

DECIDING TO CALL THE SHOTS:
AWARENESS, AGENCY, AND SHELTER-BUILDING
DURING HOME BIRTH PLANNING

by

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ABSTRACT

DECIDING TO CALL THE SHOTS: AWARENESS, AGENCY, AND SHELTER-BUILDING DURING HOME BIRTH PLANNING

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Under the Supervision of Professor Jennifer Doering

The purpose of this dissertation was to explore the decision-making process for women who choose planned home birth. Medical studies suggest that there is a greater risk of perinatal death (3.9 vs. 1.8 deaths per 1,000 births) associated with planned home birth. There is professional disagreement about provision of home birth perinatal services and social and economic barriers to home birth. The percent of home births in the United States rose by 71 percent from 2004 to 2014, indicating the presence of factors other than risk and cost in the decision-making process for planned home birth. In this dissertation, I sought to gain insight into the reasons women exit the conventional perinatal care system and choose planned home birth.

A grounded theory study, guided by the Theory of Emancipated Decision-Making, was conducted with eleven adult women who planned a home birth in the United States with a Certified Nurse Midwife. Data were collected using semi-structured, in-depth interviews.

Of the eleven women who chose planned home birth, nine gave birth at home and two transferred to the hospital under non-emergent conditions; all participants gave birth vaginally. Constant comparative analysis of interview data generated the Basic Social Process essential to

the decision to plan a home birth, *Calling the Shots*. *Calling the Shots* explained how the women in this study solved the problem of decreased agency in their perinatal care. The theoretical explanation for deciding to plan a home birth centers around three core concepts: *Realizing an Alternative*, *Deciding to Call the Shots*, and *Building a Shelter*. Agency in perinatal care was the main influence for decision-making in this sample.

This dissertation study generated three manuscripts: a qualitative literature synthesis, a grounded theory study, and a transfer policy case study. This dissertation and its manuscripts contribute to nursing's understanding of the decision-making process for women who choose planned home birth. Understanding this process informs future research about the role of agency in other types of perinatal care. Understanding the multitude of ways agency is exercised by women during perinatal care may contribute to interventions for improved perinatal outcomes.

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To Aidan, Kate, and Nola

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A midwife should have a lady's hands, a hawk's eyes, and a lion's heart.

-Aristotle

CHAPTER 1 : INTRODUCTION

Chapter one summarizes the current healthcare and cultural climate that surrounds home birth in the United States and explains the organization of this dissertation. First, home birth is discussed in terms of utilization and how it is situated within the U.S. healthcare system. Next, the practice of midwifery is examined in terms of scope of practice and healthcare setting. A discussion of the quantitative literature on home birth in the U.S. follows. The statement of the problem, purpose, and theoretical perspectives are discussed next. Research questions, assumptions, and significance of the study are addressed. The chapter concludes with a delineation of the aims and organization of the dissertation.

Home Birth in the United States

Planned home birth - a planned childbirth that occurs in one's home, usually assisted by a midwife - is a healthcare choice made by about 1 percent of American women and their families (Hamilton, 2015). In 2014, there were 38,094 home births in the U.S., and from 2004 to 2014 the percent of home birth has increased 71 percent (MacDorman & Declercq, 2016). In Wisconsin, two percent of births are planned home births, with home births disproportionately taking place in rural counties (Hamilton, 2015).

The increase in home birth persists despite conflicting birth outcomes evidence and divergent guidelines from professional organizations representing healthcare providers (ACNM, 2013; ACOG, 2017; Roome, Hartz, Tracy, & Welsh, 2016). Physician organizations, such as the American College of Obstetricians and Gynecologists (ACOG), endorse the right of a woman to choose where she gives birth, but reiterate that the hospital or hospital-affiliated birth center is the safest place to give birth (ACOG, 2017). The American College of Nurse-Midwives (ACNM) maintains support for women to choose from all birth settings – hospital, birth center,

or home - by qualified providers, such as Certified Nurse Midwives (CNMs), Certified Midwives (CMs), and physicians.

Women who choose home birth cite safety, avoidance of medical interventions, previous negative hospital experiences, desire for control, comfort, and the perception of birth as a normal physiological process (Boucher, Bennett, McFarlin, & Freeze, 2009). The typical demographic profile for women who choose home birth is white, older, multiparous, college-educated, and able to self-pay for home birth care (MacDorman & Declercq, 2016). The mechanism for making the decision to plan a home birth is less known in the U.S. as compared to other countries. The U.S. has a number of individual and systems factors – such as midwifery scope of practice and lack of universal perinatal health insurance coverage - that give it a specific healthcare context for making the decision to plan a home birth.

Variations in Midwifery Scope of Practice in the U.S.

Home birth, as a healthcare topic, becomes more complex when considering the assemblage of state and federal laws and licensing regulations that govern the practice of midwifery. There are three main types of midwife, and each with a different level of training and degree of relationship with the conventional American healthcare system. Certified Nurse-Midwives are Registered Nurses (RNs) with master's or doctoral training in midwifery and they work mainly in hospitals and outpatient clinics. Of the births in the U.S. attended by CNMs, 2.5 percent are home births, compared to 3 percent at free-standing birth centers and 94.3 percent at hospitals (Hamilton, 2015). All CNMs have prescriptive authority. Certified Midwives are not RNs, but have completed a master's degree in midwifery. CMs typically work in hospitals and outpatient settings. CMs are currently licensed in only six states – New Jersey, New York, Maine, Missouri, Delaware, and Rhode Island and have prescriptive authority in New York,

Rhode Island, and Maine. Certified Professional Midwives (CPMs) are also not RNs. Instead, they train as midwives under an apprenticeship model. CPMs practice mostly in out-of-hospital, caring for their patients at home or free-standing birth centers. CPMs are licensed in 28 states and do not have prescriptive authority, but are allowed in some states to administer medications related to perinatal care (ACNM, 2014).

Insurance Reimbursement for Midwives and Home Births

Insurance reimbursement for healthcare services varies by credentials, with CNMs having the most comprehensive reimbursement, including mandatory Medicaid reimbursement in all fifty states (ACNM, 2014). CNMs are reimbursed by most private insurance companies, as well as Medicare and TRICARE. Reimbursement rates vary by state, with CNMs having received about 60 percent reimbursement of physician rates until 2011, when healthcare reform required a higher rate of reimbursement (ACNM, 2014). Private insurance, Medicare, Medicaid, and TRICARE all have separate reimbursement arrangements for CNMs. CM services are covered by most private insurance companies and by Medicaid in New York, New Jersey, and Rhode Island. CPMs have the least insurance reimbursement, with private insurance reimbursement mandated in six states, Medicaid reimbursement in thirteen states, and coverage that varies by state in other areas (ACNM, 2014).

Health insurance coverage for home births is inconsistent in the U.S. Reimbursement is contingent on states, public or private insurance status, and provider (McCartney, 2016). Medicaid covers home birth in a limited number of states, such as Wisconsin. However, private insurance coverage for home birth is highly variable, which results in most women self-paying for the services (MacDorman & Declercq, 2016). In addition, some home birth midwives have stopped accepting the private insurance plans that cover home birth, citing reasons such as the

high cost of claims filing and billing (Anonymous/Protected, 2017). The current billing and insurance system in the U.S. is not set up to accommodate the home birth midwifery model of care, despite recent provisions in the Patient Protection and Affordable Care Act (ACA) that prohibit discrimination against licensed healthcare providers, such as midwives (Anonymous/Protected, 2017; McCartney, 2016). For example, midwives who provide a continuous care model during labor cannot bill for those hours, but rather must utilize billing codes based on a hospital model of care (Anonymous/Protected, 2017).

Home Birth Literature

The literature on home birth highlights the diversity of research methodologies and priorities put forth by perinatal care providers. The home birth literature itself is a source of controversy for professional organizations (Roome et al., 2016). There are three main branches of literature for home birth in the United States: quantitative health outcomes studies, qualitative psychosocial outcomes studies, and related literature from other high-income countries, such as Canada, Australia, the United Kingdom, and the Netherlands.

This section will discuss the quantitative literature in the U.S. The qualitative U.S. literature will be discussed at length in the qualitative synthesis of the literature in chapter two of this dissertation. The international literature will not be discussed in this section, as it is difficult to generalize home birth studies internationally, even from countries that are culturally similar to the U.S. This is due both to the presence of universal insurance coverage and a different practice scope for midwifery in other countries. Universal insurance coverage improves the integration of home birth healthcare and hospital-based healthcare (Shah, 2015), as well as removes incentives for one care setting over another. Midwifery education and scope of practice differs across nations, for example, midwives in some areas of the world have hospital admitting privileges and

can legally carry emergency supplies and equipment (Comeau et al., 2018). Therefore, this section will be limited to U.S. literature.

Studies in the U.S. have found a higher rate of perinatal mortality in planned home births versus planned hospital births (Snowden et al., 2015; Wax et al., 2010). Snowden et al. (2015) found that the rate of perinatal death was 3.9 per 1000 for planned out-of-hospital births versus a rate of 1.9 per 1000 for planned hospital births. It is noted that the Snowden et al. study used birth certificate data for out-of-hospital births, which includes both planned home births and free-standing birth centers. The Snowden et al. study was also able to account for the 16.5% of out-of-hospital births in the sample that transferred to the hospital and accurately attribute them to the planned out-of-hospital group. In prior research, these transferred births had been attributed to the planned hospital group since the birth ended up taking place in the hospital. Snowden et al. (2015) notes that in previous research this may have caused the adverse outcomes for home birth to be underestimated. Planned home birth was also associated with lower rates of caesarean section (6.2%) and medical interventions with the reclassification of planned home birth transfers to the hospital (Snowden et al., 2015).

