first as well so, to be honest, I wasn't expecting it to work. I had gone in there thinking it probably wouldn't work but it's worth a try. (Pippa, unsuccessful ECV and planned CS, antenatal interview)

Women who experienced cephalic births following successful ECVs gave positive accounts of childbirth. Only one respondent, Catherine who had experienced a forceps delivery for delay in the second stage of labour, suggested she had questioned whether having an ECV had been the right choice:

I ended up having a forceps delivery anyway because he didn't end up coming ...after I'd been labour for 24 hours and it did, the thought did pass my mind "Why did I bother having the ECV? I could of had like a planned caesarean without going through this pain." That did kind of fleetingly pass. (Catherine, successful ECV, design workshop)

However, she seemed to conclude that it had been the best option for her and still viewed having a forceps delivery as a positive outcome because she had avoided an emergency CS and because her baby had not become distressed:

My biggest fear was having to have an emergency one after going through labour... I didn't want to be in that position where the baby was going to be distressed and it was all like panicky... You know that was my biggest fear about being pregnant was that kind of him being distressed and I mean fortunately although I needed a forceps delivery he wasn't distressed it was just me that was distressed by the end of it so you know I needed sort of help but fortunately he wasn't actually distressed even though wasn't sort of coming out. (Catherine, successful ECV, design workshop)

7.2 Experiences of VBB

It was difficult to find women who chose to attempt VBB during the study time, as this decision appeared to be uncommon, but I was able to purposively recruit three women. Two respondents had chosen to attempt a VBB antenatally. Mandy, who had previously had two normal births at home, decided to have a VBB when she went into labour prior to a planned ECV. Melissa, who had previously had a normal delivery, chose to have a VBB after an unsuccessful ECV. A further participant, Catriona, chose to have a VBB during labour, when her baby was diagnosed to be breech. Key themes relating to VBB included anxiety and VBB being a better experience than they had expected.

All three women who had experienced VBB reported that they had been anxious during the birth. Melissa explained:

I felt glad there is a chance for him to come this way. But then I thought: "Well have you been silly enough to go this far? The waters have broke, what happens if the cord's wrapped round his neck? Or he gets stuck and then you need a caesarean anyway and then he's like stressed?" (Melissa, unsuccessful ECV and planned VBB, postnatal interview)

They had worried about their baby's wellbeing, whether their baby would be born with an abnormality and even if their baby would die during birth. Catriona recalled:

The only point when I did worry a bit was when she was all out apart from her head. It was a purple lifeless body that I wasn't too sure whether it was going to be alive or not. (Catriona, unplanned VBB, postnatal interview)

Some of this anxiety related to respondents perceiving VBB as an unknown entity, the negative accounts they had been given by friends and relatives and the risks which health professionals had informed them about (see Chapter 5). Mandy explained the fears she had:

Fear of what if the baby doesn't cry when it's born. What if its legs are not formed properly because it's been in the wrong position... it's more just fear of the unknown. (Mandy, planned VBB, postnatal interview)

While these respondents told me that they had been concerned that a VBB would be more challenging than a cephalic birth, all three of these women were very positive about the experience of VBB and perceived afterwards that there was little difference between giving birth to a head-first or a breech baby, having experienced both. Mandy reflected:

It was no worse than delivering the right way round...a very good labour and delivery and no problems afterwards. So, I could do it again tomorrow. (Mandy, planned VBB, postnatal interview)

Melissa had found the birth quicker than with her previous, cephalic, baby:

Once his bum was out that was it... I know it sounds horrible but he just flopped out after that... then they took him away and cleaned him up. And then that was it. It was a shorter time with me waters breaking with him than what it was for me daughter. (Melissa, unsuccessful ECV and VBB, postnatal interview)

Catriona described the relief and sense of achievement when her baby was born and was the only woman respondent to suggest that a VBB was normal:

As soon as I gave birth, I felt just so much better...It's a good experience actually and quite rewarding. I felt, I really felt, what's the word? Really quite amazed, you know? Exhilarated that you've had a normal birth because in one sense it's quite amazing. (Catriona, unplanned VBB, postnatal interview)

Like with ECV, professionals' attitudes and behaviours impacted on women's experiences. Melissa described how she had found her midwife's approach supportive during a VBB, despite her account suggesting she had been frightened into ignoring her urge to push:

She was just like a normal rough person... she wasn't talking in medical terms; it was just like layman terms... I got the urge to push and she was saying, "Look I've told ya, you cannot push. You are gonna harm him; you're gonna harm you." I said, "He [the baby]'s coming." She was due to finish her shift. She says, "I'm gonna check now before I finish the shift." And then I was thinking, "No, I don't

want her to go.” ‘Cause she was fab. And then she checked and she says... I’m so many centimetres dilated. I was like, “I’ll have the pethidine.” They were like, “No, I’m sorry it’s too late now.” So then you have to try and like refrain from pushing. And the medical team was in and moved the bottom off the bed... I had to try not to push. But then they told me when to push. (Melissa, unsuccessful ECV and VBB, postnatal interview)

When I asked how this instructive approach had made her feel, she seemed accepting of it as part of maternity care but did suggest that professionals should try and see women more as individuals:

It [being told not to push] was hard because... I knew that he was ready to come out... the same thing happened with my daughter... the doctors and nurses were saying, “They won’t be coming out yet because you don’t look as if you’re in pain.”... I knew... that he was nearly there, ready... I know you probably get women all the time crying about, “Oh the pain, the pain.” But maybe if they checked because everybody’s different. Rather than thinking... they won’t be that far on. (Melissa, unsuccessful ECV and VBB, postnatal interview)

Catriona described how her husband had felt overwhelmed when a large number of members of staff attended her unplanned VBB:

..they shouted: “Breech!” and you could hear different staff shouting it outside as well. Actually 14 members of staff came in, because they were just handing over... That made my husband a bit wobbly because he could just see teams of people pouring in and two trolleys and all this sort of thing... It definitely made us know that it was more risky (Catriona, unplanned VBB, postnatal interview)

Her account suggested the professionals involved hadn’t considered the impact of having so many unnecessary team members in the room for the birth.

7.3 Experiences of planned CS

Key themes relating to women’s experiences of planned CS for breech presentation included: anxiety, experiences of the surgery, recovery, complications, missing out on a natural birth and difficulties breastfeeding.

In Chapter 6, I reported that respondents wanted to avoid surgery because they were frightened of having operations in general, were concerned about the risks of CS and about recovering afterwards. For respondents who experienced a CS it had been an anxious experience, particularly immediately beforehand. Georgina had chosen not to attempt ECV and had opted for a planned CS because she had perceived it was the safest option for her

baby. Despite this, she described how she had found the experience “daunting” and had been anxious about the risks of surgery, particularly the morning before the surgery:

I was really disappointed and upset about [planning a CS] but I knew I had to get [name of baby] out safely, and I was thinking: “Am I literally not going to be able to pick her up? Is it going to be painful? How big is the scar going to be?... What if it went wrong? What if they needed to cut us open even further? What if they ruptured my bowel?”... It all went well, but it was a very anxious morning. You know, you’re just sitting there thinking: “I just want it to be over.” Nobody wants to put themselves through major surgery do they, at the end of the day? (Georgina, planned CS, postnatal interview)

Despite feeling nervous, some respondents reflected on how they had found the experience of having surgery calmer than they had expected and explained that they had been completely distracted once their baby was born:

...the procedure itself was brilliant... nothing to be scared of... It was just a breeze really, it was lovely to go through when you think of what is actually happening... that was what was surprising to me, that it went so smoothly and calmly and you don’t feel a thing... when I get over-nervous I shake... I was trying not to do that... I was thinking: “Don’t shake... because... I might throw the surgeons off or something... just be calm and this is all good for the baby... try to be calm throughout the procedure to make it go smoothly... [once] you’ve got your baby there and you’re... overwhelmed, distracted... the nerves sort of went more. (Lynne, unable to attempt ECV due to low AFI and planned CS, workshop)

Other respondents were also positive about their experiences of surgery, particularly the atmosphere in the operating theatre, suggesting that, like for ECV and VBB, the attitudes and behaviour of staff were important:

I mean it was amazingly quick... at every stage I felt informed. I didn't feel frightened... I think it was a pleasant surprise 'cause I'd never had an operation before. And it was just lovely how positive everybody was. Like the radio was on and everybody was happy... They were like dancing and they had Abba on... it was really fun. That's how I can describe it. It was very, very fun... and lighthearted. (Emily, unsuccessful ECV and planned CS, postnatal interview)

However, some respondents described more negative experiences, sharing accounts of difficult experiences during the surgery and particularly of the recovery period. They certainly did not perceive it as the “easy option” portrayed by relatives, friends and the media (see Chapter 5). For example, Yvette had found the experience of surgery stressful. The anaesthetist had been unable to site a spinal anaesthetic and she had felt responsible for the delay which ensued:

I had a spinal which didn't work and then they put an epidural in... it just took ages and I think we were in theatre three hours... I was kind of looking at the clock thinking: "God, I hope there's not another lady sitting waiting for a section..." It was [stressful]... I was lying there thinking, "God I'm holding everyone up... they said it, it's a small percentage of people that spinal doesn't work... they were asking me... "Are you particularly fit?"... me ligaments they were mentioning... they said something was really tight. But they finally did [get the epidural sited]. (Yvette, unsuccessful ECV and planned CS, postnatal interview)

Sophie and Grace described the sensations they had experienced during the operation:

It felt... like squeezing, like pressure but it was painful, really quite painful, I could feel it. And then when they were stitching us up I could kind of feel that as well and I was going, "I don't like this... will you please hurry up!" I was really like freaking out... I didn't like the feeling... and I nearly threw up... The anaesthetist said... "You're the most vocal patient I have ever had having a section... It's nothing like what you expect... I couldn't even properly explain what it feels like, apart from rummaging around" (Sophie, planned CS, workshop)

...all I can remember is talking to the anaesthetist and saying I could still feel it [the surgery]. And he said, "Are you sure?" And I said, "Yeah, it feels like someone's doing the washing up in my stomach" (Grace, emergency CS, workshop)

Respondents had been concerned about the risks of surgery and some did experience common complications. Alison and Emily reported that they had bled heavily during surgery, requiring them to be discharged on ferrous sulphate and Emily also had a prolonged hospital stay partly due to her anaemia and also because her baby was jaundiced:

...they were like saying: "Oh you've lost so much blood." I didn't imagine that I would lose so much blood in the operation. So they said: "Oh no, you can't go home, your iron levels are, are not right... So they were concerned about me as well as [name of baby]. So I think we were in for about six days. (Emily, unsuccessful EVC and planned CS, postnatal interview)

Both these women also experienced post-operative complications. Alison developed a haematoma and Emily had a wound infection. Martha, Yvette and Lynne also developed wound haematomas, which were unexpected and unpleasant experiences. Some of these respondents had been readmitted to hospital or required repeated review by health professionals in the community as a result of their complications:

I had... issues with the scar... a load of liquid came out and that freaked me 'cause I thought I was bleeding to death straight away... that was a lot to take in. Instantly went into shock... I didn't heal and I... went back to the hospital in the

end.... It was infected. (Lynne, unable to attempt ECV due to low AFI and planned CS, workshop)

Alison reported that she had struggled to get advice from health professionals about her haematoma and so had felt frustrated and unsupported. Her frustration worsened when she was eventually seen in the Accident and Emergency (A and E) department and the doctor implied that she should have been warned about the possibility of developing a haematoma:

I rang the Labour Ward and I was told it was nothing to do with them because I was now discharged! So I went to A and E and they seemed quite upset by the fact that I'd gone to A and E and that I hadn't gone to the Labour Ward... the lady in A and E said: "Did they not tell you that this might happen?" and I said: "No." Well had I been warned that the fluid could build up and burst out like that I wouldn't have been so shocked. (Alison, successful ECV and emergency CS, postnatal interview)

In contrast, Martha had felt well supported by her community midwife suggesting that women's experiences of support varied depending on the professionals they encountered:

I started gushing out brown blood from my scar because there was a little hole in me scar and when the midwife came there was like a sausage, like a hard haematoma, behind so it was a horrible experience... They gave us antibiotics for that. The midwife was fantastic actually 'cause she went and got the antibiotics for us because at that point my husband had gone back to work and I couldn't drive...so that was nice. (Martha, unsuccessful ECV and emergency CS, postnatal interview)

