Water VBAC: Exploring a new frontier for women's autonomy

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ABSTRACT

Background: although Vaginal Birth After Caesarean section (VBAC) has been promoted successfully as one means of reducing the caesarean section rate, the practice of VBAC using water immersion (Water VBAC) is restricted. Very little valid, reliable research evidence is available on this birth method, although initial small-scale audits indicate that Water VBAC has no adverse effect on maternal and neonatal outcomes.

Method: in-depth semi-structured interviews were carried out with a purposive sample of eight women who had undergone Water VBAC in one midwife-led unit. The interviews aimed to explore their reasons for requesting this birthing method, and their experience of the process. An interpretative phenomenological analytical approach was adopted.

Findings: the women pursued Water VBAC for two main reasons: in order to prevent a repeat of the obstetric events that previously led to a caesarean section, and to counteract their previous negative birth experiences. The women reported improved physical and psychological outcomes from their Water VBAC experience when compared with their previous experience of caesarean section. Three main themes emerged: ‘minimising’, ‘maximising’ and ‘managing’. Water VBAC entailed an attempt to minimise the medicalisation of the women’s childbirth experience. This was achieved by limiting medical staff input in favour of midwife-led care, which was believed to minimise negative physical and psychological experiences. Correspondingly, Water VBAC was perceived as maximising physical and psychological benefits, and as a means of allowing women to obtain choice and assert control over their labour and birth. The women planning a Water VBAC believed they had to manage the potential risks associated with Water VBAC, as well as manage the expectations and behaviour of friends, family and the healthcare professionals involved in their care.

Conclusions: for the women participating in this research, actively pursuing Water VBAC constituted a means of asserting their autonomy over the childbirth process. The value accorded to being able to exercise choice and control over their childbearing experience was high. These women’s accounts indicated that information-giving and shared decision-making require improvement, and that inconsistencies in the attitudes of healthcare professionals need to be addressed.

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Introduction

Contemporary maternity care in the United Kingdom (UK) is heavily influenced by the debate around choice and women’s autonomy. Although this topic is certainly not new, being 20 years since the seminal Changing Childbirth report (DoH, 1993), recent years have seen the debate evolve. For some, ‘choice’ is felt to be controlled and only offered within certain constraints (Levy, 2004), with a Healthcare Commission (2007) report finding that many women reported choice to be limited. Nevertheless, some women with significant risk factors manage to exercise choice and autonomy even in the face of clinical opposition (Symon et al., 2010). There is legal support for this expression of autonomy: the landmark ruling in Re MB (1997) held that informed decision-making involved ‘a reasoned choice made by a reasonable individual using relevant information about the advantages and disadvantages of all the possible courses of action, in accordance with the individual’s beliefs’ (per Butler-Sloss, L.J.). The question of what is ‘reasonable’ is often framed against a backdrop of risk – another of the mantras of the modern age.

The debate about the applicability of risk factors is not new either – their poor predictive value was noted in the first edition of Effective Care in Pregnancy and Childbirth (Alexander and Keirse,
1989) – but contemporary maternity care is largely organised on the premise that increasing risk factors will limit choice (Symon, 2006). Having a caesarean section (CS) usually indicates that a subsequent pregnancy will not be classified as ‘low risk’, thus restricting the birth choices available to the mother. These often include place of birth (Rogers et al., 2005), and sometimes mode of birth (Soltani and Sandall, 2012). In light of the potential risks of CS (as discussed below), particularly for the mother (RCOG, 2007; NICE, 2011), attempts have been made to reduce the CS rate which has increased in the UK from 9% in 1980 to over 24% in 2009 (Bragg et al., 2010).

An increasing number of women are challenging the restriction on their birth choices due to their risk label by requesting water birth as part of their right to Vaginal Birth After Caesarean Section (VBAC). However, the background to/circumstances of these requests, and the experience of the actual Water VBAC process, are unexplored areas. In order to set out the context of the women’s desire/wish for Water VBAC, we now briefly discuss the three central factors: VBAC, water birth, and Water VBAC.