Grunebaum, McCullough, Sapra, Arabin, and Chervenak (2017) found the risk of neonatal death to be higher for planned home birth. Neonatal death is defined as death between age 0-27 days. The authors found that the rate of neonatal death was 12.1 per 10,000 for planned home birth, 3.08 per 10,000 for hospital births attended by midwives, and 5.09 per 10,000 hospital birth attended by physicians (Grunebaum et al., 2017).

These studies highlight the ongoing effort to design a better comparison for home and hospital birth outcomes. The main issues are: (a) attempting to measure outcomes in home birth with different types of midwives with varying state-by-state scope of practice (b) differentiating

between planned and unplanned home births, (c) risk profiles of home birth mothers, and (d) accurately measuring outcomes for women and babies from planned home births who are transferred to the hospital. The risk profile for the patients of these home and hospital providers is quite different. Non-nurse home birth midwives may accept patients for vaginal birth after cesarean section (VBAC), breech births, or twins, which even hospitals may not accept for a trial of labor (Grunebaum et al., 2015). Hospital midwives generally work with low-risk patients, and hospital physicians work with all patients, from low-risk to extremely high-risk.

In addition to medical-based quantitative literature, there is a body of often-cited literature from a large database from the Midwives Alliance of North American (MANA). Midwives of all types voluntarily enter data about the pregnancies and births of their patients, which are typically planned home births or free-standing birth center births. The majority of midwives entering data into the dataset are CPMs, with a much smaller number of CNMs contributing. The most prominent study to come out of this dataset so far looked at outcomes for 16,924 planned home birth in the U.S. and found the intrapartum mortality rate was 1.30 per 1,000 births, early neonatal mortality rate was 0.41 per 1,000 births, and the late neonatal mortality rate was 0.35 per 1,000 births (Cheyney, Bovbjerg, et al., 2014). Intrapartum mortality is defined as death that occurs after the onset of labor, but before birth. Early neonatal death is defined as death at age 0-7 days, and late neonatal death is defined as death at age 7-27 days.

In summary, the quantitative home birth literature in the U.S. is mainly focused on morbidity and mortality for fetuses and neonates. There is disagreement on the risk of planned home birth, as well as lack of standardization for measurement across studies. In addition, education and scope of practice for midwives – the primary attendants for out-of-hospital births – varies widely.

Women and Healthcare in the United States

Women's Healthcare Policy

American women have been underrepresented in health conceptualization, health research, and policy-making (Center for American Women in Politics, 2017; Office for Research on Women's Health, 2015). Historically, health has been conceptualized from research on young, male participants (Office for Research on Women's Health, 2015). Women's health has traditionally been limited to female reproductive health (Weisman, 1997), and underrepresentation in scientific and governmental bodies has furthered the disparities for women's healthcare research and policy (Center for American Women in Politics, 2017; Office for Research on Women's Health, 2015). Women have an overall greater need for access to healthcare across the lifespan (U.S. Department of Health and Human Services Office of Women's Health, 2015). However, it is unclear if this greater need is matched with greater access to healthcare.

The Institute of Medicine (IOM) and the World Health Organization (WHO) have each defined women's health to provide a framework for research and practice in the field of healthcare. The IOM defines women's health as, "Health conditions that are specific to women; are more common or more serious in women; have distinct causes or manifestations in women; have different outcomes or treatment in women; or have high morbidity or mortality in women" (2010, p.1). The IOM (2010) has also stated that health outcomes for women are subject to social factors, which is an intersection that has been understudied in the U.S. The practical implication is a decreased amount and quality of health research and health information for and about women (IOM, 2010).

The WHO (2017) emphasizes inconsistencies in health outcomes between women and men. These differences are purported to be due, in part, to multiple factors related to inequalities such as, “unequal power relationships between men and women; social norms that decrease education and paid employment opportunities; an exclusive focus on reproductive roles; and the actual or potential experience of physical, sexual, or emotional violence” (2017, p.1). In the United States, it has been suggested that these power dynamics have influenced women’s access to healthcare, especially in terms of reproductive health and birth care (Andrist, 1997).

In order to decrease the disparity and increase access to healthcare for women, local, national, and international organizations have called for more and better inquiry. As stated by the IOM, “Women make up just over half the US population and should not be considered a special, minority population, but rather an equal gender whose health needs require equal research efforts as those for men” (2010, p. 1). To this end, it is important to recognize that women’s health is affected by social and environmental factors that act as determinants of health (IOM, 2010; WHO, 2016). Unequal power relationships can be considered a social factor. The last forty years have brought more awareness to disparities in women’s health, including strategies such as the creation of the Office on Women’s Health at the U.S. Department of Health and Human Services.

Barriers in Women’s Health

Meleis (2015) identifies four main barriers to health care for women: (a) the narrow way in which women’s health is defined, (b) lack of theoretical frameworks for research, (c) deficiencies in the education of healthcare providers, and (d) governmental policies that create barriers for women. All of these factors are important for conceptualizing women’s health and each is related to structural-level sexism and power imbalances.

According to the National Institutes of Health (NIH) Strategic Plan for Women's Health Research (2010), the definition of women's health must be expanded in scope and timeframe. The NIH reiterates this goal in the plan's framework of advancing the understanding of sex/gender differences in health and disease, integrating sex/gender perspectives in emerging basic science fields, and creating partnerships to improve the way health research is translated and disseminated. Considering a woman's health needs across her lifespan would help to expand the definition of women's health (Lu & Johnson, 2014). Meleis (2015) also mentions the expansion of women's health to encompass all health factors, including diseases that affect women differently than men. This normalizes the experience of being a woman within all aspects of the healthcare system, rather than situating women as a deviation of the standard male patient.

Statement of the Problem

About 38,000 women per year depart the conventional perinatal care system in the U.S. and plan a home birth, despite evidence that the rate of perinatal death is higher (Snowden et al., 2015), greater barriers to insurance reimbursement (ACNM, 2016), and higher out-of-pocket costs (MacDorman & Declercq, 2016). There is a lack of understanding regarding the decision-making process for women who choose home birth under these circumstances.

Quantitative research has suggested that women who choose home birth face access barriers. Although about 12 percent of women report the desire to be out of the hospital during birth, only about 1 percent give birth at home, although this varies depending on the state (MacDorman & Declercq, 2016; Sperlich, Gabriel, & Seng, 2017). Sperlich et al. (2017) also found that while the percentages of women who feel safest giving birth in an out-of-hospital

setting are similar across racial groups, women who give birth at home are overwhelmingly white, indicating a possible disparity in access to home birth.

Differential access also extends to geographic area. Home birth is less common in many areas of the country (MacDorman & Declercq, 2016), indicating differences in access to home birth or differences in coordination between in-hospital and out-of-hospital birth settings. However, there is limited research documenting the perceptions and experiences of deciding to plan a home birth from the perspective of the women themselves as they navigate the larger U.S. social and healthcare systems.

Women who choose home birth overwhelmingly self-pay for their care and have variable relationships with the mainstream perinatal healthcare system (Declercq, 2012; MacDorman & Declercq, 2016; Neilson, 2015; Rainey, Simonsen, Stanford, Shoaf, & Baayd, 2017). Self-payment for perinatal care involves making a market-based healthcare decision as well as a degree of financial and medical autonomy. Self-payment can also be a barrier to healthcare access (Shartzler, Long, & Anderson, 2016).

In the homebirth setting, women have greater autonomy than they have in conventional healthcare settings (Zielinski, Ackerson, & Kane Low, 2015). Autonomy, trust, and safety are factors related to increased healthcare access in the general population (Hossain, Ehtesham, Salzman, Jenson, & Calkins, 2013), but it is unknown how these factors are related to the decision-making process for women who choose home birth.

Purpose of the Study

The purpose of this study was to explore the decision-making process for women who choose home birth. A grounded theory methodology was used to generate a theoretical explanation for the decision-making process for home birth. Generating a substantive theory on

the decision-making process for home birth serves to advance the science of nursing by increasing understanding of unconventional patient decisions such as home birth.

Theoretical Perspectives

Two theoretical perspectives informed this study: symbolic interactionism and Wittman-Price's Theory of Emancipated Decision Making (EDM). Grounded theory is founded on symbolic interactionism. Symbolic interactionism is both a theory and an approach to research that posits humans interact with each other based on the meanings they have derived from previous interactions (Blumer, 1969). These interactions are interpreted by the self, which is constantly evolving based on the interpretations of interactions. In this way, all interactions are inter-relational in nature rather than a singular self, acting in a linear trajectory. Interactions are also seen as rooted in the symbols that compose them, not merely the persons, objects, situations, or institutions that are involved (Blumer, 1969). Grounded theory reflects symbolic interactionism in its method of constant comparative analysis, described later in this paper, which involves a continuous cycle of interaction with the data.

The Theory of Emancipated Decision-Making (Wittmann-Price, 2004; Wittmann-Price & Bhattacharya, 2008; Wittmann-Price & Price, 2014) emphasizes the role that socialization has on women's healthcare decision-making. Emancipated Decision-Making (EDM) states that oppression in women's healthcare decision-making can be seen in healthcare decisions where one choice is more socially acceptable than another choice. The theoretical underpinnings for EDM are derived from critical social theory, feminist theory, and Freire's Theory of Emancipated Education (Freire, 1970), highlighting the effects of inequality and oppression on society. EDM, in turn, applies these theoretical underpinnings to women's healthcare decision-making and the role that inequality and oppression have on such decisions (Wittmann-Price, 2004).

Research Questions

This study sought to answer the following research questions:

How do women decide to plan a home birth?