Complications were often unexpected, despite respondents reporting being counselled about the risk beforehand. Emily suggested this may have been because she blocked out the risks before surgery as a coping mechanism:

When I spoke to the surgeon the day before... here was a form I filled in. They did go through it... but I think I was probably at that stage, I was just, "I just want my baby. I'm just blocking it all out. I don't want to know... Just do it and get it over with." So I did know there was risks... Even with a planned section things can go wrong. (Emily, unsuccessful ECV and planned CS, postnatal interview)

Respondents who experienced complications suggested these explained why they had found recovering from surgery harder than they had expected or compared to other women they had spoken to. They seemed to want to justify why their experiences had been more difficult than they perceived others' to have been. They described other women who presented CS as an easy option as "too posh to push" whilst implying that they were different:

Well one of my very good friends has had two [CSs]... and she was one of those people who kind of bounced back quite easily from it. She didn't have any problems with her wound. She was driving after three weeks... I think most people I spoke to probably didn't have as tough a time as I did, not when I said: "Oh, I've got to be really careful. I'm all dressed around here 'cause the wound's opened." And some people were like. "Oh no, never heard of that... Mine was fine." I think most people see it as an easier route... they're too push to push. (Yvette, unsuccessful ECV and planned CS, postnatal interview)

Nevertheless, all respondents who gave birth by CS felt restricted in the postnatal period. For some women this had more impact than they had anticipated, given that lay accounts of CS had led them to believe their recovery would be quicker:

People were saying, "You'll be alright with a section. You're really fit. You know, you're slim, you'll bounce back. So you kind of thinks, "Oh, I'll be driving after three weeks. It did take the full six weeks before I could drive, six weeks before I could lift [name of toddler]. (Yvette, unsuccessful ECV and planned CS, postnatal interview)

Unsurprisingly, all respondents experienced pain after their CS. For some women this was more painful than they had expected or had been led to believe by lay accounts. Some respondents had constructed narratives for why their CS was more painful or difficult than other women's experiences, which suggested to me that they felt they had failed in some way because they hadn't had a straightforward recovery:

...the section was horrendously painful afterwards... But they had to use forceps in the section as well to get him out because he was so big and he was wedged because the cord was round his neck so they couldn't get him out. So they probably did a lot of internal bruising or whatever, so that probably caused the pain. Well you hear of people that are opting for sections and they're supposed to be fit as a fiddle afterwards but I wasn't. (Alison, successful ECV and emergency CS, postnatal interview)

As well as being misled by lay accounts of CS, several respondents also felt they had not been adequately prepared by health professionals for what to expect following a CS and had not felt well supported in the postnatal period. For some women, this was a lack of practical information such as how to care for their wound or what activities they could or couldn't do. Some respondents also suggested that they had wanted more reassurance and emotional support from health professionals whilst recovering.

The hospital certainly hadn't really prepared us and I kind of had to fend for myself... no one kind of seemed interested in my scar or how my recovery was going... I just needed a bit of reassurance, for someone to have a look and say: "Yes Georgina, that is absolutely fine and you're doing okay."... When I returned

home I didn't know whether I should be washing it [her wound] with salt water or whether it was fine just to jump in the shower and use my usual shower gel. (Georgina, planned CS, postnatal interview)

Again the attitudes and communication by healthcare professionals seemed to be very important. Some respondents gave examples of difficult interactions with staff which had left them feeling out of control:

I found it quite hard in hospital as well... obviously I couldn't sit up or anything because you've lost the use of your stomach muscles. It was very hard to get on and off the bed and also the pain... the husband's sent away and you've just got to do it yourself. Obviously the nurse is telling you "You've got to get up, because you won't recover". So obviously you get up. But there was one occasion when I was in there, where I actually physically tried to get off the bed and I tried to steady myself with me hand on the crib not realising the crib had wheels on it. So the crib started to walk itself across the room so I was going to fall on the floor. So I grabbed the buzzer and buzzed the nurse, and asked her to give me a supporting hand which she refused. She said "No" because if she did she would put her back out... So she said what she would advise me to do is to grab the back of the bed and pull myself backwards which I did, and she left the room. It was terrible I sat and sobbed and sobbed for hours because the pain was horrendous, and there was nobody there to help. (Alison, successful ECV and emergency CS, postnatal interview)

Alison's moving account revealed how vulnerable women are when incapacitated after a CS and the negative impact that non-compassionate care has on them. Other women also gave similar accounts of professionals or the healthcare system lacking compassion. Martha described how she had been told that budget cuts meant that she would not even be provided with any pain relief on discharge:

I was two days in hospital... so that was fine. But it was the not being able to move. The being in so much pain and at [name of unit] what I was told was, because they put us on codeine and diclofenac straight away for the pain and I got told on discharge from hospital: "Oh, we need to talk to you about pain relief," and I was like: "Oh great." "Well, we don't give you any now..." Apparently in the past you got discharged with drugs but because of cuts I wasn't going to get discharged with drugs. "But don't worry you can go to the doctors," and I was like: "I cannot drive, I've just had a section!" (Martha, unsuccessful ECV and emergency CS, postnatal interview)

Women who had other children reported that caring for them after surgery had been challenging. For example, Yvette commented:

And that's what I would say to anyone: "Really think hard, particularly if you've got a child... It's just you've literally been cut open, haven't you really? Cut right through?... And I still struggle some days..." And I think that's maybe what

people don't understand about a section... I've done it both ways... "Think long and hard." (Yvette, unsuccessful ECV and planned CS, postnatal interview)

Louise explained how she had attributed feelings of low mood to feeling restricted during her recovery:

I was so out of use for so many weeks... I did find that I felt a little bit, you know you get your baby blues, but I felt a bit more down after [name of baby] and I think it was because I couldn't do... Even though [name of husband] is dead supportive... does everything he can... I was so frustrated... and then [name of first child] that was breaking my heart, she was two years old, "Mummy, pick us up." And I was like, "I can't, I cannot pick you up." And she was very boisterous and running around... have an elbow in there [abdomen] and everything. (Louise, unsuccessful ECV and planned CS, postnatal interview)

Like Louise, having a partner or family available to help had been useful to respondents during their recovery. Martha described how having support from her mother, particularly with caring for her toddler, had helped her establish breastfeeding:

I was breastfeeding... on demand... me mam came and stayed for a bit... she came and she helped loads [with her older child]. So we got into a routine... I was determined, I was going to do it and it was fine. Absolutely fine. (Martha, unsuccessful ECV and emergency CS, postnatal interview)

Respondents were concerned about the potential impact having a CS might have on breastfeeding (see Chapter 6). Some respondents were concerned that having a CS might mean they were unable to have immediate skin-to-skin contact with their baby and this might make breastfeeding more challenging. However, some women had been able to have immediate skin-to-skin contact in the operating theatre:

She was straight, straight on, under my robe. [It felt] Lovely. It was a bit squished though... it feels so much different to how you see other women when you do see them on telly. It looks like they've got so much more room... I just felt like I couldn't move and she was there, and I was just like scrunched up... I didn't... dare move... I felt like I couldn't really move her... I wanted to position her... she looked very squished as well. We both were very squished. But, but again I was thinking, "Oh well just, just be still." I probably could've asked somebody to slightly move her or make us a bit more comfortable. But ...I didn't really want... you don't want to let her go... and she seemed fine. And you think, "Well she's fine and, you know, I'm fine. It's okay. This, just a few minutes longer." (Lynne, unable to attempt ECV due to low AFI and planned CS, workshop)

Lynne's account suggested that she was reluctant to ask for help with positioning her baby on the breast in case someone took the baby away from her, perhaps reflecting her feeling out of control in the operating theatre.

Several women who had a planned CS told me they had successfully breastfed their babies. However, women who had breastfed before suggested it was more challenging following surgery than after a vaginal birth:

It was harder to get established [than with older child], because obviously you're lying pretty flat for the first four hours... the midwife was really good. She... helped us get him latched on... But, because of the section, he was really mucousy and so he was struggling and he did lose weight... So that was kind of disheartening... But then he made it [the weight] back up... then it was fine after that... So the first few days were quite hard, and it was quite disappointing to think he'd lost that weight. But then he's caught up. Really caught up, so. (Yvette, unsuccessful ECV and planned CS, postnatal interview)

Some respondents had not been able to breastfeed. Emily described her disappointment when she stopped trying to nurse her baby:

I did feel really guilty... 'cause I couldn't breastfeed. What happened was [name of baby] wasn't able to suck... So I continued on, desperately trying to breastfeed... continually pumping... I went for three weeks with the breast pump so [name of baby] could have the breast milk... I was taking everything, like garlic tablets, to increase my production... there wasn't enough there... I felt... very, very pressured in hospital to breastfeed... I'd kind of got over the fact that I wasn't having a natural birth thinking, "Right, well at least I'll be able to breastfeed. I'll really be able to do that." And then I wasn't able to do that as well... the C-section didn't really bother me. You know it was a disappointment but it was very hard the breastfeeding, the fact that I couldn't do that... because you knew it would benefit the child. (Emily, unsuccessful ECV and planned CS, postnatal interview)

This account suggests that some women with a breech baby may feel that being able to breastfeed can somehow make up for missing out on a natural birth. I asked Emily to explain more about what missing out on a natural birth had meant to her:

E It wasn't a decision that we took lightly... I think because of the information that was surrounding us, and how my husband felt, I did feel that it [CS] was the safest way for the baby [to be born] and had to put that before what I wanted really.

B And how did that feel at the time?

E Just, just really disappointment that we hadn't been able to do it. Especially when it was something that, because this'll probably be our only child. You haven't had the experience... obviously having a C-section baby is completely different, 'cause you're just lying there one minute and then it's kind of like, out. And, in some ways... there was a sense of detachment of exactly what had happened. That you'd had this birth... I think if we did have another baby and I had the same scenario, I probably would go for a vaginal birth. Was it better for

the baby? I don't know... I think I probably would, just for the fact of like the weeks and weeks [of recovery] of the C-section. (Emily, unsuccessful ECV and planned CS, postnatal interview)

Other respondents also expressed disappointment at missing out on a natural birth. Georgina explained how she had felt passive during the CS and had felt distracted from her baby:

You deliver a baby to the world, when you give birth naturally, but when you have a caesarean section, the baby is taken from you... I love her unbelievably, don't get us wrong... but I just think it [natural birth] is just that more extra special... I was stuck on this bed, with the blood pressure. I had... a bit of a wobble with me asthma, and I kind of got side-tracked and concentrated on myself ... I didn't get that opportunity to give birth and put her straight on me chest and bond with her straight away. (Georgina, planned CS, workshop)

7.4 Chapter conclusions

In this chapter, I have discussed themes relating to respondents' physical and emotional experiences of ECV, VBB and planned CS. Some of these themes, such as anxiety were common to all three options. Women frequently explained how they had been worried about their baby's wellbeing. Respondents who attempted ECV described anxiety about the procedure, in particular being worried about their baby, supporting the findings of my previous research that women worry about the safety of ECV (Say et al., 2013). This is despite research evidence suggesting it is a safe procedure (see Chapter 2) and the enthusiasm of professionals for the procedure (see Chapter 5). Nevertheless, ECV was acceptable to most respondents.

Women who attempted VBB also described feeling anxious about their babies' wellbeing during birth. In contrast, respondents who experienced a planned CS did not report any particular anxieties about their baby during the birth, reflecting the view that CS is safe for babies (see Chapter 7), although they were worried about risks to themselves. This agrees with Hodnett et al. (2005) who showed that women who experience VBB are more likely to report postnatally that they were worried about their baby's health during labour than women who experience planned CS for breech presentation. Despite their concerns, overall women who experienced a VBB were positive about their experiences and thought VBB compared favourably to previous cephalic births. These positive experiences contradicted the negative accounts they had previously been given (Chapter 5). However, it is important to note that only three women in my study had experienced VBB. These women were purposively recruited, as few women chose to attempt VBB during the study period. Consequently, they may not be representative of other women, particularly those who have more negative

experiences. Nevertheless, their accounts are important in this thesis as there is so little previous research exploring women's experiences of VBB (see Chapter 2)

Although many respondents had been anxious at the prospect of having a CS, several reported that the experience had been calmer and more pleasant than they had expected. In contrast, other respondents gave more negative accounts, particularly of recovering afterwards, and some felt like they had missed out on having a natural birth. For these women the recovery had been longer, harder and more restrictive than anticipated. Respondents suggested that they had felt unprepared for the challenges they experienced, in particular complications such as discharging haematomas or wound infections. Some women had found health professionals unsupportive and had been unsure how best to seek help. As respondents had anticipated, recovery was particularly challenging for women with older children and in this circumstance having support at home was necessary and valued. Again the sample size of women who had experienced planned CS was small but again these accounts are important to this thesis as so little qualitative research has explored women's experiences of planned CS. My findings support Puia (2013) who suggests that many women feel unprepared for CS, including the intensity and duration of postoperative pain. She also found that many women reported negative birth experiences because they perceived health professionals had negative attitudes towards them and because they had felt disregarded by the system (Puia, 2013).