**VBAC**

Part of the drive to reduce the overall CS rate has included promoting VBAC (Emmett et al., 2006). VBAC has been proven to produce better outcomes than repeat planned CS with regard to maternal mortality (RCOG, 2007; NICE, 2011), but it is associated with a slightly higher risk of intrapartum maternal morbidity (post partum haemorrhage [PPH], uterine scar dehiscence, uterine rupture, hysterectomy, blood transfusion and endometritis) compared with repeat elective CS (RCOG, 2007; NICE, 2011). However, these examples do not relate to longer term morbidity such as prolonged recovery time (NICE, 2011) and the risk of serious complications in future pregnancies (RCOG, 2007), which are both associated with CS.

Compared with repeat elective CS, neonatal morbidity – specifically respiratory problems (RCOG, 2007) and admission to the Neonatal Unit (NICE, 2011) – is improved with VBAC, but the neonatal mortality rate is slightly raised. VBAC is also associated with a reduced need for pharmacological analgesia and a shorter hospital stay for women (RCOG, 2007; NICE, 2011), as well as increased reported maternal satisfaction (Meddings et al., 2006), and a more positive impact on health care professionals (NICE, 2011).

Although the National Institute for Health and Clinical Excellence (NICE) guidelines maintain that women should not be deterred from undertaking VBAC as adverse outcomes associated with VBAC are extremely rare, they also recommend that VBAC is attempted only in a delivery unit with immediate access to CS and on-site blood transfusion services, and that continuous electronic fetal monitoring be performed throughout labour (NICE, 2011). These factors need to be addressed in any exploration of the experiences or motivations of women planning a Water VBAC.

**Water birth**

Water birth has become a popular option for labouring women in the last 20 years (Cluett and Burns, 2011). The Royal College of Midwives (RCM), Royal College of Obstetricians and Gynaecologists (RCOG) and NICE all advocate offering the use of a water pool to labouring women with uncomplicated pregnancies at term (RCOG/RCM, 2006; NICE, 2007). Labouring in water can reduce the need for pharmacological analgesia and reported maternal pain without adversely affecting labour duration, operative delivery rates or neonatal well-being (RCOG/RCM, 2006; NICE, 2007; Cluett and Burns, 2011). Immersion in water also increases women’s reported satisfaction with the second stage of labour, and with the childbirth experience in general (Cluett and Burns, 2011). Although there are criticisms that water birth presents potential dangers to mother and infant, namely aspiration and infection, Young and Kruske (2013) observe that the empirical basis for these claims is often lacking. They note in addition that appropriate practice guidelines can help to avert such potential poor outcomes.

**Water VBAC**

Despite the attempts to reduce the CS rate by offering VBAC, and the now widespread use of water labour and water birth, the combination of VBAC and water birth is a step too far for some policy makers and practitioners. Such opposition comes regardless of an apparently growing demand for Water VBAC (Garland, 2006; Sellar, 2008). Correspondence with practitioners from a number of units confirms two principal reasons for this opposition: the need for continuous electronic fetal monitoring (EFM), and the need to site an intravenous cannula in view of the potential risk of PPH or transfer to Theatre due to uterine scar dehiscence/uterine rupture (various personal communications). Yet the recent availability of telemetry for EFM means that underwater continuous monitoring is now feasible, and an intravenous cannula can be secured safely, even in water. From the available (albeit limited) literature, it is clear that Water VBAC has indeed been offered in certain birth units, with some limited evidence from audits as to its efficacy.

Brown (1998) reports a clinical audit of birth outcomes in the English Midlands for 541 mainly low risk primigravid and multigravid women who laboured in water. She noted that 343 (63.4%) went on to give birth in the pool, of whom 10 had undergone previous CS. This audit reported several outcomes, including infection risks, perinatal trauma, blood loss and maternal satisfaction. However, it did not analyse separately the outcomes for women attempting Water VBAC, simply noting that ‘all ten delivered in the pool with no adverse effect’ (Brown, 1998: 237).

Garland (2006: 217) reports a three-year audit of a risk assessment process intended to ascertain if it was ‘safe and realistic’ for suitable pre-selected women in a maternity unit in England to attempt Water VBAC. The article also outlines the care plan for Water VBAC, and presents data on mode of birth and use of analgesia. Of the 92 women who wanted Water VBAC, 80 were included in the audit, but only 15 women actually laboured in water, with just four experiencing water birth. The initially promising number of participants was thus reduced to a very limited sample size, and no comparison was made between the outcomes for these four women with the equivalent statistics for non-VBAC water births or VBACs without the use of water immersion.