- a. What is the decision-making process as women move from considering home birth to having a homebirth?
- b. What are the environmental and structural factors that influence women's decisions to choose home birth?
 1. What are the facilitators and barriers to a first home birth?
 2. What are the facilitators and barriers to a subsequent home birth?
- c. How do the characteristics of women and their families interact with facilitators and barriers to choosing home birth?

Assumptions

There were several theoretical and methodological assumptions for this study. First, it was assumed that the participants in this study engaged in a decision-making process for home birth, rather than having the decision made for them by another person or entity. While it is acknowledged that some religious sects such as the Amish have an established cultural norm of choosing home birth (Sieren, 2016), it was presumed that the women in this study are themselves the primary decision-makers for their place of birth.

The following assumptions were methodological. It was assumed that participants in the study were able to describe their experiences with the decision-making process for home birth in a descriptive and accurate manner. It was also assumed that rapport between the participants and researcher was sufficient to elicit narrative illustrations of the decision-making process, including possible antecedents and outcomes.

Significance of the Study

A better understanding of the decision-making process for home birth is needed to inform inter-professional aspects of perinatal care. Perinatal care encompasses many healthcare providers, including midwives, physicians, specialists, nurses, and other healthcare staff. Perinatal care takes place in homes, clinics, outpatient centers, emergency departments, and hospitals. For women who choose home birth, there is a perception of lack of understanding from conventional perinatal care providers (Rainey et al., 2017). Lack of understanding of home birth can become problematic when 11 to 16.5 percent of women who plan a home birth end up transferring their care to a hospital during the intrapartum period (Cheyney, Everson, & Burcher, 2014; Snowden et al., 2015). The objectivity of hospital-based providers could be threatened when influenced by bias against home birth due to distrust of home birth and negative experiences with home birth to hospital transfers (Rainey et al., 2017). Despite the increase in home births in the U.S. over the last 10 years, there is a lack of research exploring the decision-making process for home birth, particularly as to how it relates to the conventional perinatal system.

For this study, a qualitative, grounded theory approach was proposed to gather the decision-making experiences involved in planning home birth. Qualitative research is a holistic method of gaining an understanding of a phenomenon, especially when the researcher wants to explore meaning (Polit, 2012). Grounded theory is appropriate and useful when little is known about a concept, and the researcher seeks to generate theory of a complex phenomenon (Glaser & Strauss, 1967).

Aims and Organization of the Dissertation

This dissertation is a portfolio of scholarly inquiry on the decision-making process for home birth. This collection of papers was written to explore the current literature on home birth and critically analyze it as well as undertake a grounded theory study in order to better understand the issues surrounding home birth in the United States. This dissertation also lays the groundwork for a program of research focusing on women's agency in healthcare decision-making.

This chapter - the introduction - describes the background, problem, purpose, theoretical perspectives, research questions, assumptions, and significance. Chapter Two is a synthesis of the qualitative literature on home birth in the U.S. that examines the perceptions and characteristics of women who choose home birth. Chapter Three contains the methodological constructs of the grounded theory study, and serves as a detailed description of the design, data collection, and analysis methods. Chapter Four is a manuscript of original, grounded theory research exploring the decision-making process for home birth with the purpose of generating a substantive theoretical explanation. Chapter Five is a case study sub-analysis on planned home birth to hospital transfer. It explores the patient perspective of home-to-hospital transfer. Chapter Six is a synthesis of the three manuscripts, including the contribution of the manuscripts to nursing and the implications for policy, practice, and research. Table 1.1 summarizes the three manuscript chapters included in this dissertation.

Table 1.1 Manuscript Chapters of the Dissertation with Aims and Potential Target Journals

Chapter	Title	Aim	Target Journals
2	Planned Home Birth in the United States: A Qualitative Synthesis	To identify the perceptions, characteristics, and values of women who choose home birth.	1. Birth: Issues in Perinatal Care
			2. Journal of Midwifery and Women's Health
4	Deciding on Home Birth: A Grounded Theory Study	To explore the process of choosing a home birth instead of a hospital birth or birth center birth and to develop a substantive theoretical explanation of the decision-making process.	1. Journal of Midwifery and Women's Health
			2. Birth: Issues in Perinatal Care
5	Home to Hospital Transfers: What Does Home Birth Have to Teach Us?	To explore the patient perspective of home-to-hospital transfer in the intrapartum period and compare them to best practice guidelines.	1. Birth: Issues in Perinatal Care
			2. Journal of Midwifery and Women's Health

Conclusion

The purpose of this dissertation is to explore the decision-making process for women who choose home birth. Beyond that, this dissertation serves to promote greater understanding between women who choose home birth and hospital-based perinatal providers. Manuscripts will be shared with the home birth community where the research took place in addition to being submitted for publication. The results of this dissertation contribute to the qualitative literature on home birth in the U.S., inform future research on home birth and other unconventional

healthcare decisions, offer insights into women's healthcare decision-making, and contribute to evidence for best practices in planned home birth to hospital transfer.

CHAPTER 2 : QUALITATIVE LITERATURE SYNTHESIS MANUSCRIPT

Chapter 2 is a qualitative literature synthesis of the qualitative home birth literature in the U.S. between the years 2000-2017. It is formatted as a complete manuscript in the style of the Journal *Birth*, the target journal for publication, and contains its own abstract, purpose, and set of references specific to this manuscript. It begins by describing the background of the qualitative home birth literature in the U.S., followed by a description of the qualitative synthesis review methods. Next, the results of the qualitative synthesis are described. The results are discussed in terms of their relationship to the U.S. qualitative literature and future research is considered.

Planned Home Birth in the United States: A Qualitative Synthesis

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Abstract

Background. The number of home births in the United States continues to rise, despite social and economic barriers. There is increased interest in research examining home birth as a patient choice related to health, safety, and quality of life. However, there is a lack of research on home birth from the home birth woman's point of view. This paper aims to identify the perceptions and characteristics of women who chose home birth.

Methods. Qualitative synthesis methods were adapted to conduct a thematic analysis of the studies as well as formulate analytic themes. The design for this qualitative synthesis was guided by the Enhancing Transparency in Reporting the Synthesis of Qualitative Research and thematic synthesis.

Results. The attributes valued by women who chose home birth were: (a) trust, (b) rejection of authority, (c) choice, and (d) safety. The qualitative synthesis process revealed four major hypotheses about the characteristics of women who chose home birth (a) setting up autonomy in advance, (b) valuing 'other' knowledge, (c) wanting assistance vs. doing it for me, (d) unwillingness to integrate the sacred with the mundane.

Conclusions. The attributes and characteristics affecting the decision-making process for home birth should be studied in further depth in order to better understand why women choose to exit the conventional perinatal care model.

Keywords: planned home birth, qualitative synthesis, nursing, midwives, literature review

Women who choose home birth make up about 1 percent of the total number of birthing women in the United States (MacDorman & Declercq, 2016). Despite making up such a small number of the overall births in the U.S., there is interest in the nursing and medical fields in knowing more about the characteristics of this group. According to MacDorman and Declercq (2016), the number of home births rose by 71 percent from 2004 to 2014. This level of increase has prompted more inquiry about women who choose home birth, particularly the decision-making processes that result in this unconventional choice. The exploration of these processes is needed in order to better inform collaboration and understanding between in-hospital and out-of-hospital providers and systems of care.

Background

There are several important differences from the general population of perinatal women seen in women who choose home birth. Sixty-seven percent of home births are self-paid as compared to 3.4 percent of hospital births (MacDorman & Declercq, 2016). In addition, there are differences in race and geographic location for population with an increase in home birth. Non-Hispanic white women have had the largest increase in home births since 2004 and are more likely than other racial groups to have a home birth (MacDorman & Declercq, 2016). The Pacific Northwest has the overall highest percentage of home births compared to other areas of the U.S. (MacDorman & Declercq, 2016).

MacDorman and Declercq (2016) have suggested that these differences may be due to issues of access to home birth healthcare. Some of the possible barriers include laws governing non-Certified Nurse-Midwives (such as Certified Professional Midwives [CPM]s), the atmosphere of support from hospital-based providers, rates of vaginal birth after Cesarean section [VBAC], health insurance coverage, and ability to pay.(MacDorman & Declercq, 2016)

The purpose of this review is to construct a foundation of understanding, established from the current qualitative literature, of the perceptions and characteristics of women who choose home birth. Quantitative literature on home birth has focused on demographic characteristics,(MacDorman & Declercq, 2016) morbidity and mortality (Snowden et al., 2015), and satisfaction with the birth experience (Fleming et al., 2016). A qualitative synthesis is necessary to address a gap in the home birth literature regarding the patient perspective. In order to answer the review question, “What are the perceptions and characteristics of women who chose home birth?”, a qualitative synthesis was conducted.

The Review

Aim

The aim of this qualitative synthesis was to review, appraise, and synthesize findings from qualitative research that examined perceptions and characteristics of adult women in the U.S. who choose home birth.

Design and Methods

This qualitative synthesis was guided by both the Enhancing Transparency in Reporting the Synthesis of Qualitative Research [ENTREQ] as described by Tong, Flemming, McInnes, Oliver, and Craig (2012) and methods for conducting thematic synthesis (Thomas & Harden, 2008). The ENTREQ approach to qualitative synthesis outlines steps to increase the rigor and transparency of qualitative synthesis (Tong et al., 2012). It includes a checklist of twenty-one items to guide the review, which are sub-divided into (a) introduction, (b) methods, (c) literature search and selection, (d) appraisal, and (e) synthesis of findings. Thematic synthesis (Thomas and Harden, 2008) guided the search strategy and analysis techniques, as it a systematic method

of organizing the literature search and data abstraction that also allows for analysis of new insights (Tong et al., 2012).