A number of respondents, who made different decisions about the management of breech, shared negative accounts of healthcare they had experienced. Some demonstrated that they had been able to negotiate control over their healthcare but others were disempowered by a system that appeared to be often lacking in respect and compassion. These accounts contrasted greatly with the examples of good care women described which were most often characterised by excellent communication by healthcare professionals. Thus the attitudes and behaviours of staff impacted on women's experiences whatever decisions they made.

Respondents also reflected on the control they had in relation to experiencing pain. Pain was seen as a necessary component of childbirth but for some women, when associated with ECV, it could be avoided. Most respondents had been unsure what level of pain to expect from ECV and their experiences varied. They gave vivid accounts of the sensations involved in ECV (and CS) and most reported that ECV was painful, which contrasted with information given by professionals (see Chapter 6). By including these descriptions in the animated film, women may have more realistic expectations of ECV and feel better prepared. They may also

prompt discussion with professionals about options for pain management during ECV, such as breathing exercises or analgesia.

A number of respondents described their experiences of breastfeeding. Antenatally respondents had been particularly concerned about the impact of having a CS on breastfeeding. Although some women described having good breastfeeding support, including skin-to-skin contact in the operating theatre and help with positioning their baby afterwards, others had not had the support they needed and had given up nursing their baby. Follow-up of women in the Term Breech Trial found no difference in breastfeeding rates at three months between women who were randomised to have a planned a CS and women who were randomised to planned VBB, with 68.9% of participants reporting that they were breastfeeding (Hannah et al., 2002). However, as only 17% of women in the UK exclusively breastfeed at three months (McAndrew et al., 2012) it is unclear how generalisable the Term Breech Trial findings are to a UK population. Other research has suggested that rates of initiation of breastfeeding are lower amongst women who have planned CS compared to women who experience vaginal births (Prior et al., 2012) and no research has compared breastfeeding rates amongst women with experience of breech presentation in the UK. These data are likely to be of interest to women and professionals seeking to support them. Having presented and discussed all these data, in Sections 7.5-7.6 I show how they were used to inform the design of the PDA, consisting of the website (breech-decisions.ncl.ac.uk) and animated film.

7.5 Website content relating to these themes

As explained in the previous chapter, the website content is categorised under headings which relate to women's values. The majority of information in the website is evidence-based, rather than experiential, as the purpose of the film is to provide the experiential information. However, respondents' accounts have guided the selection of information provided. For example, in the section on ECV 'Will it hurt?' research-evidence is provided to demonstrate that women have varied attitudes towards the pain associated with ECV but I also used these data to explain that for some women the pain lasts for a few minutes whereas others report that their abdomen is tender afterwards.

As some respondents experienced unsuccessful ECVs or were not able to attempt ECV, information about factors affecting the success rate is included as well as reasons why women may not be offered an ECV. Users are prompted to discuss the possibility of attempting ECV

on another occasion with their doctor or midwife. As not all women who experience a successful ECV go on to have a natural birth, data about mode of delivery following a successful ECV are provided.

In relation to vaginal breech birth, the benefits of experiencing a vaginal birth and avoiding surgery are emphasised. There is no research which has compared VBB to vaginal birth in cephalic babies (see Chapter 2) so I am unable to provide evidence-based information reflecting respondents accounts that VBB was no worse. Similarly, while the Term Breech Trial follow-up demonstrated no difference in how easy it was for mothers to care for their babies between women planning a VBB and women planning a CS, I was unable to corroborate respondents' views that it was harder to care for older children following surgery as this had not been addressed in previous research.

The additional information about Polly's story is used to emphasise the importance of having support from a partner or other family members after a CS. In Rachel's story, I suggest she would have chosen a VBB if the ECV was unsuccessful to represent similar multiparous respondents who made this choice.

7.6 Film content relating to these themes

As discussed in Chapter 4, the main aim of the film was to provide experiential information to women, so all of their accounts were used to influence the film script and images. Due to funding limitations and our collaborators' advice about the most appropriate length for an educational short film (see section 8.7), we were advised to have only two characters in the animation. As many respondents reported that they had found ECV hard to imagine (see Chapter 4) and as most women had chosen to attempt ECV before planning a CS or VBB, we chose to have one character who had a successful ECV and another who had an unsuccessful one. As most respondents chose to plan a CS rather than a VBB, Polly, who experiences an unsuccessful attempt at ECV, goes on to choose a planned CS. As the film could only be seven minutes long (see section 8.7), we also couldn't provide detailed information about the experience of birth after a successful ECV or a planned CS. The limitations of the film are discussed in detail in Chapter 8.

Nevertheless, as well as reflecting the different possible outcomes of ECV, Polly and Rachel's stories also reflect women's varied attitudes towards pain as Polly finds ECV painful but Rachel does not. The rich descriptions of ECV and visual representations in the film are informed by respondents' accounts. For example, Polly describes her unsuccessful attempt at

ECV as feeling like “a Chinese burn” and explains how difficult it was for her husband to watch (see quotes in Sections 7.1 above).

Women’s concerns about their babies’ safety are reflected in the anxiety described by both characters. As so many respondents were worried about risks to their unborn babies and such concerns were so important in decision making, it seemed essential that the babies should be seen in the uterus. Both are shown safe and content during attempts at ECV, reflecting both the good outcomes respondents experienced and research evidence that ECV is safe (Nassar et al., 2006b).

Rather than attempt to confront the complexities of respondents’ negative experiences of care, the professional in the film was designed to represent best practice. She is courteous, gives clear information and emphasises that Rachel can ask her to stop during the attempt at ECV if necessary. Similarly, rather than focus on the challenges some women experienced with breastfeeding, both women are shown successfully breastfeeding.

Chapter 8. Conclusions

8.1 Introduction

This was a qualitative research study which used a feminist methodology to examine the experiences of women whose babies were breech at the end of pregnancy and who made decisions about ECV, VBB and planned CS. Using observed consultations, semi-structured interviews and user-centred design workshops, I explored the process of decision making about breech from both women's and health professionals' perspectives. This involved investigating the sorts of information women and professionals view as essential to underpin SDM about breech presentation; exploring women's attitudes and experiences to understand women's values which affect their decisions; and using all these data to develop a PDA for future women and their supporters facing decisions about ECV, VBB and planned CS.

The study contributes to the small body of qualitative research which has examined women's attitudes towards, and experiences of, ECV, VBB and planned CS. As discussed in Chapter 2, this evidence base was not only small but also had significant methodological limitations. Therefore, these results will be of use to anyone with an interest in this area, such as pregnant women, obstetricians, midwives, researchers and policy makers. The PDA also functions as a way of disseminating some of the data in a novel and accessible way that may reach audiences who would not read this thesis or future academic publications.

The PDA is the first to cover ECV, VBB and planned CS and is the first web-based PDA available to women with a breech baby. An existing paper-based PDA, with an audio component, is available to support decision making about ECV (Nassar et al., 2007). This was developed in Australia so some of the content about clinical pathways is not relevant to women in the UK and it is not used routinely in clinical practice. The current PDA was developed using a user-centred design process. As such, it is hoped it will meet the needs of as many women receiving NHS care as possible. The generalisability of the research findings to different populations is discussed below in Section 8.5.

In the last four chapters, I presented and discussed data in relation to the diagnosis of breech presentation; how women seek information and support; the key information provided to them by health professionals and lay people; women's key values in relation to breech presentation, ECV, VBB and planned CS; and women's experiences of the different options. I have also demonstrated how these themes have informed the development of a PDA. In this chapter, I

discuss the themes developed in previous chapters, considering the challenges to SDM in the context of decision making about breech presentation; the implications of a distributed decision making process; and the importance of women's values in decision making. I discuss the potential benefits and limitations of the PDA and consider the limitations of this study. Finally, I make recommendations for clinical practice, policy and future research.

8.2 Shared decision making

As defined in the introduction (Chapter 1), SDM is a process in which patients and clinicians collaborate together to make decisions about health care (Elwyn et al., 2010). Adapting the model proposed by Elwyn et al. (2010) for use in decisions about breech, health professionals and pregnant women would need to communicate together so that an obstetrician or midwife could: share evidence-based information about ECV, VBB and planned CS with women; support women in deliberating about the options available to them; facilitate women in developing informed preferences for treatment based on their own values and goals for pregnancy and birth; and help implement the decisions made.

However the analysis of data from this study has shown that there are significant barriers to SDM about breech presentation. These include women and professionals having different preferences for the appropriate time to access information about options for management; some professionals having a poor understanding of the evidence-base which should inform decision making about ECV, VBB and planned CS; directive counselling by health professionals; and a failure of professionals to explore women's values about their options.

The first barrier, regarding the timing of providing information, is that professionals appear not to understand women's preference to have information as soon as the possibility of breech presentation is raised. Although this may be well intentioned - professionals suggest they are concerned about causing unnecessary anxiety for women who are later found not to have a breech presentation - such attitudes do not take account of the considerable efforts women go to researching options themselves prior to being referred to hospital (see Chapter 4). Women reported using a variety of sources of information, some of which, for example the NHS Choices website, were likely to contain high quality information. However other sources, such as tabloid newspapers and internet forums, may have been of poorer quality. This means that women may be faced with conflicting, inaccurate or misleading information at a time when they are keen to become rapidly informed so they can make the right choices for themselves and their families (see Chapter 4). Little is known about the best timing for

provision of PDAs but previous research has also suggested that women may benefit from earlier access to decision support (Shorten and Shorten, 2014).

Nevertheless, several respondents suggested they had made decisions about ECV and mode of delivery prior to consultations because they felt they were sufficiently well informed. During interviews, professionals acknowledged this happened. Despite being aware of this, during observations and interviews it appeared that professionals did not routinely attempt to explore the sources of information women had used or assess how well informed a woman was (see Chapter 4). Elwyn et al. (2012) argue that for SDM to happen, patients need to move from initial preferences, based on an understanding of the options available to them and existing knowledge, to informed preferences based on their values (see below) and understanding the most relevant potential benefits and risks. Therefore, some women making decisions about ECV, VBB and planned CS may be doing this based on their initial preferences without access to evidence-based information about the potential benefits and harms most relevant to them.

The second barrier is that some professionals appear to have a poor understanding of the evidence base about the management of breech presentation, or struggle to communicate it to women. In relation to mode of delivery, they focused on the Term Breech Trial (Hannah et al., 2000) but did not discuss other important research, such as the PREMODA study (Goffinet et al., 2006). During observations, some professionals provided women with erroneous information and others misrepresented previous research. They usually communicated risks either by using verbal qualifiers (for example, “higher”) or used relative risks or percentages. Most also only framed risks one way, meaning that they presented risks either positively or negatively as opposed to explaining the data both ways to give a more balanced view. I could not identify any previous research which had explored obstetricians’ and midwives’ understanding of research evidence but Lyster et al. (2007) note that risk communication in pregnancy is complex and challenging, in particular because of the potential need to reconcile different risks for women and babies. Furthermore, experts in risk communication argue that many doctors are “statistically illiterate” and that society as a whole struggles to understand health statistics (Wegwarth and Gigerenzer, 2011 loc 1790 (35%)). In terms of improving risk communication, absolute risks should be used as research has shown that relative risks are harder to understand and, as they may be more persuasive than absolute risks, can be misleading (Ahmed et al., 2012). It is also recommended that professionals use natural frequencies rather than percentages as they are better understood (Ahmed et al., 2012). With regard to framing information, research suggests that positive

framing (only mentioning the positive effect of an intervention, for example stating that 50% of attempts at ECV are successful but not being explicit that 50% of attempts are unsuccessful) means patients perceive interventions as more beneficial but that this does not seem to affect the decisions which they make (Ahmed et al., 2012). Best practice is to frame information both positively and negatively so that decisions can be as fully informed as possible (Edwards et al., 2002).