Sellar’s (2008) audit of 26 women who experienced VBAC in a Scottish midwife-led unit (MLU) noted that 10 of these women had a water birth. The audit reported no adverse effect for these 10 cases in terms of neonatal morbidity (based on Apgar scores, infection rates and admissions to a Neonatal Unit), but its small scale and the fact that it provided no comparative statistics limit its impact. Sellar also reported an increase in maternal satisfaction levels among women who perceived themselves as being able to exercise choice and control over their labour and birth. However, resistance from senior management and medical staff was noted, meaning that Water VBAC was not routinely offered to antenatal women. For women to ‘opt in’, they must therefore have prior knowledge of this birth method.

Audits and empirical research are important in helping to establish whether practice is safe and acceptable in terms of clinical outcome, but the actual/lived experience of health care is much more than the reflection of clinical outcome variables, particularly because the offer of choice and control are integral.
to modern maternity policy (cf. Midwifery 2020, 2010). While the limited literature does indicate high maternal satisfaction with the Water VBAC service currently available in the NHS, the numbers involved are small and do not lend themselves well to quantitative analysis. There is also a lack of understanding of the experiences of women undergoing Water VBAC, and indeed of what prompts them to seek an option that many consider to be ‘high risk’. The current study proposes to fill some of this empirical gap by examining the experiences and motives of women who have undertaken Water VBAC.

Methods

In setting out to explore women’s experiences of Water VBAC, this study adopted an interpretative phenomenological analysis (IPA) approach (Smith and Osborn, 2003). Phenomenology involves exploring how individuals perceive and understand their experiences (Smith and Osborn, 2003). It emphasises the individual’s unique subjective viewpoint, as well as measuring the meanings that each person attaches to these experiences. The interpretative aspect of IPA emphasises that research is a dynamic process: the researcher must interpret – rather than simply report – the perceptions and experiences of the research participants.

Between 2008 and 2011 a total of 10 women experienced Water VBACs in the Scottish MLU selected for this study, which is an ‘alongside’ unit next to an obstetric unit. All had consented at the time to be contacted if future research were ever to be undertaken. Following formal ethics committee approval (UREC 11/09), the 10 women were sent an initial contact letter with a questionnaire. Semi-structured interviews conducted between March and April 2012 explored the women’s reasons for requesting Water VBAC, their sources of information when planning their birth method, and the support received and opposition faced from health care practitioners, family and friends. The interviews also explored the women’s experiences of Water VBAC.

The interviews were recorded and played back to each participant at the end. No revisions were requested, and the interviews were transcribed verbatim. Major themes were identified using the constant comparative method (Barbour, 2008). Exceptions, inconsistencies and contradictions to these themes were continuously examined in order to ensure analytical rigour, and to allow the evolution of more sophisticated themes.

The women’s medical records were not accessed at any time during the study; all the factual information relating to these eight women’s labour and birth experiences originates from their own accounts.

Findings

The women were aged between 24 and 40 years, and they had at the point of undertaking Water VBAC between one and four children. All reported being unaware of any problems throughout their Water VBAC labour and birth, or with their infant following birth. None had experienced continuous EFM at any point during their labour, the fetal heart rate being monitored intermittently by means of a handheld Doppler while the women remained in the pool. All of the participants had one-to-one midwifery care.

Three principal themes emerged from the interviews. The first revolved around the women’s perceptions of Water VBAC as a way of ‘minimising’ the medicalisation of their childbirth experience. The second theme concerned their use of Water VBAC as a means of ‘maximising’ four aspects of their childbirth experience: physical, psychological, choice and control. The third theme related to how the women ‘managed’ the potential risks associated with Water VBAC, and also managed the expectations and behaviour of their family, friends, and the health care professionals participating in their care.