Search Strategy

The literature search was conducted using the search terms *home birth*, *home birth*, *planned home birth*, *home childbirth* and *out of hospital birth* after an initial search to determine the various ways that home birth is described in the scientific literature. The search strategy (see Figure) applied these terms as keywords in the following electronic databases: CINAHL, MEDLINE (PubMed), PsycINFO, Women's Studies International, JStor, and Cochrane Review. In addition, a hand search of reference lists and Google Scholar was completed.

Inclusion criteria consisted of scholarly, peer-reviewed articles in English conducted in the U.S. between the years 2000 and 2017. This timeframe represents the years in which the most recent increase in home birth took place. Studies were included according to the following criteria: (a) original qualitative data, (b) participants were adult women who had chosen home birth, (c) study results included perceptions of home birth and/or home birth mothers. Quantitative studies, case studies, committee opinions, commentaries and studies conducted outside of the United States were excluded.

One reviewer screened the titles and abstracts and applied the inclusion and exclusion criteria (see Figure). After retrieving the articles that met the inclusion criteria, full texts were read and further evaluated for inclusion and exclusion criteria. Further studies were excluded after this process, resulting in the final set of articles that are included in the synthesis.

Search Outcome

Initial database searches yielded 716 articles. Hand searching of reference lists and Google Scholar produced two additional articles that were not duplicates. Of the combined 718

studies, 263 duplicates were removed. Four hundred fifty-six records were screened for eligibility, and an additional 430 records were not eligible and thus excluded. Twenty-six full-text articles were assessed for eligibility, with 17 excluded, as these did not meet the criteria upon a full reading. Of these 17 articles, nine of the articles were commentaries, 4 did not use qualitative methods, 3 were case studies, and one study did not take place in the U.S. The qualitative synthesis included 9 journal articles (Table 2.1).

Quality Appraisal

The studies were evaluated for quality (Appendix A) using the Critical Appraisal Skills Programme [CASP] Qualitative Research Checklist (Critical Appraisal Skills Programme, 2017). The principal investigator evaluated the studies using the CASP 10-item checklist. No studies were assessed to be of excellent quality, 5 were found to have good quality, 3 were found to have average quality, and one study was considered to be unacceptable. Six of the nine studies included for synthesis met the quality appraisal standards, and three were excluded during this process (Appendix A). The three excluded studies failed to meet ethical standards for quality (Appendix A), as the authors did not confirm a written request for evidence of Institutional Review Board (IRB) approval. The final number of studies included in the thematic synthesis and analysis was six.

Data Abstraction

Data from the included studies were extracted to evidence tables to facilitate organization and synthesis. The evidence tables included (a) authors (b) aims/objectives, (c) design, (d) setting, (e) participant characteristics, (f) data collection method, (g) analysis strategy, (h) findings, and (i) strengths and limitations (Appendix B).

Synthesis

Synthesis methods were adapted from Thomas and Harden (2008) to conduct a thematic analysis of the journal articles. First, the thematic findings section of each study was coded by hand to reflect themes. Each thematic findings section was coded line-by-line, including the authors' interpretations of findings as well as verbatim examples from the raw data. Thomas and Harden (2008) indicate that utilization of the entire findings section is necessary in order to include all of the qualitative data for synthesis. Including only quotations would limit the concepts and summaries necessary to synthesize the studies' results (2008). After coding was complete, the author structured the codes into groups or themes that provided descriptions of home birth concepts.

The third step in the synthesis process was what Thomas and Harden (2008) describe as “[going beyond] the findings of the primary studies and generated additional concepts, understandings, or hypotheses” (p.7). This step, generating analytical themes, is considered crucial to the development of a true synthesis of the literature (Thomas & Harden). In this step, the researcher uses her knowledge of the research field to create a new understanding from the descriptive themes to answer the review question. For this qualitative synthesis, the research question facilitated exploration of home birth from the point of view of the women who chose home birth. Perceptions were interpreted by the researcher using the descriptive themes distilled from the original studies. Going back to the literature with these interpretations yielded new insights, which were compared to the codes and themes and refined until there were no new insights.

Results

The results included six cross-sectional, qualitative studies carried out in the United States within the past 10 years. To collect data, one utilized a focus groups, (Bernhard, Zielinski, Ackerson, & English, 2014) five collected data through in-depth interviews, (Cheyney, 2008; Cheyney, 2011; Fleming, Healy, Severtsen, and Donovan-Batson, 2017; Lothian, 2013) and one study used an online questionnaire (Boucher, Bennett, McFarlin, & Freeze, 2009). Participants for the studies were all women who had given birth at home. Bernhard et al. (2014) specifically looked at women who had previously given birth at a hospital, with a home birth within the past 10 years. Boucher et al. (2009) recruited women who either had a home birth or were planning a home birth at any time. Cheyney (2008) focused on the home birth patients of direct-entry midwives. Lothian (2013) interviewed woman who were in the planning stage of home birth. Two studies included additional data from participant observation (Cheyney, 2008; Cheyney, 2011).

Themes

Four themes were identified related to perceptions and characteristics of women who chose home birth: (a) trust, (b) rejection of authority, (c) choice, and (d) safety. Each theme was derived from the synthesis of the group of studies as a whole, with subthemes that were also common across studies.

Trust. Trust was the primary theme that emerged in this synthesis, and it was described in several distinct forms: (a) trust in the physiologic birth process, (b) trust of the midwife, and (c) the self-trust that was obtained through the comfort of the home environment. For home birth to occur, all three types of trust needed to be present during the perinatal period.

Trust in the physiologic birth process was related to as a desire for a ‘natural birth’ (Bernhard et al., 2014; Fleming et al., 2017; Lothian, 2013). While the term is ambiguous, in the context of home birth it tends to refer to a lack of interruption in the birth process, either physically, mentally, or emotionally. Trust in the physiologic birth process was also described in this literature as an ability to utilize intuition in order to facilitate labor and birth (Cheyney, 2008; Cheyney, 2011).

Trust between the woman and her midwife was paramount to home birth, forming the basis of collaborative care (Bernhard et al., 2014; Cheyney, 2011; Fleming et al., 2017). The intimacy and friendship present in this relationship was thought to increase openness of communication, promote disclosure of pertinent health-related information, and improve overall care quality. The trust built between the woman and her midwife also resulted in a greater feeling of ‘connection’ to the pregnancy for the woman due to the confidence conferred in this relationship (Bernhard et al., 2014; Lothian, 2013).

The home environment fostered self-trust through attributes such as comfort, coziness, familiarity, and a deep sense of relaxation and belonging (Bernhard et al., 2014; Boucher et al., 2009; Cheyney, 2008; Cheyney, 2011; Fleming, et al., 2017). Another aspect of self-trust was that giving birth at home provided ‘permission’ to do things that were not ‘allowed’ in the hospital, such as eat and drink during labor, be alone without interruption, labor at will, and prolonged skin-to-skin exposure with the newborn after the birth (Bernhard et al., 2014; Boucher et al., 2009; Cheyney, 2008; Cheyney, 2011; Fleming et al., 2017; Lothian, 2013). Self-trust also emphasized emotion-based feelings as a valid gauge of the birth process. Across all studies, women indicated that feelings and desires were not dismissed by the provider at any time, thus increasing self-trust.

Rejection of Authority. Rejection of authority emerged as theme with two variations: rejection of obstetrical/hospital protocols and procedures as well as a rejection of a fear-based perinatal care model. According to the studies, rejection of authority was commonly associated with negative social judgement of home birth.

Hospital protocols and routines were rejected on the premise that they are disruptive, traumatic, and disempowering (Bernhard et al., 2014; Boucher et al., 2009; Cheyney, 2008; Cheyney, 2011; Fleming et al., 2017; Lothian, 2013). Women suggested that hospital protocols and routines resulted in decreased levels of satisfaction for birth, particularly in those participants who had previously experienced a hospital birth (Bernhard et al., 2014). Obstetrical protocols during pregnancy care were also rejected in favor of the home birth midwifery model of care. This model emphasizes a low-technology, woman-based approach that includes bi-directional knowledge flow (Bernhard et al., 2014; Cheyney, 2008; Cheyney, 2011; Fleming et al., 2017; Lothian, 2013).

Home birth women rejected perinatal care that was fear-based (Bernhard et al., 2014; Cheyney, 2011; Fleming et al., 2017; Lothian, 2013). They placed less authority on a fear-based model of care, often described as high-technology and less holistic, and replaced that authority with a trust-based model of care (Boucher et al., 2009; Cheyney, 2008). The process of rejecting authority relied on extensive information-gathering and questioning, which was encouraged by home birth midwives (Cheyney, 2008; Lothian, 2013).

Choice. The theme of choice was connected to the perception of a lack of choice in a hospital setting, as well as the autonomy and empowerment that accompanied exercising choices in the home birth setting (Bernhard et al., 2014; Boucher et al., 2009; Cheyney, 2008; Cheyney, 2011; Fleming et al., 2017; Lothian, 2013). The women who had previous hospital births

indicated their perception that choices in the hospital setting were limited due to protocols and routines, and the choices that were made there were often dismissed (Bernhard et al., 2014b). Questioning in the hospital setting was not as encouraged as it was in the home, and perception of control was perceived to be limited (Bernhard et al., 2014; Boucher et al., 2009; Cheyney, 2011; Fleming et al., 2017; Lothian, 2013).

In contrast, choice in a home birth setting was described as having increased autonomy, empowerment, and control (Bernhard et al., 2014; Boucher et al., 2009; Cheyney, 2008; Cheyney, 2011; Fleming et al., 2017; Lothian, 2013). Examples of choices included whom to have present at the birth, location of labor and birth within the home, and position for giving birth. Participants made a distinction between the ‘real choices’ at home and ‘false choices’ at the hospital, such as the ability at the hospital to choose which family members are present, but not which doctors, nurses, assistants, technologists, or other personnel who might be present in the woman’s care (Bernhard et al., 2014).