The third barrier is that professionals appear to have clear preferences in relation to options for managing breech presentation and directly counsel women to choose these options (see Chapter 5). Most favour an attempt at ECV and, if this is declined or is unsuccessful, recommend that women opt for a planned CS. Whilst clinicians having preferences need not be a barrier to SDM, if they are explicit about them and the reasons why they hold a particular view, in this study this seemed problematic because directive counselling appeared to be routine. This manifested in various ways. Some professionals presented ECV as normal and routine practice in their departments. This was reflected in clinical pathways which often required women to be booked in “provisionally” for an ECV before they had made a final decision. Others provided much more information about ECV than about the other options; downplayed the likelihood of it being painful and presented the 50% success rate in a positive way (see Chapter 5). Few professionals were able to provide numerical estimates of risks associated with ECV and some over-estimated the success rates in their units. As colleagues and I have noted previously (Say et al., 2013), health policy emphasises the importance of reducing the CS rate (NHS Institute for Innovation and Improvement, 2007) and increasing the uptake of ECV is one approach to achieve this. For example, the RCOG recommends that: “local policies should be implemented to actively increase the number of women offered and undergoing ECV” (RCOG, 2006a). This is likely to contribute to professionals enthusiasm for ECV and potentially restrict women’s choices, despite other maternity policies advocating SDM (NICE, 2012). Such policy conflicts may need to be resolved in the future to facilitate SDM (see policy recommendations below). Lyster et al. (2007) also suggest that clinical guidelines need to take account of the range of women’s values in order that obstetricians and midwives can provide evidence-based care in a patient-centred way.

In relation to planned CS, some women explained that, if professionals did not agree with their decision to opt for a planned CS rather than attempt ECV, some obstetricians and midwives tried hard to change their minds, using approaches which seemed manipulative. For example, focusing on potential risks of planned CS such as increased miscarriage rates and even the greater costs associated with surgery. Whilst it may not be unreasonable to

discuss these issues it appeared that they had been raised in a confrontational way and had been the focus of, rather than part of, a discussion sharing ideas and information about options. However, if ECV had been unsuccessful or if women opted for a VBB then CS was presented much more positively and women who chose to attempt VBB felt under pressure to change their minds and opt for CS.

The fourth barrier is that professionals do not explore women's values about breech presentation during consultations. This, along with them not exploring women's knowledge, may result in women feeling unsupported during the decision making process, as well as professionals being unable to assess whether women's decisions are congruent with their values or not. Enacting SDM involves professionals helping patients to develop informed preferences based on the issues which are most relevant to them (Elwyn et al., 2012). If professionals do not explore women's values it is not possible for them to provide this relevant information. It is unclear why professionals do not explore women's values and little previous research has explored whether individual components of SDM occur in routine consultations, or the reasons why they may not (Edwards and Elwyn, 2006). It may be that professionals do not understand the importance of women making decisions based on their values and consequently would benefit from training about SDM. It may also be because professionals have such clear preferences themselves that they focus on directive counselling rather than SDM. Another possibility is that time pressures mean it is easier to simply accept a woman's decision at face value. Women certainly gave accounts of how busy clinics were and how they felt care was sometimes impersonal.

Little previous research has explored the barriers to SDM in maternity care. One qualitative study suggested that midwives may adopt an approach of "protective steering" when supporting women making decisions (Levy, 1999). This means that, while aiming to provide unbiased advice, they acknowledged they often had strong feelings about options and sought to stay in control of decision making in order to protect women (Levy, 1999). Midwives perceived themselves as gatekeepers of information and reported using information provision to influence the decisions women made. Previous qualitative research found that obstetricians feel a moral responsibility to guide decision making based on their medical knowledge but some do seek to balance this with patients' preferences (Danerek, 2010).

A systematic review of perceived barriers to SDM across all medical specialties found that the most commonly cited barriers by professionals were time constraints and that SDM was perceived as not being applicable due to patient characteristics or the clinical scenario (Legare

et al., 2008). Perceived facilitators included the professional's own motivation and them believing SDM had a positive impact on clinical processes and patient outcomes (Legare et al., 2008). These support the current findings that professionals' attitudes underpin some of the barriers to SDM about breech presentation and also my suggestion that time pressures may impact on professionals' willingness to explore women's understanding and values.

8.3 Distributed decision making

This study showed that pregnant women gather information about breech presentation during a number of clinical and lay interactions. As well as seeking out factual information for themselves, they also want to explore other women's experiences of breech presentation. Women seek experiential accounts from female relatives, close friends, internet contacts and more remote acquaintances. This sort of information goes beyond factual information by helping women to consider the emotional aspects of their decisions as well as helping them to understand how different choices may be experienced. These findings are supported by Entwistle et al. (2011) who found that patients facing a range of different healthcare decisions valued personal experiences because they helped them to identify and appraise the options available to them, including considering "what it might be like". Thus, while biomedical facts are important to patients, they may be insufficient to address the uncertainties and emotional complexities inherent in decision making. Nevertheless, women were commonly given multiple and often contradictory accounts of ECV, VBB and CS which could be problematic for them, particularly when people shared horror stories. Such stories may be anxiety provoking and women can feel pressured by others to make a particular decision.

As well as sourcing factual and experiential information, women also receive factual information from a number of different health professionals as clinical pathways are structured such that multiple professionals provide information and counselling. Rapley (2008), considering decision making in a range of different clinical contexts, defined distributed decision making as occurring over a series of consultations with different health professionals and encounters with various other key informants and technologies, rather than occurring in a single dyadic consultation. I have shown this to be the case with breech as women gather information and seek support during a variety of clinical and lay interactions. Rapley (2008) argues that lack of recognition of distribution may explain why SDM is frequently judged not to happen in individual consultations when in fact it may occur across all of these different sorts of interactions. This may in part explain why SDM did not seem to

be happening in the observed consultations but it does not account for the barriers discussed above. Conceptualising decision making about breech presentation in this way is useful as it demonstrates the importance of providing training for health professionals at all stages of the process and ensuring that women have access to high quality, consistent information whenever they interact with professionals (see Section 8.8). It also acknowledges the importance of women's interactions with lay people and technology, recognising the information and expertise found in such sources (Rapley, 2008). If the importance of lay experiences and expertise is accepted by professionals, it may become easier for women to interrogate the conflicting accounts and horror stories they are given by discussing them with professionals more openly, with the benefit of them being able to access evidence-based information as well.

8.4 Women's values

The data suggest a number of different values underpin women's decisions about ECV and mode of delivery for breech presentation. Respondents described wanting to keep their baby safe; wanting to experience a natural birth and to avoid surgery; wanting to be able to care for other children; wanting to have control; and wanting to breastfeed. Women's values about ECV, VBB and planned CS have been explored in few previous studies, several of which had significant limitations (see Chapter 2). However, previous research supported the current findings that women are concerned about the safety of their baby (Founds, 2007; Guittier et al., 2011; Menakaya and Trivedi, 2013; Say et al., 2013; Rosman et al., 2014); value natural birth (Menakaya and Trivedi, 2013; Say et al., 2013; Rosman et al., 2014); and prefer to avoid CS (Founds, 2007; Guittier et al., 2011).

In terms of professionals addressing women's values in future consultations, some values, such as keeping their baby safe or avoiding surgery, relate directly to available research evidence which could readily be discussed. For example, Berhan and Haileamlak (2015) provide absolute risks of various adverse outcomes for babies associated with VBB and planned CS and Hofmeyr et al. (2015b) demonstrate that ECV reduces the rate of CS. However, there are significant methodological limitations to the studies included in both of these systematic reviews and Berhan and Haileamlak (2015) do not address risks to mothers (see Chapter 2). Other values, such as having control, caring for other children and breastfeeding have not been adequately explored in the literature so at present it would be more challenging for professionals to provide research information to support women

deliberating about these. However, it is important not to devalue them simply because there is little research evidence available, so they should still be discussed in consultations. In this situation professionals could take a more supportive role, for example acknowledging in relation to caring for other children that individual women know their own personal situations and children's needs better than anybody else.

Feminists have argued that more attention should be given to the experience of birth (Oakley, 1980; Trevathan, 1997; Schiller, 2015). Despite this, little attention is paid to women's experiences of maternity care in medical research, which focuses on clinical outcomes such as mortality data. This is partly because clinical outcome data are easier to collect but also because researchers, clinicians and policy makers infrequently prioritise experiential outcomes and remain focused on collecting so called objective data (Letherby, 2003). In response to the lack of research addressing women's values about and experiences of ECV, planned CS and VBB, I explored respondents' experiences to contribute to the evidence base available to future women. Key findings, which may be of interest to future women, included women being concerned about their baby's wellbeing and, because of this, many had experienced anxiety about their baby's safety, particularly during attempts at ECV or VBB. In contrast, planned CS was generally viewed as safe for babies but riskier for mothers. Many respondents had found recovering from a CS difficult because of the inherent restrictions on them or because of unexpected complications. Women with older children had found caring for them particularly challenging and had valued support with this from their partner or other family members. Similarly, some women had experienced difficulties establishing breastfeeding following a planned CS.

Respondents reflected on the levels of control they had felt. Some shared accounts of poor quality care where they had felt out of control and disempowered by the healthcare system. Others explained how excellent communication by professionals had supported them during decision making. Although pain was seen as inherent to childbirth, some women had wanted to avoid the pain associated with ECV so had chosen not to attempt it. Women who attempted ECV reported different levels of pain and many gave vivid descriptions of the sensations involved. Watching an attempt at ECV was sometimes distressing for women's partners. These data were also used to inform the content of the PDA, in particular the script of the animated film.

8.5 Limitations to this research

As I have provided a detailed critique of the methods used in Chapter 3, in this discussion I highlight five key issues: unpredictable challenges arising during data collection; the time consuming nature of qualitative research; generalisability; reflexivity; and the need for evaluation. As qualitative research aims to explore people in natural settings it is common for unexpected challenges to arise. As a result Edwards and Ribbens (1998) argue that in qualitative research there must always be a compromise between theoretical and practical issues. During this study I modified my research plan to respond to respondents' needs and the practicalities of clinical pathways. For example, switching from videoing to observing consultations and then needing to record rather than physically observe consultations in Unit Two (see Chapter 3). This limited the sorts of data I could collect, but was necessary to be able to collect data at all. One negative impact of these changes was the delay in data collection inherent in applying for ethical approval of the protocol amendments. However, I learned useful lessons for planning future research studies. For example, I would feel able to justify not requiring a 24 hour cooling off period for potential respondents to consider participation if researching in a setting where this would not be practical. Learning how to respond to challenges as they arose was a valuable part of my learning experience throughout this project and helped me gain confidence as a researcher.

Qualitative research is time consuming, both in terms of data collection and data analysis. However, the richness and variety of data collected enables researchers to explore in detail questions which could not be so thoroughly investigated using quantitative methods. By combining observations, semi-structured interviews and design workshops I was able to explore the context, process and experience of decision making about breech presentation in detail from both women's and health professionals perspectives. However, the burden of the time involved was not just mine: respondents also gave up their time to take part. This may be potentially off putting to some potential respondents and will affect who chooses to take part. Professional respondents, in particular, made me aware of the time pressures on them and this may have limited the quality of data I were able to collect, particularly when interviews were interrupted (see Chapter 3).

A potential limitation of all research is generalisability, which may be a particular issue for qualitative research which uses non-random samples. Purposive sampling was used to include women who made a range of decisions and women who had and had not had children

before. This was challenging at times as, for example, few women chose to attempt VBB, although every effort was made to capture a broad range of views. No women experienced harm or the death of their baby relating to ECV or the birth so these data do not represent women who experience very poor outcomes relating to breech. The views of women recruited in three units in the North East of England may also not be generalisable to women in other parts of the UK, or to women in other countries, with experiences of different healthcare systems and cultural expectations for pregnancy and birth. In Chapter 3, I provided a description of the research context and by including further details in the data chapters, as well as quotations from respondents, I hope that readers will be able to judge how generalisable results may be.