Minimising

The desire not to repeat previous negative intrapartum experiences led some women to see Water VBAC as a mechanism by which the medicalisation of childbirth, and caesarean section in particular, could be resisted:

One thing leads to another when they start to interfere. But they couldn’t strap me to any machines when I was in the pool… they just left me to it really and couldn’t get at me… so they weren’t able to tell me I needed a C-Section. (R1)

The participants’ descriptions of their physical as well as psychological experiences of undergoing CS were vivid: adjectives included ‘barbaric’ (R1), ‘horrific’ (R5), ‘horrendous’ (R6) and ‘outrageous’ (R7). The immobility associated with continuous EFM was a particular feature that rankled from their previous labours, as was the experience of oxytocic augmentation of labour. Intravenous cannulation had caused pain and irritation, and the uterine contractions brought on by oxytocin infusion were thought to be particularly painful and ‘unnatural’ (R8), with one respondent (R7) blaming it for causing the fetal distress which had led to an emergency CS. The need for frequent vaginal examinations by an increased number of medical staff was also highlighted:

They just kept on examining me… I don’t think they could agree on how far on I was… Every time I took a breath someone new was in the room wanting to examine me. At one point I thought they were going to ask the jannie [janitor] in to have a shot. (R7)

Five of the woman maintained that their previous CS had created postnatal psychological problems, including negative feelings, a lack of bonding with their infant, and one diagnosis of postnatal depression:

I felt a total sense of failure… I felt my body had let me down. It just wasn’t the birth I had imagined, and I couldn’t get over that. (R3)

Some expressed indifference to the operation due to ‘sheer exhaustion’ (R1), and their feelings that they had ‘reached the end of the road’ (R2), but even this relief could give way to a lasting negative legacy:

At the time it was actually a relief, but afterwards I was gutted. (R5)

Minimising input by medical staff was seen as a way of avoiding a recurrence of similar problems. Giving birth in a MLU was one step along this road, and labouring in water was an extra line of defence:

Doctors don’t do water births, they just do caesareans. There are no doctors in the Midwife Unit and no doctors doing water births, so there would be no doctors telling me I needed a caesarean like last time. (R6)

All the interviewees highlighted the importance of feeling supported by their midwife, with the midwife’s emotional support being rated by most as more relevant than her ability to fulfil the woman’s physical requirements.
Maximising

Water VBAC was regarded as a means of maximising four aspects of the women's childbirth experience: the physical benefits, psychological benefits, choice and control.

The main improved physical outcomes (reported by six women) were improved sensations of support, comfort, mobility and relaxation while in the pool. Three also highlighted better pain relief. All reported a more positive postnatal experience resulting from the positive physical outcomes attributed to their Water VBAC:

I honestly think the pool's better than an epidural. You just float around and for the first time in nine months you don't just feel like a big fat heifer ... And afterwards, when you're not tired and sore, the postnatal bit's a lot easier ... There's a big difference in six hours and six weeks. (R5)

Psychological benefits were of even greater significance to the women interviewed than the beneficial physical outcomes. These included experiencing a more positive mental attitude to childbirth, and a heightened awareness of their bodies. All of the women underlined their more positive mental state postnatally. Moreover, most of the women highlighted their ability to focus more attention on their new baby, partner, and existing children, rather than on their own physical and mental well-being:

The difference in me mentally was unbelievable; I was definitely a lot mentally safer this time. I honestly believe [the Water VBAC] turned me into Supermum. What a difference when your head's in the right place! ... When I got home it was about my baby this time, not my scar and my feelings of failure. (R1)

The women felt that maximising their childbirth options following CS involved being given choice. However, the choice of Water VBAC was decidedly lacking, as the women had all had to ask for the option of Water VBAC, as this was not routinely offered antenatally:

I'd heard about Water Birth for women who had C-Sections and thank goodness because the midwife certainly wasn't about to tell me about it! So I had to bring it up myself, which is a bit ridiculous. (R2)

Indeed, some women described having to go as far as to 'pursue' and 'push for' Water VBAC:

You'd definitely need to be someone who isn't afraid to speak their mind ... [and] doesn't shy away from confrontation ... it's probably only the pushy middle class who get their [VBAC] Water Birth! (R6)

As a result, all of the women interviewed insisted that information on Water VBAC should be made available to all pregnant women, and that this birth option should be 'an actual choice' [R2], rather than 'a secret that you have to actively go after' [R7]. Taking the initiative with regard to choice also allowed the women to maximise their sense of control over their own body, as well as over the childbirth experience as a whole:

... it just wasn't invasive this time; I was calling all the shots ... What a difference this time being in control; it made the whole experience a much more positive one. (R1)

Managing

The third theme related to 'managing'. Each woman felt that she had been required to manage to a certain degree the concept of potential risk attached to Water VBAC. They also believed that they had needed to manage the expectations and behaviour not only of their family and friends, but also of the health care professionals participating in their care.