Safety. Safety, like choice, was contrasted in the studies between the hospital and home birth settings. Home birth women indicated that they felt home birth was safer than hospital birth, with the acknowledgement that many in the U.S. felt the opposite, including conventional medical authorities (Bernhard et al., 2014; Boucher et al., 2009; The American College of Obstetricians and Gynecologists, 2017). Included in the concept of safety for home birth women was physical, mental, and emotional security, not just the reduction of physical risk (Bernhard et al., 2014; Boucher et al., 2009; Cheyney, 2011; Fleming et al., 2017; Lothian, 2013). Safety was achieved in the home through autonomy, trust, lack of disruption to the labor process, and the feeling of protection provided through the woman-midwife relationship (Bernhard et al., 2014; Boucher et al., 2009; Cheyney, 2008; Cheyney, 2011; Fleming et al., 2017; Lothian, 2013). This

alternative definition of safety was assigned authority in the place of medical-based statistics and risk-reduction (Boucher et al., 2009; Cheyney, 2008; Fleming et al., 2017; Lothian, 2013).

A second component of safety was lack of hospital interventions, such as induction of labor or interference in the birth process (Boucher et al., 2009; Lothian, 2013). Women in the studies indicated that unwanted interventions disturbed the flow of labor, and believed this could cause a decrease in safety (Bernhard et al., 2014). There was a perception among participants that ‘fear-based’ perinatal care and ‘invasive’ interventions at the hospital increase the chance of a poor birth outcome (Boucher et al., 2009; Lothian, 2013). However, the definition of a poor birth outcome was more nuanced for home birth women than a ‘live mother and baby’, encompassing disempowerment and emotional or mental distress (Bernhard et al., 2014; Boucher et al., 2009; Cheyney, 2011; Fleming et al., 2017; Lothian, 2013).

Analytical Hypotheses

Analytical hypotheses were derived from renewed consideration of the review question, “What are the perceptions and characteristics of women who choose home birth?” after the completion of the thematic synthesis. The qualitative synthesis process revealed four hypotheses about home birth women (a) setting up autonomy in advance, (b) valuing ‘other’ knowledge, (c) wanting assistance vs. doing it for me, (d) unwillingness to integrate the sacred (birth) with the mundane (hospital protocol).

Setting Up Autonomy In Advance. The studies in this review described an extensive amount of information-gathering, discussion, and planning done by home birth women during both before and after the decision-making process for place of birth. They described asking detailed questions of their midwives about a variety of ‘what-if’ scenarios, which were answered and discussed to the satisfaction of the patient. The substantial questioning of the midwife

seemed to be an integral part of the process of setting up autonomy for the birth. As such, the labor and delivery were free from the type of basic negotiations seen in a hospital birth, such as permission to eat.

Setting up autonomy in advance also seemed to assure the home birth women of their ‘permission’ to give birth their way. Many women mentioned being ‘allowed’ to conduct themselves freely in labor, rather than spending time negotiating or permission-seeking. The idea of ‘being allowed’ to experience a physiological process as one sees fit is related to themes that have also been explored in feminist theory (Cohen Shabot, 2016; Young, 1980).

Valuing ‘Other’ Knowledge. Home birth women often expressed the value of other ways of knowing. Several of the articles framed this in terms of authority. However, home birth women reported less confidence in the knowledge put forth by the conventional medical model, such as morbidity and mortality statistics. The participants valued other ways of knowing, such as in-depth discussions with their care providers, self-care, and self-trust. It is unknown how this sample of women relate to other medical care providers or how these beliefs affect other medical decisions.

Wanting Assistance vs. Doing It for Me. Overall, the synthesis of the literature indicated that the women desired guidance and assistance during their perinatal care, but on their own terms. They expressed a determination to ‘give birth’ rather than have birth happen *to* them. The idea of caregiving was also discussed in terms of the balance of power belonging to the mother and baby, rather than the caregiver.

Unwillingness to Integrate the Sacred and the Mundane. Home birth women in review often discussed the sacred nature of birth, and that an institutional setting did not seem to ‘honor’ the event of birth (Bernhard et al., 2014; Boucher et al., 2009; Cheyney, 2008; Cheyney,

2011; Fleming et al., 2017; Lothian, 2013). Feelings of love, joy, peacefulness, and transformation were incompatible with the technology and other forms of power found in the hospital setting. The mundane routines of institutional birth, such as hourly rounding, also failed to resonate with this group.

Discussion

In the U.S., the home birth patient population often has to go to great lengths, both financially and socially, to procure home birth care. Despite this, the number of home births has continued to increase (MacDorman & Declercq, 2016). Further research examining the decision-making process for home birth is needed to explain this increase. There is a lack of research on home birth from the patient perspective in the U.S., particularly rigorous qualitative research. This type of research would provide insight into patient access and navigation of a perinatal care situation that is unsupported by the U.S. healthcare system, either through integration with the conventional medical or insurance systems.

This qualitative synthesis found that trust, rejection of conventional authorities in birth, choice-making, and safety were all perceived by women who choose to give birth at home. Understanding these concepts - as well as the thoughts, beliefs, and actions that lead to the unconventional choice of home birth – can be applied to further research about home birth. Home birth, as a small sub-section of perinatal women, is a distinctive place to conduct research about patient access to healthcare. Patients who choose such an alternative care setting can offer insights about deficits in conventional care that motivate rejection of it.

Increased research into the motivation for rejection of the conventional perinatal care setting is needed to decrease the neonatal mortality rate for home birth. Recent medical research indicates that the neonatal mortality rate for home birth is 12.75 per 10,000 births, compared

with 6.02 per 10,000 for hospital physician-attended births and 3.52 per 10,000 for hospital midwife-attended births (Grünebaum et al., 2017). Perinatal risk factors, patient characteristics, and provider training compose the nuances of this research, but the increased risk of neonatal mortality requires providers to seek further understanding to lower this rate.

The limitations of this study include the paucity of current, rigorous qualitative studies from the perspective of the home birth patient. Therefore, generalizability is limited to the participants of the studies. Participants were self-selected, increasing the possibility of bias in the selection. Bias of the researcher was generally not discussed in the studies, which could have increase the rigor of both the original studies and this review. In addition, only one nurse scientist-researcher conducted the search, screening, quality evaluations, analysis, and writing of this review. The review would have benefitted from more than one nurse scientist contributing to the review process.

Conclusion

Factors affecting the decision-making process for home birth should be studied in further depth in order to contribute to a better understanding of how the conventional perinatal care model is inadequate for some patients. Trust, choice, and safety are perceived by home birth patients as factors contributing to the rejection of conventional perinatal care in favor of a home birth-midwifery model of care. Existing qualitative studies have looked at some of the reasons for choosing to give birth at home. Quantitative research emphasizes morbidity and mortality statistics. Future research should seek to integrate the findings of both types of research from home birth and medical settings in order to better integrate the two models of care, as well as their philosophical underpinnings. Integration in research and practice could contribute to improved birth outcomes for women who choose home birth.

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Table

Table 2.1 Studies included in the qualitative synthesis

Authors	Design	Setting	Participants	Data Collection Method
Bernhard <i>et al.</i> (Bernhard et al., 2014)	Qualitative	Southwestern Michigan, USA	n = 20 women with a hospital birth followed by a home birth in the past 10 years	Focus Groups
Boucher <i>et al.</i> (Boucher et al., 2009)	Qualitative	The Internet, USA	n = 160 women who were U.S. residents and planned at least one home birth	Internet Survey Essay Question Response
Cheyney (Cheyney, 2011)	Qualitative	Phase 1: Pacific Northwest college town Phase 2: Midwestern college town	n = 50 women who received perinatal care with direct-entry midwives	Open-ended, semi-structured interviews and participant observation
Cheyney (Cheyney, 2008)	Qualitative	Northwest and Midwest USA	n = 50 home birthing mothers	Interviews
Farrish & Robertson (2014)	Qualitative	Throughout the USA	n = 25 (22?) African American women who chose home birth	In-depth Interviews
Fleming <i>et al.</i> (Fleming, Healy, Severtsen, and Donovan-Batson, 2017)	Qualitative	Washington State, USA	n = 9 childbearing women with at least one home birth between 2010 and 2014	One-to-One In-depth Interviews
Klassen (2001)	Qualitative	Two Northeastern States, USA	n = 45 women who had given birth at home	Face-to-face Interviews
Lothian (Lothian, 2013)	Qualitative	Very Large City in the Northeast, USA	n = 13 women who were planning a home birth	Informal interviews and observations
Merg and Carmoney (2012)	Qualitative	Northern and Southern California, USA	n = 11 women who had a home birth after a hospital birth	In-depth, semi-structured interviews