Reflexivity, considering the influence of the researcher on the data (and the data on the researcher), is an important component of qualitative research. It is particularly important in feminist research which rejects objectivity and emphasises the importance of interrogating power imbalances inherent in research (Cook and Fonow, 1986; Letherby, 2003). In Chapter 3, I considered how my own position as a trainee in obstetrics and gynaecology and later as a pregnant woman may have influenced the research process. In this discussion, I wish to add that following the completion of data collection and the majority of data analysis, whilst writing this thesis, I resigned from training in obstetrics and gynaecology. Therefore during this work I transitioned from professional and researcher to pregnant woman and mother. I include this information so that the reader may interpret the results with the possible influences of these transitions in mind.

The final key limitation of this research is that I was not able to undertake an evaluation of the PDA during the period of my doctoral research. Undertaking a user-centred evaluation will be necessary to refine the design of the PDA and complete the iterative user-centred design process (British Standards Institution, 2010). Whilst some PDAs have been evaluated using randomised controlled trials (Stacey et al., 2014), this may not always be the most appropriate method for evaluation of complex interventions such as PDAs, particularly as the high costs are hard to justify (Craig et al., 2008). Randomised controlled trials also do not investigate whether interventions work in everyday practice and might not be appropriate in this context when the PDA is envisaged to be used in slightly different ways by different users. For example, women may prefer to access it in different stages of pregnancy; some may find it for themselves; others may be directed to it by a professional; their partners and other family members may also find it useful. This makes an experimental design unfeasible as, in accordance with the user-centred approach, I would not wish to restrict how women use the

PDA. Research also suggests that PDA use is not harmful (Stacey et al., 2014).

Acknowledging this, the research team has made the PDA available to women. Thus any future evaluation will need to consider use in everyday practice.

8.6 Reflections on consciousness-raising, empowering women and transforming patriarchy

As set out in Chapter 3, key epistemological components of feminist research include the importance of consciousness-raising and a focus of the research being on empowering women and transforming patriarchy (Cook and Fonow, 1986). In presenting the results of this study, I have sought to raise awareness of some of the difficulties experienced by and harms done to women whilst they make decisions about and experience ECV, VBB and planned CS. These include both the challenges to SDM and also negative experiences of clinical care during management of breech presentation. Some of these relate to the attitudes of staff, others to problems with the healthcare system such as difficulty accessing assistance after developing complications following a planned CS (see Chapter 7). By presenting these data to clinicians during the dissemination process I have been able to challenge some of these behaviours and system problems directly and by publishing these data in the future I hope to further raise awareness of these issues.

SDM is based on the principle that self-determination is desirable and that professionals should try to support patients to achieve this, whenever it is feasible (Elwyn et al., 2012). This is in agreement with the goals of feminists, who advocate for woman-centred and woman-controlled healthcare (Oakley, 1980), and radical patient organisations set up to improve women's experiences of pregnancy and childbirth such as Birthrights (birthrights.org.uk) and the Association for Improvements in the Maternity Services (aims.org.uk). In fact, SDM was conceptualised partly in response to feminist critiques of healthcare and the advocacy of such groups (Rapley and May, 2009). Therefore, on this basis supporting SDM seems to be an appropriate goal for feminist research as it promotes the rights of women within healthcare.

Nevertheless, feminists have raised potential concerns about SDM, including that research is most often quantitative and designed by members of the dominant medical culture and so often ignores issues of gender (Szumacher, 2006). Szumacher (2006), discussing SDM about breast cancer, argues that PDAs are often developed on the basis of a generic patient without

attention to women's needs. She calls for more qualitative research to investigate SDM from women's perspectives. This study meets these requirements as it is qualitative, uses a feminist methodology and a user-centred design process for developing the PDA. Therefore, this is a further contribution of this work to the literature.

A final important aspect to considering empowerment is the potential implications for women (and professionals) of being respondents in this study. Many women respondents were positive about participating in the study during interviews and design workshops. Potential benefits to participation which women mentioned included the desire to help future women; the desire to help me complete my research; and, for respondents on maternity leave, the opportunity to interact with an adult and contribute to an intellectual process. Nevertheless, as Letherby (2003) argues while participating in research may be empowering, there is always the potential for respondents to be disempowered as well. For example, recognising women's power to generate knowledge as research respondents is unlikely to change their material circumstances and encouraging them to analyse their negative experiences may undermine their coping strategies (Letherby, 2003). This may be true of this research study as, although I strove to be sensitive to women's cues during interviews, it is possible interviews and design workshops may have covered topics which respondents would have preferred not to discuss; may have required them to reconcile their experiences again; or explain things they didn't want to have to explain. Letherby (2003) suggests that this tension between giving women a voice and the potential ways they may be disempowered through generating knowledge is unavoidable. During interviews and design workshops with health professionals, I usually felt that they were more powerful than me. For example, because they limited the length of interviews or took phone calls during them. Letherby (2003) argues that in this way, power imbalances in research are situational and, as some respondents already have social power, they may not feel they need or desire to be empowered through participating in research.

In conclusion, whilst this study may have had the potential to disempower some respondents, it is hoped that it will contribute to consciousness raising about the challenges to SDM about breech and women's negative experiences of decision making, ECV, VBB and planned CS. It is hoped that disseminating the results of the study and the PDA may empower future women by challenging existing negative practices and supporting women with a breech baby to be involved in making decisions about their care.

8.7 The PDA

Based on the data collected and using a user-centred design process, I developed a PDA for pregnant women with a breech baby, comprising of a website (breech-decisions.ncl.ac.uk) and animated film (available on the website). As the aim of the PDA is to support SDM about breech presentation, the design addresses the barriers to SDM identified above. The website and film are freely available and can be accessed by women and their supporters whenever they choose. This means that women can use it to research options before referral to hospital and they can share information readily with their partners and other family members or friends. Hoffman et al. (2013) argue that high levels of Internet use internationally, as well as the potential for Internet PDAs to be interactive, use multimedia, and facilitate accessibility, justify delivering PDAs online. However, they note that there is little evidence about the most appropriate role of the Internet in delivering PDAs, the usability of different sorts of interfaces, nor the implications for use in different patient groups or cultural settings (Hoffman et al., 2013).

A potential limitation of making the PDA freely available on the Internet, rather than depending on professionals to provide it to women, is that it may be hard for them to find. Morris et al. (2008) found that PDAs for a range of medical conditions were difficult to access unless multiple search engines and specific search terms were used. Amid all the information available to women, particularly that on popular online resources for pregnant women such as the BabyCentre, it may be that the website does not make it into the top few items found by common search engines, which women suggested was what they looked at (see Chapter 4). That the animation is under review by NHS Choices for inclusion on their website (expected to be later in 2016), which is likely to improve access if they do publish it. Also, during dissemination events it became apparent that some health professionals were directing women to the website which will improve women's access, particularly if community midwives do so when they first suspect a baby is breech. Future evaluation work could address whether or not users would recommend it to other pregnant women and how best to promote the resource.

The PDA may not be readily accessible to women who do not have Internet access at home or on a mobile device. The Internet is available free to the public in libraries but using it there may not be practical or desirable to pregnant women and no previous research has investigated this. Nevertheless, as discussed in Chapter 4, previous research does suggest that

Internet use by pregnant women is high so the PDA should be accessible to most women (Lagan et al., 2010).

The PDA may also not be accessible to women who do not speak English as a result of there not being funds available at the present time to translate it into other languages. Accessibility may also be limited for women who have visual impairment, are deaf or who have a learning disability. Again funding limitations meant that I was not able to explore or respond to the specific needs of these groups of women. The accessibility of the PDA in general should be explored in any future evaluation and the needs of particular groups of women could also be explored in future research.

The content of the website focuses on research evidence about ECV, VBB and planned CS. To communicate numerical risks, absolute risks and natural frequencies are used and information is framed both positively and negatively. This is not intended to replace a consultation with a health professional. However, it is hoped that having a summary of the evidence may be useful for professionals as a learning resource to help them communicate risks and benefits more accurately. There is also an explanation of the limitations of the evidence base. This is complex but is important to ensure women are aware of the uncertainties associated with the research data. At present little is known about the most effective ways to communicate such uncertainty and the effects of doing this on patients' understanding and decision making (Trevena et al., 2013). I chose to focus on the controversies in the evidence base, in particular the limitations of the Term Breech Trial (Hannah et al., 2000) discussed in Chapter 2, as women may come across these when using other resources, in particular Internet forums. Women's attitudes towards this approach should be investigated in any future evaluation of the PDA. As information is presented in a balanced way and acknowledges uncertainty, it is hoped this may counteract the directive counselling provided by many professionals. A note taking feature may encourage women to ask their midwife or obstetrician any questions which occur to them whilst using the PDA and facilitate discussion about the evidence. Further observational research would be needed to explore the impact of PDA use on consultations and directive counselling.

Statistical information about the risks and benefits of ECV, VBB and planned CS were not included in the film. This was partly due to time restrictions (see below) and also because evidence may change and the film would be harder to update than the website. Instead, the animated film focuses on two fictional women, Polly and Rachel, as they make decisions about ECV and mode of delivery. In particular it explores their emotional experiences, as

well as their physical experiences of ECV. The script was written using the language and words used by respondents in interviews and workshops. The two women are based on many different respondents to ensure that they do not overly represent individual women and in order to protect respondents' anonymity. The use of patient narratives in PDAs is controversial, in part because it has not been well researched (Bekker et al., 2013). The potential advantages include: being able to describe the emotional aspects of the options and decision; being able to emphasise the importance of exploring all the options prior to making a decision; providing an example or examples of how people go about making decisions; presenting information in a more accessible and attractive way; being able to show how important people's values and experiences are in decision making; and providing a social context to medical decisions (Bekker et al., 2013). However, experts remain concerned about the potential for personal stories to introduce bias (Bekker et al., 2013). Specific concerns include: use of value-laden language; limiting discussion or consideration of all the facts about options; encouraging users to only consider the values important to the narrator rather than to them; and that patients may be influenced by their attitudes towards the narrator. Bekker et al. (2013) argue that well-designed PDAs should not need to include patient narratives to be effective, recommending that more research is needed to explore how using patient narratives can support high quality decision making. In particular research needs to ensure users make decisions based on their own values and engage with other sources of factual information (Bekker et al., 2013).

Despite these controversies, including women's stories seemed appropriate in this context because women valued experiential information so highly. Such a view is supported by experts in the use of the Internet in health settings (e-health) who argue that patients in general will continue to seek out other's accounts of their experiences online because they value this sort of information (Ziebland and Wyke, 2012). No previous research that I am aware of has examined the effects of using animation to tell patients' stories in PDAs. Potential advantages may be that the use of simple line drawings may prevent users from over-identifying with the characters as physical attributes such as age, hair colour and ethnicity are not explicit. This may avoid some of the bias that Bekker et al (2013) are concerned about in relation to how users respond to the narrator. However, the characters do still have accents and the stories include personal information (for example that Polly is married and Rachel a single mother) which users may respond to and make assumptions about. The implications of using animation should be explored in any future evaluation of the PDA.

Polly and Rachel's stories are also intended to provide implicit values clarification, that is help women think about what is important to them when making a decision but not requiring them to explicitly rate the importance of particular values (Fagerlin et al., 2013). Entwistle et al. (2011) argue that understanding other people's reasoning is useful to patients in a range of clinical settings, without necessarily encouraging them to make the same choice as the narrator. At present it is not known whether implicit or explicit values clarification is more effective (Fagerlin et al., 2013) - and either meets the definition of a PDA (Stacey et al., 2014). I chose to use this implicit method because it seemed likely that women would engage in considering their own values through exploring the women's stories because they were used to seeking out such accounts themselves to help them make decisions. Also, explicit values clarification usually necessitates limiting values to a predefined list and, as so little is known about women's values about breech presentation, I was wary about limiting future women using the PDA to a list of values obtained from this study alone.

A further advantage of using animation was the ability to explore the physical experiences of ECV and respond to women's concerns that it was hard to imagine and potentially unpleasant for them and their babies. For this reason, the attempts at ECV (one successful, the other unsuccessful) are shown from both the women and babies' perspectives. This is a novel approach, and clearly unique to animation. Women's responses to this should be explored in any future evaluation of the PDA.