All of the women asserted that they had not considered themselves as 'high risk' pregnant women. One reported that when told she was 'high risk' she had ascribed this to her raised Body Mass Index, and not to her previous CS. The women had all accessed information of some description regarding the risks involved with Water VBAC, but the lack of empirical studies meant that this was often anecdotal evidence. All had sought out information online, and some had contacted women from other countries who had experienced Water VBAC. These 'personal' (R8) accounts ranked more highly than 'impersonal' (R2) academic research and obstetric recommendations. With respect to water labour and water birth, the only negative outcome that any of the women had heard of was 'the baby drowning' (R2). However, the four who mentioned this particular risk factor disregarded it as 'rubbish' (R2), 'highly unlikely' (R4), 'scare tactics' (R5) and 'urban myth' (R6).

'Horror stories about babies drowning' (R4), however, were influential factors for the women's families, and all the interviewees felt that they had had to manage such expectations and fears. Some who reported resistance from relatives and friends claimed that it was 'harder to convince them than the doctors' (R2). By contrast, nearly all the women portrayed their partners as being extremely encouraging about Water VBAC:

He was really up for it, probably because he was totally scarred by the previous experience, you know, the C-Section ... He just said he knows me, and he knows I know my own body. (R2)

'Managing' health care professionals presented different issues. Each interviewee contended that neither their GP nor the midwives they encountered in the early stages of their pregnancy mentioned Water VBAC as an option. Three reported being 'pre-warned' (R4) that this would not be an option. Five women who only realised after their initial booking visit that they were designated 'high risk' recounted how they subsequently had their 'arguments ready' (R1) in favour of Water VBAC for their next antenatal appointment. One went so far as to present her consultant obstetrician with 'an essay with references and footnotes and everything' (R3) outlining her reasons for wishing Water VBAC:

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suited to the exploration of individuals’ unique subjective viewpoints. Indeed, the reflexivity required in order to analyse the meanings and interpretations of the interview conversation (cf. Biggerstaff and Thompson, 2008) is particularly suited to midwifery, with its focus on trying to see things from the woman’s viewpoint.

The women attempted to minimise the medicalisation of childbirth by limiting medical staff input. Opting for Water VBAC was a means of avoiding the ‘cascade of obstetric interventions’ (Chalmers, 1976: 735) which they felt typified their previous experience of birth by CaS. Midwifery philosophy describes childbearing as a normal, ‘low risk’ process (RCM, 2006). In a health care culture which values ‘doing’, and a medical environment which holds technology in high regard (Kennedy, 2000), midwifery focuses on keeping childbirth as ‘normal’ as possible by implementing ‘the art of doing ‘nothing’ well’ (Kennedy, 2000: 4). Such an approach reflects the ‘low risk’ paradigm, but it is intriguing that none of the women in this study considered themselves to be ‘high risk’. They therefore did not wish to have their birth care management limited to ‘obstetric-led’ options. Emmett et al. (2006) suggest that women do have some control over deciding mode of birth after CaS, but that comprehensive information is often lacking.

Every woman participating in this study undertook Water VBAC with the aim of maximising their physical and psychological experiences and outcomes, largely through maximising control of the childbirth experience. Government reports throughout the UK make explicit the rights of women to be involved in decisions regarding all aspects of their care during pregnancy and childbirth (DoH, 2004; MSAG, 2011; Welsh Government, 2011; DHSSPS, 2013). The RCM underlines the importance of women exercising informed choice in terms of the options available to them during pregnancy, labour and the postnatal period, such as the place of birth and the providers of care (RCM, 2008). Moreover, NICE (2011) proposes that women be allowed to choose their preferred method of birth in consultation with the relevant health care professionals. Although the lack of empirical evidence is obviously a hindrance in informing this discussion, this study found that women are not offered information on Water VBAC antenatally unless they raise the issue themselves. Health care professionals may unintentionally or deliberately allow their own opinions to determine what information they give to women. This ‘professional dominance’ (Stapleton et al., 2002) or ‘protective steering’ (Levy, 2004) means that in order to protect both the women in their care and themselves as professionals, midwives limit the information they pass on.