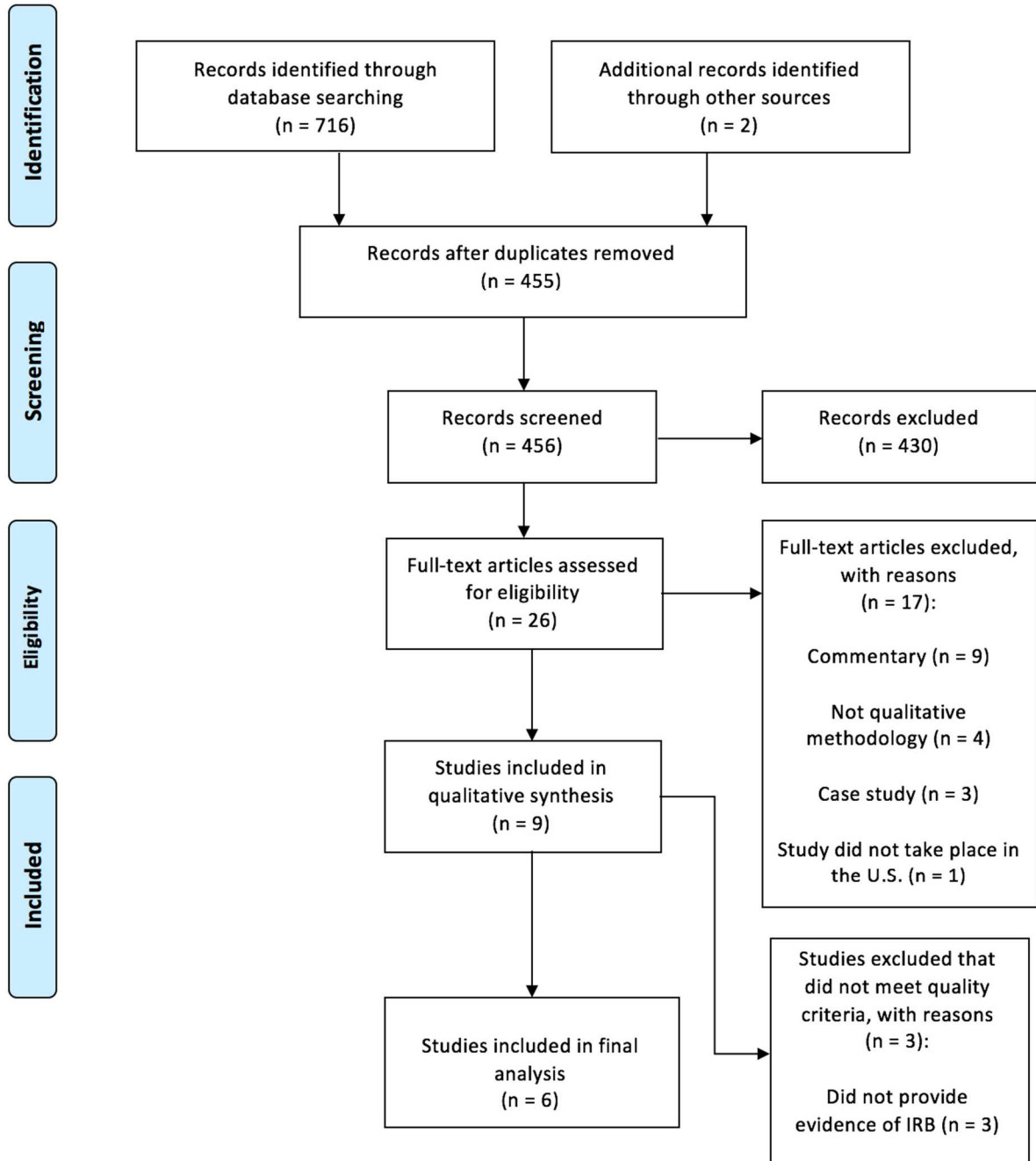


Figure 1 PRISMA flow chart of the evidence review process.

CHAPTER 3 : METHODS

The purpose of this chapter is to explicate the grounded theory methods used to conduct the grounded theory study exploring the process of decision-making surrounding home birth. As the Chapter 4 Results are written in a manuscript format, there is limited space for a detailed explanation of the methods. Therefore, this chapter served as a reference for the dissertation committee on the grounded theory methodology employed for this study. This chapter describes the (a) research design, (b) recruitment, (c) setting, (d) sampling, (e) data collection procedures, (f) instruments and measures, (g) ethical considerations, (h) data management, (i) analysis, (j) rigor, (k) limitations, and (l) strengths.

Although the number of women choosing home birth is about 1 percent of the total birthing population in the U.S., this number has been increasing (MacDorman & Declercq, 2016). Like many women's health topics, home birth receives social critique from outside entities (Lewis, 2015). Recently, research using more comprehensive birth certificate data has been conducted to inform women and providers of the risks and benefits of home birth. Techniques such as separating planned home birth from unplanned home birth in statistical data has improved the accuracy of quantitative findings (Snowden et al., 2015).

While quantitative research emphasizing the relationship between home birth and health outcomes still dominates the literature, there is a growing interest in other components that shape the decision to plan a home birth. Other factors require a more in-depth approach to fully describe the concepts. Qualitative research allows for the exploration of other influential factors for home birth, such as trust, autonomy, respect, comfort, safety, and empowerment (Bernhard, Zielinski, Ackerson, & English, 2014; Boucher et al., 2009; Farrish & Robertson, 2014; Merg &

Carmoney, 2012). Less is known about the impact of these factors on women who choose home birth.

Women who choose home birth are a unique population due to their high rate of self-pay for birth-related health services as well as their unconventional choice of birth setting (MacDorman & Declercq, 2016). Despite the fact that they have an important perspective on patient decision-making, there is a lack of qualitative research on this population. In addition, this population faces negative opinions of their choice of birth setting from the medical community (Rainey et al., 2017).

Research Design

A grounded theory research design was used to explore the decision-making process for home birth. The objective of a grounded theory study is to develop a substantive theoretical explanation of a social process using an iterative method of data-gathering and analysis (Glaser & Strauss, 1967). In this study, it was assumed that there was a social process and/or patterning involved in the decision to leave the conventional perinatal care system and choose home birth.

Recruitment

Approval to conduct the study was obtained (see Appendix C) from the University of Wisconsin - Milwaukee Institutional Review Board (IRB#18.071) prior to initiating recruitment. Participants were recruited from a medium-sized midwestern city and the surrounding area. In order to become familiar with home birth care settings and build rapport with possible gatekeepers and participants, the researcher integrated into the setting through a key informant. The key informant is a Certified Nurse Midwife (CNM) with a home birth practice in the medium-sized midwestern city. Participants for this study were recruited by the researcher through referrals from the key informant.

Flyers (Appendix D) were available electronically to describe the study, and the home birth CNM was informed of the inclusion criteria. Potential participants contacted the researcher via cell phone by voice or text at a study-specific cell phone number, which will be disconnected when the study is closed with the IRB to protect the privacy of both the participants and the researcher. The researcher then contacted back the potential participant by cell phone, either by voice or text message, whichever was preferred by the participant. Several participants requested to be contacted back via e-mail, and so the researcher contacted the IRB representative to inquire about the use of e-mail, as it was not in the original protocol. Once approved, a study-specific e-mail address was set up to contact participants who wished to communicate via e-mail. The study-specific e-mail account was deleted at the completion of data collection and analysis.

Potential participants were contacted back to determine eligibility for the study (Appendix E). Following confirmation of eligibility, the potential participant was asked if she would like to participate. If affirmative, an overview of the study and consent procedures was given. The participant was asked if she had any questions. Finally, the researcher arranged for a meeting time at a convenient and private location such as the woman's home, a shared office space, or another place of the participant's choosing.

Research Setting

The research setting is a medium-sized, midwestern city with a large, public university. It was chosen as the research setting due to a comparatively large population of women who choose home birth as well as the presence of a key informant. The key informant's home birth practice serves the research setting and a large outlying area around it. Home birth practices are stand-alone health centers with one or more midwives. They provide health education, prenatal care, postnatal care, and well-woman checkups.

The home birth population in the research setting has a well-developed support network, including midwives, doulas, and education classes. It includes a robust homebirth population from which to recruit participants. The supportive environment for home birth in the research setting is unique, however, within the United States. The state where the research setting is located has a higher rate of home birth than most other areas of the U.S. (Martin & Mathews, 2017); however, the home births are disproportionately concentrated in rural areas of the state (DeClercq & Stotland, 2017). These demographic factors may have had implications for the study sample. For example, the sample may not have been as rural as the average woman who chooses home birth in the state where the study took place. Also, the sample may not have represented the average experience of planning a home birth due to the number of structural resources in the research setting, which is higher than other areas of the state and country.

The recruitment setting was a home birth practice of a Certified Nurse-Midwife (CNMs). Certified Nurse-Midwives are only one of several professional birth attendants that attend home births (ACNM, 2011). Because one of the goals of this study is to advance the science of nursing, the study focused on CNMs rather than other home birth professionals.

Sampling

Theoretical sampling was used to guide the recruitment of participants. According to Glaser and Strauss (1967), analysis of the data serves to guide the sampling of participants and the evolution of the interview questions. Theoretical sampling is a method of sampling that takes into account previous analyses of the collected data (Corbin & Strauss, 2008). The researcher seeks to sample for additional information on the concepts that have emerged during prior analyses (Corbin & Strauss, 2008). The ongoing data analysis guided the researcher to recruit participants who were able to provide data for the next step in theory development (see Table

3.2). At the outset of the study, sampling was open to any woman who fit the inclusion criteria, given that no concepts had yet been established for analysis. The sample recruitment became more specific, guided by theoretical sampling, as the study progressed. For example, after the first round of data collection and analysis, it was determined that first impressions of home birth were an important concept to explore further. Thus, participants who could describe their early perceptions of home birth were recruited. Using theoretical sampling, participants were recruited based on their ability to describe events and processes that would further the theory development. Subsequent rounds of participant recruitment were conducted in the same manner (see Table 3.2).

Inclusion criteria. Inclusion criteria were women aged 18 and older, fluent in English, who had planned a home birth with a CNM and live in the designated research setting area. Women who experienced a transfer from home to hospital met the inclusion criteria, as this study focused on decision-making rather than outcomes. In addition, women who had chosen to give birth at home but were ultimately unable to move forward with home birth during the planning process were sought for inclusion.

Exclusion criteria. Women who chose hospitals, free-standing birth centers, or unassisted home birth were excluded from the study, as were women whose home birth midwife was not a CNM. Unassisted home birth is a separate category of out-of-hospital birth that is beyond the scope of this study.