Expert advice was that Internet users tend to watch only parts of educational films and to optimise the chance of people watching the whole film the length should be limited to approximately seven minutes (Land and Fenton, 2014). They also recommend that in a short film there should only be two characters to avoid the story being over-complex but lacking in detail. As discussed in Chapter 7, Polly and Rachel were developed to best represent respondents in the study. Nevertheless, a potential limitation is that neither woman chooses a VBB. This means that the film may be perceived as biased against VBB despite the intention being that the character's stories prompt users to consider what is important to them, rather than encourage them to make particular choices. However, to address this potential for bias additional information about both women's stories is included on the website and it is emphasised that Rachel believes she would have chosen a VBB if her ECV had been unsuccessful. Future evaluation of the PDA should address whether users watch the whole film; their attitudes towards the stories that were chosen and their attitudes about neither character choosing a VBB. If this is perceived as a potential limitation by women, consideration could be given to making a second film focusing on options for birth.

Whilst previous research has established the potential benefits of PDAs in research settings (Stacey et al., 2014), much less is known about implementing and evaluating them in routine practice (Say et al., 2011). In a variety of clinical contexts, research suggests that barriers to PDA use include: lack of support from clinicians (including their concerns about data quality and time constraints); lack of an organised distribution system (and hence a lack of awareness of their existence); and clinicians' negative perceptions about patients' attitudes towards participation in decision-making (Holmes-Rovner et al., 2001; O'Donnell et al., 2006; Legare et al., 2008; Silvia et al., 2008). Within a maternity care setting, one qualitative study has explored healthcare professionals' views on two computer-based PDAs for women choosing mode of delivery after previous CS (Rees et al., 2009). While the majority of professionals were positive about the PDAs, perceived barriers to their use included service, communication and people issues (Rees et al., 2009). Overcoming such barriers may necessitate cultural changes and adaptations to clinical pathways (see Section 8.9.2). Another potential barrier to use in the long-term is the need to keep the website up-to-date. There are time and financial costs associated with this which need to be addressed (see Section 8.10).

8.7.1 Dissemination

I have presented this research and the PDA at various different events (see Appendix 5). All respondents were emailed a link to the PDA if I had their current email address. Women respondents were invited to two launch events at different times of day. Only one woman expressed interest in attending but did not come on the day. Professional respondents were also invited to a launch event and I offered to present my research at each participating unit; two of which invited me to hold further dissemination events.

The film has also been shown at a number of educational events (see Appendix 5) and has also been disseminated via YouTube (<https://m.youtube.com/watch?v=BSw2f0Qa4zo>) with 1176 views (13/01/15). NHS Choices will also feature the film on their website later in 2016, which will facilitate access to it for both women and health professionals.

8.8 Recommendations for clinical practice

Based on the findings of this thesis, I suggest the following changes to clinical practice.

8.8.1 *The timing of information provision*

Health professionals should ask pregnant women when they would like information about breech presentation and direct women to a source of high quality information such as the PDA at the appropriate time. As this is likely to be earlier than information is currently provided, if women choose to access information before 37 weeks of pregnancy, professionals should reassure them that most (97-98 in every 100) babies spontaneously turn into a cephalic position by 37 weeks of pregnancy and only a minority (3-4 babies in every 100) will remain breech.

8.8.2 *Supporting women who have undertaken their own research*

Health professionals should ask pregnant women what information they have found about breech presentation for themselves (including professional and lay resources) and discuss the strengths and limitations of such information. They should also ask women if they have any questions based on their own research. Professionals should recognise the value of experiential information to women and direct them to resources such as the PDA. They should also discuss any concerns women have as a result of reading or hearing other women's accounts.

8.8.3 *Training for health professionals*

Midwives and obstetricians should receive training about the evidence base underpinning the management of breech presentation. This could form part of annual clinical skills updates that already include sessions about the management of breech presentation. Their understanding of this evidence could be assessed using existing supervision procedures and work-based assessments.

Health professionals should also receive further training about SDM and risk communication. Again these could be integrated into existing training and assessment procedures. For example, communication about risk could be taught during the risk management reviews held in all maternity units. The RCOG and Royal College of Midwives (RCM) should require training in SDM for all obstetricians and midwives and assessment of these competences should also be integrated into routine work-base assessments. As part of training about SDM professionals should be informed of the importance of routinely asking women about their values and given the opportunity to practice different approaches to doing this, for example using role play. This is a key competence which should then be assessed. Women's

experiences of SDM should be sought as part of existing 360 degree appraisal processes for obstetricians.

8.8.4 Auditing SDM

Individual units should audit whether or not SDM occurs in routine practice and identify barriers to and facilitators of SDM at a local level.

8.9 Recommendations for policy

Based on the results of this study I suggest the following policy changes.

8.9.1 Clinical guidelines

Future clinical guidelines should embed the principles of SDM in maternity care. For example, SDM should be included in future NICE and RCOG guidelines so it becomes routine in maternity care. Those developing guidelines should avoid the discrepancy of advocating SDM at the same time as trying to achieve other policy goals which might limit women's choices. Future NICE and RCOG guidelines should include appropriate data to support SDM, for example, the inclusion of absolute risks.

8.9.2 Commissioners

Commissioners should receive training about SDM and the potential benefits of it for women using maternity services. SDM should then be embedded in routine commissioning systems and processes. This should involve reviewing clinical pathways to ensure they facilitate SDM; engaging with all key stakeholders (including involving users of maternity services) and identifying managers to have responsibility for SDM; and using incentives such as the English Commissioning for Quality and Innovation (CQUIN) framework (Capita Group Plc, 2013).

8.10 Recommendations for the PDA

As soon as possible, the PDA should be subjected to a user-centred evaluation. As per the British Standard 'Ergonomics of human-system interaction – part 210: Human-centred design for interactive systems ISO 9241-210:210' (British Standards Institution, 2010), the protocol for this should be developed by a multi-disciplinary team. I recommend that this team should include women with experience of breech presentation and health professionals involved in

managing breech presentation as this may improve the experience of potential respondents and ensure that relevant outcomes are chosen (NIHR, 2014). Based on the findings of this evaluation, the PDA should be refined. Following this, a long-term plan to decide how to keep the website updated should be made and appropriate funding secured. This should involve a review of women's and professionals' needs to support SDM about breech presentation.

8.11 Potential future research questions

Many potential areas for future research arose from the findings of this study.

8.11.1 *Evaluating the PDA*

Key questions which could be addressed in a future evaluation include:

1. Does the PDA meet users' needs and how could it best be refined?
2. What are the benefits and limitations of the PDA?
3. How do pregnant women and their supporters use the PDA?
4. What are the barriers and facilitators to using PDAs routinely in maternity care?
5. What are the advantages and disadvantages of web-based PDAs for pregnant women?
6. What are the advantages and disadvantages of using animation to tell patients' stories in PDAs?

8.11.2 *Women's; attitudes towards breech presentation, ECV, VBB and planned CS*

As the evidence-base about women's attitudes towards breech presentation, ECV, VBB and planned CS is so small it would be useful to undertake further qualitative studies in different research settings. This would expand the literature available to inform the development of future decision support and also enable the generalisability of the results of this study to be explored.

8.12 Final conclusions

This thesis adds to the literature in that it explores and describes women's experiences of making decisions about ECV, VBB and planned CS and in doing so offers the reader a deeper understanding of the process of decision making in this setting; women's values about ECV, VBB and planned CS; and their experiences of these options. This research has revealed barriers to SDM about breech presentation from both women's and professionals' perspectives.

In addition, this work describes the user-centred development of a PDA, consisting of a website and animated film, which seeks to address some of these barriers and is now available for pregnant women, their supporters and clinicians to use. In the future, this PDA should be subjected to a user-centred evaluation and a future assessment of women's and professionals' needs to support SDM about breech presentation should be made to ensure the PDA remains up to date and fit for purpose.

Appendix 1: Respondent Information Sheets



Participant Information Sheet for Women Considering Participation in Observed Consultations and Semi-Structured Interviews

A decision aid and decision quality instrument for breech presentation

Dr Rebecca Say, Dr Catherine Exley, Professor Stephen Robson, Professor Richard Thomson

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it will involve for you. One of our team will go through the information sheet with you and answer any questions you have. Please read this carefully and ask us if you would like any more information. Talk to others about the study if you wish.

What is the purpose of the study?

If your baby is bottom first (breech presentation) after 36 weeks of pregnancy, you have to decide whether to try to have your baby turned (called an external cephalic version or ECV) or to deliver the baby by Caesarean section.

In order to help women make these decisions we need to know what sort of information they need and how best to present it. Our aim is to develop a website to help women making decisions about breech presentation (a decision aid). We want to observe consultations to understand the present situation and understand what information we need to include in the decision aid. We would like to interview women making these decisions to find out what information they want and how a decision aid might help them. We also want to develop a way of measuring decision quality called a decision quality instrument. To do this we need to define the essential knowledge required by women to make decisions about breech presentation and understand the things which affect their decisions.

This study is being carried out as a PhD by Dr Rebecca Say.

Why have you been chosen and do you have to take part?

We are asking women who are pregnant with a breech baby to take part in this study. It is up to you to decide whether or not to take part. You can change your mind at any time and without giving a reason. Whatever you decide it will not affect the care you receive.

What will happen to me if I take part and what will I have to do?

You will be asked today if you are interested in taking part in the study and, if so, whether we can observe the conversation you have today with the doctor or midwife about decisions about your breech baby. We would also like to interview you afterwards to find out what information you found useful and what influenced your decisions. This interview could either happen today or at a later time to suit you. If you would like to have some more time to think about taking part in the interview we can contact you again after at least 24 hours either by telephone or email at a time to suit you and invite you to take part.

The consultation length will not be affected by the study but the interviews are expected to last up to 45 minutes. We will ask you to sign a consent form to take part and for us to record the consultation and the interview. We will be asking you about what information you found useful and how you made your decisions.

Expenses and payments

We will pay all your travel expenses if you provide us with a receipt. Unfortunately childcare costs cannot be funded.

What are the risks and benefits of taking part?

There are no risks of taking part, only the possible inconvenience of giving up your time to be interviewed. You will not directly benefit from taking part in the study, but you will be giving us valuable information to help improve support for women in the future making decisions about breech presentation.

What happens when the research study stops?

We will offer to send you a report of our findings and show you the decision aid we develop.

What will happen if I don't want to carry on with the study?

You can withdraw from the study at any time and any information you have given us will not be used. If you want to withdraw please contact Professor S Robson (Tel 2824132).

Will my taking part in this study be kept confidential?

Yes, we will follow ethical and legal practice and all information about you will be handled in confidence. Only the research team will have access to the audio recordings. All the information you give us will be anonymised so you cannot be identified. All our records will be kept securely in Newcastle University in accordance with the Data Protection Act 1998. If you tell us anything that suggests you have experienced malpractice or misconduct, or suggests that you are in danger of harm we would ask your permission to report this to someone who could help.

What if there is a problem?

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions (0191 2824132). If you remain unhappy and wish to complain formally, you can do this by contacting the hospital's Patient advice and Liaison Service. If you are harmed during the research and this is due to someone's negligence you may have grounds for a legal action and compensation against the Newcastle upon Tyne Hospitals NHS Foundation Trust but you may have to pay your legal costs.

What will happen to the results of the research study?

The results will be used to develop a decision aid for women with a breech baby. We anticipate the results will be published in a medical journal. You will not be identified in any report or publication.

Who is organising and funding the research and who has reviewed the study?

The study is being funded by the National Institute for Health Research and carried out by Newcastle University. All research in the NHS is looked at by an independent group of

people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by Sunderland Research ethics Committee.

Contact for further information

If you have any further questions about the study please contact Professor S Robson (Tel 2824132). In case of an emergency please use the following numbers which are also available in your hand-held maternity notes (please telephone the hospital where you are receiving your maternity care):

Thank you for reading this information sheet



Participant Information Sheet for Women Who Have Had a Breech Presentation Considering Participation in Semi-Structured Interviews

A decision aid and decision quality instrument for breech presentation

Dr Rebecca Say, Dr Catherine Exley, Professor Stephen Robson, Professor Richard Thomson

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it will involve for you. One of our team will go through the information sheet with you and answer any questions you have. Please read this carefully and ask us if you would like any more information. Talk to others about the study if you wish.

What is the purpose of the study?

If your baby is bottom first (breech presentation) after 36 weeks of pregnancy, you have to decide whether to try to have your baby turned (called an external cephalic version or ECV) or to deliver the baby by Caesarean section.