For these women, managing health professionals included taking the initiative. All the women emphasised the importance of feeling in control of their childbearing experience, particularly with regard to their actual labour and birth. Such a feeling of being in control of their own bodies was maximised by labouring and giving birth in water. One mother acknowledged that a level of articulacy (being in the ‘pushy middle class’ [R6]) was required, and it is recognised that social inequalities have the effect of restricting choice (DoH, 2007a). Jomeen (2010) notes that this explanation can be an over-simplification; other less explicit variables also affect the ability to exercise choice.

It can be argued that the informed choice these participants made to undertake Water VBAC was at variance with the risk management strategy favoured by health care professionals which focuses on ‘clinically appropriate choices’ (DoH, 2007b: 6), but women’s perceptions of risk in childbirth do not always accord with biomedical perspectives (Edwards and Murphy-Lawless, 2006). Indeed, one of the ways in which these women managed the potential risks of Water VBAC was by asserting their own lack of ‘high risk’ status, and Water VBAC’s apparently good outcomes.

The women in this study all preferred internet-sourced ‘personal’, ‘low risk’ accounts of other women who had actually experienced Water VBAC, rather than the ‘impersonal’, ‘high risk’ obstetric recommendations currently available on the practice. This can be seen as evidence of ‘confirmation bias’, whereby people actively seek out and assign more weight to evidence that supports their own viewpoint, while ignoring or playing down contrary evidence (Manktelow, 2012).

When faced with unyielding risk-based protocols, some find that their only acceptable option is to seek alternatives to NHS care (Symon et al., 2010). There are claims that the focus on risk management has led to childbirth becoming a medical event in which women are passive recipients of care (Harper, 2005), yet midwifery philosophy regards the concept of salutogenesis – focusing on health and how to promote it – as fundamental to maternity care because of its emphasis on the centrality of the woman (Lindström and Eriksson, 2005). Care during pregnancy, labour, and the postnatal period should therefore be based on ‘health factors’ as opposed to ‘risk factors’ (Day-Stirk and Palmer, 2003), with the emphasis on ‘normality’ as far as possible (RCM, 2006).

Limitations

Comparatively few women in the UK have experienced Water VBAC, which in itself makes the participants in this study unlikely to be representative of the wider pregnant population. This study only included women who had successfully achieved Water VBAC; those who attempted this birth method unsuccessfully may have very different perspectives. Future research on this topic might involve a larger sample, preferably from a wider range of socioeconomic and ethnic backgrounds than those found in eastern Scotland where the study took place. Any small scale research such as this is necessarily limited in terms of its ability to draw wider lessons. One of the researchers (JMcK) works in the MLU in question, and this may have been seen by participants as a factor in their discussions, notwithstanding guarantees about confidence. Respondent validation was limited to playing back the interview to each participant.

Conclusion

Water VBAC is still a rare event, but for the few women who achieve this birthing method it appears to be a positive and significant expression of their autonomy. Perhaps because of the paucity of empirical data on the topic, much of the drive towards this achievement was founded on other women’s ‘personal’ and ‘low risk’ accounts of Water VBAC.

The eight women in this study reported improved outcomes as a result of their Water VBAC – greater overall satisfaction, a greater sense of control, and improved comfort and mobility. Even better than the enhanced physical outcomes was the sense of psychological achievement. In resolving not to have their birth care management determined by an obstetric-led model, they asserted their autonomy and achieved an outcome many would not have predicted. This maximising of control over the childbirth experience should not come as a surprise when the policy rhetoric so clearly identifies the woman as the centre of decision-making, and yet these achievements often came despite (rather than because of) the proffered management plan. This sense of being in control is clearly important, and cannot be limited only to the ‘pushy middle classes’.
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