Sample size. The study called for a sample adequate to attain thematic and conceptual saturation. Final sample size (n=11) was determined by the quality of the data obtained during the interview process (Grove, 2013). Saturation of data was monitored throughout the constant comparative process (see Table 3.2), and the sample was complete when further interviews no

longer provided new contributions to the emerging theory (Glaser & Strauss, 1967). In this case, concepts became redundant after eight interviews; however, three more interviews were conducted to verify saturation of data and complete the substantive theoretical explanation.

Data Collection Procedure

The primary investigator (PI) for the study conducted each interview. Upon meeting at the pre-arranged, participant-requested, private site, the study was explained. The participant had the opportunity to ask any further questions about the study, the data collection procedure, or anything else with which they were interested or concerned. After the participant was satisfied that her questions had been addressed, the consent procedure was explained, and the consent form presented (see Appendix H). The PI and the participant reviewed the consent form together. If the participant agreed with the terms of the consent form, she signed it. Once consent was obtained, data collection proceeded. The demographic data form (see Appendix G) was completed by the participant, followed by a semi-structured, in-depth interview guided by a questionnaire (see Appendix F). Interviews lasted between 26 and 70 minutes. Interview and demographic data is summarized in Figure 2 of Chapter 4.

Instruments and Measures

Measures. The primary data collection method was an in-depth, semi-structured interview. The initial interview questionnaire (see Appendix F) had been devised to elicit answers to the research question: How do women decide to plan a home birth? The initial interview guide was based on the qualitative literature on planned home birth. It served as a guide for the first round of questions, but the participants were free to discuss any topic that arose during the interview (Corbin & Strauss, 2008). Interview questions evolved as the data collection proceeded, based on the constant comparative analysis and the emerging theoretical

explanation. IRB amendments were obtained for each iteration of the interview questions. Table 3.1 illustrates the evolution of the interview questions during the four rounds of data collection.

Table 3.1 Example Interview Questions by Phase of Study

Main Question: Can you tell me about the births of each of your children?	
Initial Phase	
Can you tell me about the process of deciding on a home birth? What was it like to make that decision?	Can you tell me what factors were important to you during your pregnancy and birth care? To your partner (if you have one)?
What influenced you to have a home birth?	If you could talk to people like midwives, doctors, and nurses, or hospital administrators what would you tell them about getting pregnancy care?
Middle Phase	
What is the first thing you ever heard about homebirth?	What or whom helped you decide to have a homebirth?
What were your favorite things about your pregnancy and birth care?	What do people who haven't had a homebirth ask you about or say about it?
Final Phase	
Do you remember the first thing you ever heard about home birth?	What did you do when you found out you were pregnant with your home birth baby?
Can you describe your relationship with your CNM?	What does home feel like?

All interviews were digitally recorded using primary and backup digital recording devices and transcribed verbatim for analysis by a professional transcription company under a confidentiality agreement. Transcriptions were then verified by the researcher by listening to each recording while reading the verbatim transcript.

Demographic data. Demographic data was collected with a socio-demographic data form given to the participant (see Appendix G). The following information was requested from the participants: (a) age, (b) race, (c) income level, (d) relationship status, (e) caregiving status, and (f) education level. Each of these categories is related to general healthcare access

(Lombardo et al., 2014; Rae & Rees, 2015) and therefore added to the understanding of the interview data.

Ethical Considerations

The study design was evaluated by the IRB at the University of Wisconsin – Milwaukee (see Appendix C). The IRB approval for all aspects of the study was obtained prior to commencement of participant recruitment and data collection. Interviews involved questions about deciding on homebirth, and some of the questions had the potential to bring up negative feelings or feelings of discomfort. If this had occurred, which it did not, the participant had the right to stop the interview or refuse to answer the question. If a participant had become distressed, the researcher was prepared to either stop the interview and offer therapeutic communication or refer the participant to her CNM or other nurse-centered care in the community setting.

Written informed consent (see Appendix H) included a description of the protections for the participants' confidentiality. The only identifying information was the informed consent paperwork, which was securely stored by the researcher in a locked filing cabinet at the researcher's office. Participants were assigned a number and chose a pseudonym and all other possible identifying data was removed and destroyed from interview materials, including recordings. Participants were not named aloud by the researcher on the digital recordings and any names, such as children's or partners' names, that were mentioned by the participant were deleted in the transcripts of the recordings. Once commenced, all study data was held in a locked filing cabinet in the researcher's office or on a secure, password-protected server and hard drive on the researcher's computer. At the close of the study in May of 2018, the digital recordings will be destroyed. The cell phone used by the researcher to contact participants was

erased of all data for increased confidentiality and will be disconnected at the close of the study in May of 2018.

Data Management and Analysis

Upon receiving the Word document containing the interview transcription, the document was de-identified. The interviews were encrypted and stored on the researcher's password-protected computer and hard drive. Accompanying field notes were transcribed and securely stored for further review and analysis. Security and confidentiality was ensured through de-identification and locked storage of all electronic and hard copies of the data.

Constant comparative analysis. Analysis of the data was conducted concurrently with data collection, as described in Glaser and Strauss (1967). Constant comparative analysis included four components: coding each incident in the data and comparing it to previous incidents in the data, developing categories based on the codes and comparing new data to these categories, generating the theory, and writing the theory (Glaser & Strauss). Comparison of the data, memoing, and going back to the data, or 'grounding' were critical steps for data analysis.

During this process, writing about the concepts that came up in the data and making drawings on paper that illustrated possible connections between the concepts was important to the facilitation of constant comparative analysis. Going back to the interview data was made easier through the use of searchable Word document tables, but the recordings of the interviews were also listened to more times during this process. The researcher found that listening to the words of the participants often facilitated deeper connections with the emerging theory and its concepts.

As the theory began to take shape, theoretical sampling continued along with analysis as described in the above section. Participants were sought who could describe aspects of decision-

making that furthered the theory development. In one case, a participant was recruited because she had an opposite perspective – she seemed initially not to engage in a decision-making process at all for home birth. After collecting additional data and applying the constant comparative method, the process was repeated in an iterative manner throughout the data collection and analysis process (see Table 3.2).

*Table 3.2 Data Collection and Analysis Over the Course of the Grounded Theory Study**

Objective	Sampling	Interview Questions	Coding
Initial Phase			
Be open to all possibilities	Open sampling. All interested participants who meet study criteria are invited to participate. Example: The first few women who contacted researcher were interviewed.	General; based on the qualitative literature on home birth. Example: Tell me about the births of each of your children.	Open. Words and phrases were coded line by line into concepts. Example: Participant quote with concepts in parentheses, "...seeing her labor where she wanted (<i>autonomy</i>) and then seeing her sitting on the couch after (<i>being home</i>) and eating a doughnut (<i>autonomy</i>) was like, wow, that was really cool (<i>I want that</i>).” <i>I want that</i> was a reaction to <i>being home</i> and <i>autonomy</i> .
Intermediate Phase			
Express relationships among the concepts in the data.	Concept-based sampling. Descriptions of concepts are sought in the participant sample in order to build knowledge of the concepts. Example: Relationship-building between the woman and her midwife is a category in the data, however, more information is needed to understand how this is associated with the point of decision to plan a home birth.	More specific. Example: Can you tell me about your favorite part of pregnancy care?	Open to Selective. Categories and concepts are arranged in relation to each other within the coding tables. Example: Concepts of <i>building a relationship</i> and <i>building a shelter</i> are merged in the coding model, with <i>building a shelter</i> becoming a sub-theme of the overall theoretical model and <i>building a relationship</i> related to the purpose of <i>building a shelter</i> .
Advanced Phase			
Integrate categories, concepts, and sub-concepts	Theoretical sampling. Sampling is conducted with the goal of saturating categories and validate the	Specific. Example: Some women have described a process of building a shelter for home birth. Is your	Selective and Theoretical. The theory and its central concepts, <i>realizing an alternative, deciding to call</i>

into a substantive theoretical framework.	emerging theory. Example: The theory is developed, and participants are sought who can either identify gaps or confirm conceptual relationships in the theory.	experience similar to this, or different?	<i>the shots</i> , and <i>building a shelter</i> are placed centrally in the model and new codes are used to support or refute the Basic Social Process (<i>deciding to call the shots</i>).
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*Constant comparison method, a non-linear process, utilized throughout.

Glaser and Strauss (1967) emphasize parsimony and scope at the theory-generation stage, while continuing to remain grounded in the data. Theory generation allowed for reduction of a smaller number of higher-level concepts that continued to be refined during this stage of the study. Theoretical saturation was monitored, comparing new data with previous categories to determine if the data pointed in a new direction. After the second round of interviews, there were no new conceptual categories, and saturation was tested during the third round of interviews. Using questions designed to draw out any remaining data that would contribute to the emerging theory, the concepts of the theory – *Awareness, Agency, and Shelter-Building* - were verified. Interview questions such as “Some women have said that they only told certain people about their decision to have a home birth. Is that what you experienced?”, helped to solidify theory development. Drawing the conceptual relationships on paper to see how they fit together, based on the data, was done continuously while refining the theory. This was the last step in the constant comparative process. According to Glaser and Strauss (1967), the theory should at this point be substantive, systematic, accurate, and usable. Writing the theory employed the coded data, theoretical drawings, field notes, mentoring and the researcher’s memos.

Coding. Once an interview was transcribed, coding was conducted by the researcher on an ongoing basis in order to document occurring concepts for continuing comparison with new interviews as well as form categories and check for data saturation. Coding was done by hand in

using concepts extracted from the analysis process before moving the data to a computer-based organizational system in Word document tables and is described below.