In order to help women make these decisions we need to know what sort of information they need and how best to present it. Our aim is to develop a website to help women making decisions about breech presentation (a decision aid). We would like to interview women who have made these decisions to find out what information they wanted; what they thought of the decision making process and how a decision aid might have helped them. We also want to develop a way of measuring decision quality called a decision quality instrument. To do this we need to define the essential knowledge required by women to make decisions about breech presentation and understand the things which affect their decisions.

This study is being carried out as a PhD by Dr Rebecca Say.

Why have you been chosen and do you have to take part?

We are asking women who have recently been pregnant with a breech baby to take part in this study. It is up to you to decide whether or not to take part. You can change your mind at any time and without giving a reason. Whatever you decide it will not affect the care you receive.

What will happen to me if I take part and what will I have to do?

We are asking if you are interested in taking part in the study and, if so, whether we can telephone or email you to arrange an interview after you have had some more time to think about the study. If you are interested in taking part please return the expression of interest form to us in the enclosed pre-paid envelope (no stamp needed).

If you agree we will contact you at a time to suit you and invite you to take part in an interview. The interview can take place at a time and place to suit you (such as your home or the hospital) and is expected to last up to 45 minutes. We will ask you to sign a consent form to take part in the interview and for us to record the discussions. We will be asking you about what information you found useful and how you made your decisions.

Expenses and payments

We will pay all your travel expenses if you provide us with a receipt. Unfortunately childcare costs cannot be funded.

What are the risks and benefits of taking part?

There are no risks of taking part, only the possible inconvenience of giving up your time to be interviewed. You will not directly benefit from taking part in the study, but you will be giving us valuable information to help improve support for women in the future making decisions about breech presentation.

What happens when the research study stops?

We will offer to send you a report of our findings and show you the decision aid we develop.

What will happen if I don't want to carry on with the study?

You can withdraw from the study at any time and any information you have given us will not be used. If you want to withdraw please contact Professor S Robson (Tel 2824132).

Will my taking part in this study be kept confidential?

Yes, we will follow ethical and legal practice and all information about you will be handled in confidence. Only the research team will have access to the audio recordings. All the information you give us will be anonymised so you cannot be identified. All our records will be kept securely in Newcastle University in accordance with the Data Protection Act 1998. If you tell us anything that suggests you have experienced malpractice or misconduct, or suggests that you are in danger of harm we would ask your permission to report this to someone who could help.

What if there is a problem?

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions (0191 2824132). If you remain unhappy and wish to complain formally, you can do this by contacting the hospital's Patient advice and Liaison Service. If you are harmed during the research and this is due to someone's negligence you may have grounds for a legal action and compensation against the Newcastle upon Tyne Hospitals NHS Foundation Trust but you may have to pay your legal costs.

What will happen to the results of the research study?

The results will be used to develop a decision aid for women with a breech baby. We anticipate the results will be published in a medical journal. You will not be identified in any report or publication.

Who is organising and funding the research and who has reviewed the study?

The study is being funded by the National Institute for Health Research and carried out by Newcastle University. All research in the NHS is looked at by an independent group of

people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by Sunderland Research ethics Committee.

Contact for further information

If you have any further questions about the study please contact Professor S Robson (Tel 2824132). In case of an emergency please use the following numbers which are also available in your hand-held maternity notes (please telephone the hospital where you are receiving your maternity care):

Thank you for reading this information sheet



Participant Information Sheet for Women Considering Participation in Design Workshops/ One-to-One Prototype Testing Sessions

A decision aid and decision quality instrument for breech presentation

Dr Rebecca Say, Dr Catherine Exley , Professor Stephen Robson, Professor Richard Thomson

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it will involve for you. One of our team will go through the information sheet with you and answer any questions you have. Please read this carefully and ask us if you would like any more information. Talk to others about the study if you wish.

What is the purpose of the study?

If your baby is bottom first (breech presentation) after 36 weeks of pregnancy, you have to decide whether to try to have your baby turned (called an external cephalic version or ECV) or to deliver the baby by Caesarean section.

In order to help women make these decisions we need to know what sort of information they need and how best to present it. Our aim is to develop a website to help women making decisions about breech presentation (a decision aid). We want to find out how easy the decision aid is to use. We will be holding three workshops with women with a breech baby to ask their opinions about the design of the decision aid and what information should be included.

We also want to develop a way of measuring decision quality called a decision quality instrument. To do this we need to understand the essential knowledge required to make decisions about breech presentation and the things which affect women's decisions. We will ask for your thoughts on these during the workshops.

This study is being carried out as a PhD by Dr Rebecca Say.

Why have you been chosen and do you have to take part?

We are asking women who are pregnant with, or who have experienced having, a breech baby after 37 weeks of pregnancy to take part in this study. It is up to you to decide whether or not to take part. You can change your mind at any time and without giving a reason. Whatever you decide it will not affect the care you receive.

What will happen to me if I take part and what will I have to do?

You will be asked today if you are interested in taking part in the study and, if so, whether we can telephone or email you to ask you to come to a workshop in the hospital after you have had some more time to think about the study. If you agree we will contact you at a time to suit you and invite you to attend a workshop. The workshops are expected to last about two hours. We will ask you to attend up to two workshops because we would like to ask what you think about the decision aid as it is developed. If you prefer not to attend a second workshop but would like to give us more feedback we will offer you a one-to-one feedback session in a place which suits you, such as your home or the hospital. You may also choose to attend the first workshop only. We will ask you to sign a consent form to take part in the workshop and for us to record the discussions. We will be asking you about the design of the decision aid; what you think should be included; and how easy it is to use. We will use your feedback to update the design of the decision aid.

Expenses and payments

We will provide refreshments at the workshops and pay all your travel expenses if you provide us with a receipt. Unfortunately childcare costs cannot be funded.

What are the risks and benefits of taking part?

There are no risks of taking part, only the possible inconvenience of giving up your time to come to the workshops. You will not directly benefit from taking part in the study, but you will be giving us valuable information to help improve support for women in the future making decisions about breech presentation.

What happens when the research study stops?

We will offer to send you a report of our findings and show you the decision aid.

What will happen if I don't want to carry on with the study?

You can withdraw from the study at any time and any information you have given us will not be used.

Will my taking part in this study be kept confidential?

Yes, we will follow ethical and legal practice and all information about you will be handled in confidence. Only the research team will have access to the audio recording. All the information you give us will be anonymised so you cannot be identified. All our records will be kept securely in Newcastle University in accordance with the Data Protection Act 1998. We will ask your permission to tell your General Practitioner that you have taken part in the study. If you tell us anything that suggests you have experienced malpractice or misconduct, or suggests that you are in danger of harm we would ask your permission to report this to someone who could help.

What if there is a problem?

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions (0191 2824132). If you remain unhappy and wish to complain formally, you can do this by contacting the hospital's Patient advice and Liaison Service. If you are harmed during the research and this is due to someone's negligence you may have grounds for a legal action and compensation against the Newcastle upon Tyne Hospitals NHS Foundation Trust but you may have to pay your legal costs.

What will happen to the results of the research study?

The workshops will be used to develop a decision aid for women with a breech baby. We anticipate the results will be published in a medical journal. You will not be identified in any report or publication.

Who is organising and funding the research and who has reviewed the study?

The study is being funded by the National Institute for Health Research and carried out by Newcastle University. All research in the NHS is looked at by an independent group of

people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by Sunderland Research ethics Committee.

Contact for further information

If you have any further questions about the study please contact Professor S Robson (Tel 2824132). In case of an emergency please use the following numbers which are also available in your hand-held maternity notes (please telephone the hospital where you are receiving your maternity care):

Thank you for reading this information sheet



Participant Information Sheet for Health Professionals Considering Participation in Observed Consultations and Semi-Structured Interviews

A decision aid and decision quality instrument for breech presentation

Dr Rebecca Say, Dr Catherine Exley, Professor Stephen Robson, Professor Richard Thomson

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it will involve for you. Please read this carefully and ask us if you would like any more information.

What is the purpose of the study?

We are aiming to develop a decision aid for women with breech presentation which could be used to help them make a decision about whether or not to have an external cephalic version (ECV) and whether to have an elective caesarean section. As well as involving women with breech presentation in the development process, we want to involve health professionals (both obstetricians and midwives). We also want to develop a way of measuring decision quality called a decision quality instrument. To do this we need to define the essential knowledge required by women to make decisions about breech presentation and understand the things which affect their decisions.

The first phase of this study is for us to observe consultations between women making decisions about breech presentation and health professionals counselling them. This will help us to better understand the current care pathways and to identify essential information women need to make these decisions as well as the things which influence their choices.

We also want to develop a way of measuring decision quality called a decision quality instrument. To do this we need to understand the essential knowledge required to make decisions about breech presentation and the things which affect women's decisions. We will ask for your feedback on these during the interviews.

This study is being carried out as a PhD by Dr Rebecca Say.

Why have you been chosen and do you have to take part?

We are asking health professionals who manage breech presentation to take part and plan to recruit women they are counselling. It is up to you to decide whether or not to take part and this will have no effect on your future employment. We will not inform your employer of your decision. You can change your mind at any time and without giving a reason.

What will happen to me if I take part and what will I have to do?

Once you have had some time to read this information sheet and consider taking part you will be contacted by the research team by telephone or email to invite you to take part. If we do not hear back from you we will contact you a second time. You will be asked if you would be willing for us to observe and audio record consultations with participating women. The length of consultations will not be affected by the study.

We would also like to interview you to find out what information you think is essential for women making decision about breech presentation and what influences their decisions. We will also ask you how you think a decision aid could be used in the current care pathway and what advantages and disadvantages it may offer. Interviews are expected to last up to 45 minutes. We will ask you to sign a consent form to take part and for us to record your consultation and the interview.

What are the risks and benefits of taking part?

There are no risks of taking part, only the possible inconvenience of giving up your time to be interviewed. You will not directly benefit from taking part in the study, but you will be giving us valuable information to help improve support for women in the future making decisions about breech presentation.

What happens when the research study stops?

We will offer to send you a report of our findings and show you the decision aid we develop.

What will happen if I don't want to carry on with the study?

You can withdraw from the study at any time and any information you have given us will not be used.

Will my taking part in this study be kept confidential?

All the information you give us will be anonymised so you cannot be identified. Only the research team will have access to the audio recordings. All our records will be kept securely in Newcastle University in accordance with the Data Protection Act 1998.

What will happen to the results of the research study?

The results will be used to develop a decision aid for women with a breech baby. We anticipate the results will be published in a medical journal. You will not be identified in any report or publication.

Who is organising and funding the research and who has reviewed the study?

The study is being funded by the National Institute for Health Research and carried out by Newcastle University. This study has been reviewed and given favourable opinion by Sunderland Research ethics Committee.

Contact for further information

If you have any further questions or concerns about the study please contact Professor S Robson (Tel 2824132).

Thank you for reading this information sheet

**Participant Information Sheet for Health Professionals Considering
Participation in Design Workshops/ One-to-One Prototype Testing Sessions**

A decision aid and decision quality instrument for breech presentation

Dr Rebecca Say, Dr Catherine Exley, Professor Stephen Robson, Professor Richard Thomson

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it will involve for you. Please read this carefully and ask us if you would like any more information.

What is the purpose of the study?

We are aiming to develop a decision aid for women with breech presentation which could be used to help them make a decision about whether or not to have an external cephalic version (ECV) and whether to have an elective caesarean section. As well as involving women with breech presentation in the development process, we want to involve health professionals (both obstetricians and midwives). This phase of the study consists of design workshops and one-to-one prototype testing sessions. This will enable us to get feedback on the design of the decision aid and adapt it in response.

We also want to develop a way of measuring decision quality called a decision quality instrument. To do this we need to define the essential knowledge required by women to make decisions about breech presentation and understand the things which affect their decisions. We will ask for feedback on these during the workshops/ feedback sessions.

This study is being carried out as a PhD by Dr Rebecca Say.

Why have you been chosen and do you have to take part?

We are asking health professionals who manage breech presentation to take part in the design of the decision aid. It is up to you to decide whether or not to take part and this will have no effect on your future employment. You can change your mind at any time and without giving a reason.

What will happen to me if I take part and what will I have to do?

Once you have had some time to read this information sheet and consider taking part you will be contacted by the research team by telephone or email to invite you to take part. If we do not hear back from you we will contact you a second time. We will invite you to take part in a design workshop with up to seven other health professionals. Workshops are expected to last about two hours. We will also ask you to attend up to two workshops because we would like to ask what you think about the decision aid as it is developed. If you prefer not to attend a second workshop but would like to give us more feedback we will offer you a one-to-one feedback session in a place which suits you, such as your office. You may also choose to attend the first workshop only. We will ask you to sign a consent form to take part in the workshop and for us to record the discussions. We will be asking you about the design of the decision aid; what you think should be included; and how easy it is to use. We will use your feedback to update the design of the decision aid.

Expenses and payments

We will provide refreshments at the workshops and pay your travel expenses if you provide us with a receipt.

What are the risks and benefits of taking part?

There are no risks of taking part, only the possible inconvenience of giving up your time. You will not directly benefit from taking part in the study, but you will be giving us valuable information to help improve support for women in the future making decisions about breech presentation.

What happens when the research study stops?

We will offer to send you a report of our findings and show you the decision aid we develop.

What will happen if I don't want to carry on with the study?

You can withdraw from the study at any time and any information you have given us will not be used.

Will my taking part in this study be kept confidential?

All the information you give us will be anonymised so you cannot be identified. Only the research team will have access to the audio recordings. All our records will be kept securely in Newcastle University in accordance with the Data Protection Act 1998.

What will happen to the results of the research study?

The results will be used to develop a decision aid for women with a breech baby. We anticipate the results will be published in a medical journal. You will not be identified in any report or publication.

Who is organising and funding the research and who has reviewed the study?

The study is being funded by the National Institute for Health Research and carried out by Newcastle University. This study has been reviewed and given favourable opinion by Sunderland Research ethics Committee.

Contact for further information

If you have any further questions or concerns about the study please contact Professor S Robson (Tel 2824132).

Thank you for reading this information sheet

Appendix 2: Expression of interest forms



Expression of Interest Form

A decision aid and decision quality instrument for breech presentation

Dr Rebecca Say, Dr Catherine Exley, Professor Stephen Robson, Professor Richard Thomson

Please initial boxes

1. I confirm that I have read and understand the information sheet dated 2 August 2011 (version 2.0) and am interested in being contacted about participating when I have had some more time to think about the study.

2. My preferred method for you to contact me is telephone/ email/ either (please delete) and my telephone number/ email address is _____.

_____.

3. The most convenient time for me to be contacted is:

_____.

_____.

4. I understand that my personal contact information will be stored in a secure location in Newcastle University and give permission for this.

Name

Date

Signature



Expression of Interest Form

A decision aid and decision quality instrument for breech presentation

Dr Rebecca Say, Dr Catherine Exley, Professor Stephen Robson, Professor Richard Thomson

Please initial boxes

1. I confirm that I have read and understand the information sheet dated 14 May 2012 (version 1.0) and am interested in being contacted about participating when I have had some more time to think about the study.

2. My preferred method for you to contact me is telephone/ email/ either (please delete) and my telephone number/ email address is _____.
_____.

3. The most convenient time for me to be contacted is:

_____.

4. I understand that my personal contact information will be stored in a secure location in Newcastle University and give permission for this.

Name

Date

Signature

Appendix 3: Consent Forms



Consent Form for Observed Consultations and Interviews: Women
A decision aid and decision quality instrument for breech presentation

Centre number:

Study number:

Participant Identification Number:

Name of Researcher(s):

Please initial box

1. I confirm that I have read and understand the information sheet dated 21 November 2011 (version 3.0) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.
3. I agree to allow the researchers to observe and audio-record the consultation and audio-record the interview. I understand that direct quotes may be used in the final report or scientific publications, however these will be anonymised and no personal information which could identify me will be used.
4. I understand that all data collected will remain anonymous and confidential, and will be stored in a locked filing cabinet and on password protected computers located in the Institute of Health and Society at Newcastle University.
5. I understand that during the consultation/ interview if any disclosures are made that would indicate malpractice or misconduct, or suggest that any individual was in danger of harm; this information will be disclosed to the appropriate personnel.
6. I understand that once transcribed, the audio-recordings will be destroyed and transcripts stored in locked files in accordance with the Data Protection Act.
7. I understand that relevant sections of my medical notes and data collected during the study, may be looked at by individuals from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.
9. I agree to take part in the observed consultation in the above study.
10. I agree to take part in the interview in the above study.

 Name of participant Date Signature

 Name of person Date Signature
 taking consent

When completed, 1 for participant; 1 for researcher site file; 1 to be kept in medical notes.



Consent Form for Semi-Structured Interviews: Women Who Have Had a Breech Presentation

Centre number:

Study number:

Participant Identification Number:

Name of Researcher(s):

Please initial box

1. I confirm that I have read and understand the information sheet dated 14 May 2012 (version 1.0) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.

3. I agree to allow the researchers to audio-record the interview. I understand that direct quotes may be used in the final report or scientific publications, however these will be anonymised and no personal information which could identify me will be used.

4. I understand that all data collected will remain anonymous and confidential, and will be stored in a locked filing cabinet and on password protected computers located in the Institute of Health and Society at Newcastle University.

5. I understand that during the interview if any disclosures are made that would indicate malpractice or misconduct, or suggest that any individual was in danger of harm; this information will be disclosed to the appropriate personnel.

6. I understand that once transcribed, the audio-recordings will be destroyed and transcripts stored in locked files in accordance with the Data Protection Act.

7. I understand that relevant sections of my medical notes and data collected during the study, may be looked at by individuals from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.

8. I agree to take part in the interview in the above study.

Name of participant Date Signature

Name of person Date Signature
taking consent

When completed, 1 for participant; 1 for researcher site file; 1 to be kept in medical notes.



Consent Form for Design Workshops/ Prototype Testing Sessions: Women
A decision aid and decision quality instrument for breech presentation

Centre number:

Study number:

Participant Identification Number:

Name of Researcher(s):

Please initial box

1. I confirm that I have read and understand the information sheet dated 2 August 2011 (version 2.0) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.
3. I agree to allow the researchers to audio-record the workshop/ prototype testing session. I understand that direct quotes may be used in the final report or scientific publications, however these will be anonymised and no personal information which could identify me will be used.
4. I understand that all data collected will remain anonymous and confidential, and will be stored in a locked filing cabinet and on password protected computers located in the Institute of Health and Society at Newcastle University.
5. I understand that during the workshop/ prototype testing session if any disclosures are made that would indicate malpractice or misconduct, or suggest that any individual was in danger of harm; this information will be disclosed to the appropriate personnel.
6. I understand that once transcribed, the audio-recordings will be destroyed and transcripts stored in locked files in accordance with the Data Protection Act.
7. I understand that relevant sections of my medical notes and data collected during the study, may be looked at by individuals from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.
8. I agree to take part in the above study.

 Name of participant Date Signature

 Name of person Date Signature
 taking consent

When completed, 1 for participant; 1 for researcher site file; 1 to be kept in medical notes.



**Consent Form for Observed Consultations and Interviews: Professionals
A decision aid and decision quality instrument for breech presentation**

Centre number:

Study number:

Participant Identification Number:

Name of Researcher(s): **Please initial box**

1. I confirm that I have read and understand the information sheet dated 21 November 2011 (version 2.0) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	<input type="checkbox"/>
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.	<input type="checkbox"/>
3. I agree to allow the researchers to audio-record the consultation and the interview. I understand that direct quotes may be used in the final report or scientific publications, however these will be anonymised and no personal information which could identify me will be used.	<input type="checkbox"/>
4. I understand that all data collected will remain anonymous and confidential, and will be stored in a locked filing cabinet and on password protected computers located in the Institute of Health and Society at Newcastle University.	<input type="checkbox"/>
5. I understand that during the consultation/ interview if any disclosures are made that would indicate malpractice or misconduct, or suggest that any individual was in danger of harm; this information will be disclosed to the appropriate personnel.	<input type="checkbox"/>
6. I understand that once transcribed, the audio-recordings will be destroyed and transcripts stored in locked files in accordance with the Data Protection Act.	<input type="checkbox"/>
7. I agree to take part in the observed consultation in the above study.	<input type="checkbox"/>
8. I agree to take part in the interview in the above study.	<input type="checkbox"/>

Name of participant Date Signature

Name of person taking consent Date Signature

When completed, 1 for participant; 1 for researcher site file



Consent Form for Design Workshops/ Prototype Testing Sessions: Professionals
A decision aid and decision quality instrument for breech presentation

Centre number:

Study number:

Participant Identification Number:

Name of Researcher(s):

Please

initial box

1. I confirm that I have read and understand the information sheet dated 22 June 2011 (version 1.0) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	<input type="checkbox"/>
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.	<input type="checkbox"/>
3. I agree to allow the researchers to audio-record the workshop/ prototype testing session. I understand that direct quotes may be used in the final report or scientific publications, however these will be anonymised and no personal information which could identify me will be used.	<input type="checkbox"/>
4. I understand that all data collected will remain anonymous and confidential, and will be stored in a locked filing cabinet and on password protected computers located in the Institute of Health and Society at Newcastle University.	<input type="checkbox"/>
5. I understand that during the workshop/ prototype testing session if any disclosures are made that would indicate malpractice or misconduct, or suggest that any individual was in danger of harm; this information will be disclosed to the appropriate personnel.	<input type="checkbox"/>
6. I understand that once transcribed, the audio-recordings will be destroyed and transcripts stored in locked files in accordance with the Data Protection Act.	<input type="checkbox"/>
7. I agree to my contact details being recorded on password protected computers located in the Institute of Health and Society at Newcastle University for the purposes of inviting me to participate in a further workshop/ prototype testing session.	<input type="checkbox"/>
9. I agree to take part in the above study.	<input type="checkbox"/>

Name of participant Date

Signature

Name of person Date
taking consent

Signature

When completed, 1 for participant; 1 for researcher site file

Appendix 4: Interview Schedules

Interview schedule for semi-structured interviews with women after observed consultation

- Recap purpose of study
- Thank for participation in videoed consultation
- Overview of semi-structured interview

Start recording with dictaphone here

- Please can you tell me what you know about the decisions you need to make about breech presentation?
- What information did the health professional give you about breech presentation?
- What information did the health professional give you about ECV?
- What information did the health professional give you about caesarean section?
- What information did the health professional give you about vaginal breech birth?
- What have you decided to do?
- Why have you decided to do that?
- What was important to you in making the decision?
- What does having a breech baby mean to you?
- How did you feel about the way you were given information?
- How could we improve the ways we give information about breech presentation to women?

Interview schedule for post-natal semi-structured interviews

- Recap purpose of study
- Thank for participation
- Overview of semi-structured interview

Start recording with dictaphone here

- Please can you tell me about your experience of having a breech presentation?
- What did having a breech baby mean to you?
- How did you decide whether or not to have an ECV?
- What information did the health professional give you about breech presentation?
- What information did the health professional give you about ECV?
- What information did the health professional give you about caesarean section?
- What information did the health professional give you about vaginal breech birth?
- How did you feel about the way you were given information?
- How did you decide how to give birth?
- Why did you decided to do that?
- What was important to you in making the decision?
- How do you feel about the decisions you made now?
- How could we improve the ways we give information about breech presentation to women?

**Interview schedule for semi-structured interviews with health professionals after
observed consultation**

- Recap purpose of study
- Thank for participation in videoed consultation
- Overview of semi-structured interview

**Start recording with dictaphone
here**

- Please can you summarise the consultation you have just had?
- What information do you give women about breech presentation?
- What information do you give women about ECV?
- What information do you give women about caesarean section?
- What information do you give women about vaginal breech birth?
- What do you think is important to women making decisions about breech presentation?
- What different ways of giving information to women do you use and why?
- How could we improve the ways we give information about breech presentation to women?

Appendix 5: Dissemination Events

Date	Event	Audience
30 June 2015	Film Premiere at the Tyneside Cinema, Newcastle upon Tyne	Invited audience of 40 respondents and key stakeholders
9 October 2015	Presentation of research and film viewing, Sunderland Royal Hospital, Sunderland	20 obstetricians and midwives
9 October 2015	Film viewing at educational event for pregnant women, Sunderland Royal Hospital, Sunderland	Approximately 50 pregnant women, their partners and supporters, obstetricians, midwives and interested college students
14 October 2015	Presentation of research and film viewing, Newcastle University, Newcastle upon Tyne	All women respondents invited, unfortunately none attended
21 October 2015	Presentation of research and film viewing, Kings College London	Approximately 300 midwives, student midwives and one obstetrician. This was a public event and 390 people booked to attend.

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