Open coding. Initially, the data were coded using open coding. Coding began immediately with the first reading of each interview transcript. The researcher read through the interview line-by-line and extract significant words, lines, and phrases that have to do with home birth decision-making. Line-by-line open coding of the text was completed by first highlighting the critical words, phrases, or paragraphs and then writing out the meaning or intent. Open codes were then grouped into concepts in the Word document table. During open coding, the researcher aimed to be disinterested and/or unbiased toward the data, coding as freely as possible to capture descriptions, ask questions about the data, locate themes, and engage in reflective thinking about the data (Corbin & Strauss, 2008). This process allows the researcher to let the data guide the direction of the analysis and eventual theory generation (Glaser & Holton, 2004). The codes were organized into concepts as more data were added.

Selective coding. As the study moved forward and *Agency* emerged as a central concept, the researcher shifted to selective coding (see Table 3.2). This iteration of coding involved analyzing the context and circumstances in which the concept occurs. For the concept of *Agency*, this entailed selective coding of the antecedents and outcomes of agency. In this step, coding focused on pieces of data that related directly to the central concept, thus building up the theory (Glaser & Holton, 2004). Along with memoing and analysis of field notes, the theory began to take shape as a three-part process. Selective coding revealed that exposure to the idea of home birth was integral to the woman's eventual decision-making process. Whether the exposure to the idea of home birth happened recently or in the distant past, it continued to

resonate with the women in this sample. In addition, it was during selective coding that the idea of relationship-building with the midwife emerged as a possible outcome of *Agency*.

Theoretical coding. This final phase of coding thoroughly analyzed the intersections of the codes to complete the generation of theory (Glaser & Strauss, 1967). Examining the way that the codes related to each other and coding additional data with this in mind both directed further theoretical sampling and supported the emerging theory. Theoretical coding identified the relationships that formed the framework of the theoretical model, *Deciding to Call the Shots*.

During theoretical coding, the concepts of awareness, agency, and shelter-building became clear, especially during what became the last participant interview. This interview was conducted and coded with the theory in mind, and specifically examined the process of moving from awareness of home birth to agency/action and a detailed description of shelter-building. It was also at this stage that the theoretical explanation was presented to other women who had chosen a home birth for member-checking and theory validation.

Basic Social Process. The substantive theoretical model helps to explain a basic social process, or BSP (Glaser, 1978). A BSP has at least two stages or steps that appear consistently over time, indicating different phases of the phenomenon that can help to explain variation across a study sample (Glaser & Strauss, 1967). Working through the steps of grounded theory determined whether or not a BSP was present in the central concept of the theory. In short, if a BSP is present and uncovered in the theory, it will help explain the solution to the problem – in this case, decreased agency in perinatal care.

For this study, the BSP was *Deciding to Call the Shots*. *Deciding to Call the Shots* described the process of solving the problem of decreased agency or the perception of severe

curtailing of agency during perinatal care. While the central concept of the theory is agency in perinatal care, *Deciding to Call the Shots* is the activity that reclaims agency.

Memoing. Memoing began at the outset of the study and recorded the thought process of the researcher throughout the research process. Memoing was an important part of the theory development process when performed alongside coding, as it helped the researcher to clarify theoretical propositions or discussions (Glaser & Strauss, 1967). A memo in a grounded theory study is a written record of the thinking process that accompanies the analysis of data (Corbin & Strauss, 2008), and in this study the memos were of varying length and depth. Some were a few words describing the antecedents of a concept, and some were several pages of concept development following a participant interview. Memoing allowed the researcher to track the progress of theory development and develop diagrams, as well as the decisions made for each iteration of the data collection and coding process (Corbin & Strauss, 2008). Memoing also assisted the researcher in moving back and forth between grounding in the data and the conceptual level of theory generation (Glaser & Holton, 2004).

Electronic organization. Final organization for coding was accomplished using tables in Word for Mac to systematize codes with passages of text from the interview data. This allowed for visualization of the data as well as ease of comparison between participants and questions through the use of searchable text in Word. Once new themes ceased to emerge and the researcher determined - with input from the supervising grounded theory researcher - that saturation of themes was achieved, data collection was considered complete. For this study, saturation occurred after eleven interviews and two member-checks. At that time, a final synthesis was completed as an overview of the findings, which was explicated in a manuscript in Chapter 4 of this dissertation.

Ensuring Scientific Rigor

Ensuring rigor in qualitative research is contingent on establishing credibility, transferability, dependability, confirmability, and authenticity (Lincoln & Guba, 1985). The main components of scientific rigor include the concepts of thoroughness, diligence, and accuracy. In order to provide evidence for scientific rigor in the qualitative research process, the researcher engaged in scholarly exercises before, during, and after data collection. Lincoln and Guba (1985) recommend several processes for demonstrating rigor in qualitative research. The following strategies were utilized in the study are described in further detail: (a) reflexive journaling, (b) documentation of the decision trail (c) comprehensive field notes, (d) audiotaping and verbatim transcription, (e) saturation of data, (f) transcription rigor, (g) codebook development, (h) peer review and/or debriefing (i) disclosure of researcher credentials, and (j) documentation of reflexivity. In addition, the home birth CNM as a key informant allowed for increasing trust in the researcher for the participants, increasing the overall efficacy of the study (Taylor, Bogdan, & DeVault, 2015).

Reflexivity. Reflexive journaling addressed researcher bias and awareness of the effect of the researcher on the context of the research (Polit, 2012). Writing about the thoughts and experiences within the study notes and discussing them with a grounded theory mentor helped to create an awareness of bias. The researcher's influence was always present, and exploring that researcher's presence through writing was a way of ongoing identification and acknowledgement of bias and added to the trustworthiness of the study (Polit, 2012). Documentation of reflexivity, along with documentation of the decision trail for the research process and comprehensive field notes created the transparency that increased rigor and trustworthiness. All documentation from

this study was examined by the grounded theory advisor as well as an outside auditor to increase rigor.

A comprehensive confirmability audit was completed by a doctorally-prepared nurse researcher who has worked previously with grounded theory methods. The independent auditor was not a member of the dissertation committee, and reviewed all of the researcher's transcripts, field notes, thematic and conceptual diagram drawings, decision trail notes, demographic data, and coding tables. The independent auditor traced the coding process from open codes through theory, back to the data, and forward through the conceptual process. The auditor determined that the data supported the theoretical explanation and that the theoretical explanation could be traced back to the data and issued written confirmation to the dissertation committee.

Power dynamics. Participant-researcher power dynamics could have influenced the results and credibility of the study (Mkandawire-Valhmu, Rice, & Bathum, 2009). One way this was addressed was through integration into the community setting and engagement with gatekeepers for advice and planning. The home birth CNM provided helpful guidance and additional pertinent contacts, such as other CNMs, during the study. Having a deep understanding of the setting and gatekeeper was one strategy to diffuse power dynamics and increase the quality of the study. Meeting the participants at a site of their choosing also helped to diffuse power dynamics, especially because many of the interviews took place at the women's homes. In that setting, the researcher was an invited guest. In addition, the demographic similarity to the researcher lessened the influence of power during this study. The limitations of the demographic similarity between the participants and researcher is discussed separately in this paper.

During data collection. Data collection was another area to increase scientific rigor. Digital recording and transcription were verbatim to ensure the integrity of the data. Interview questions were based on the results of the qualitative synthesis literature review in Chapter two of this dissertation, but also developed in a way that allowed the participants to describe their experiences and possible alternative perspectives, as is expected when conducting a grounded theory study. There was a participant who had a dissimilar experience from the other women, and this was prepared for, as this viewpoint was valuable to the data and analysis. The initial interview questions (see Appendix F) were written to be open-ended, so as to not be interpreted as ‘leading’ or looking for specific answers or experience descriptions (Polit, 2012). Power dynamics can insert themselves into the interview process, especially in the community setting (Mkandawire-Valhmu et al., 2009). Power dynamics and data collection were addressed through the grounded theory design and reflexivity as described above. Theoretical sampling also served to increase the diversity of descriptions of study concepts.

Limitations

There are several limitations to this study. Question bias could have limited the descriptions that the participants gave. The questions were developed based on qualitative synthesis of the home birth literature and refined based on theoretical sampling and constant comparative method. The interview guide evolved as the grounded theory study progressed. However, the use of an interview guide carries with it the possibility for perceived bias in the question, even with an evolving questionnaire. There may be participant perspectives that were not captured due to the structure of the interview guide.

Self-selection bias is another limitation of the study. The participants were volunteers who were motivated to engage in the study. This likely resulted in a sample of participants that

are different from the general population pool for the study and perhaps more motivated in general. There was no comparison group, and therefore the self-selection sample was the data source.

Power dynamics – a difference in the balance of power within the interview process - are a limitation. Power dynamics include researcher bias. For example, the participants all identified as white. It is unknown whether or not power dynamics kept women of color from participating. The acknowledgement by the researcher of this possibility and the underlying social structures that promote it is part of the reflexivity and transparency exercise that was undertaken in the study. However, there may have been influence from power dynamics despite the specific strategies to address them. This study did not capture the home birth decision-making experiences of women of color.

In addition to racial homogeneity, the participants in this study were all married or partnered, and that is another limitation of the study. This study does not capture the experiences of women who are un-married or un-partnered and choose home birth. This would have been an important viewpoint to examine and should be the target of further studies.

The findings of the study are applicable to the women who made up the sample but will not be generalizable to other populations in the research setting or women in locations other than the research setting. However, the findings will be able to be used to generate theory, further understanding, and add to the discussion of home birth decision-making.

The study was conducted and the data analyzed by one researcher. This is the largest limitation of the study. The study would be strengthened by the presence of one or more fellow researchers. However, an experienced researcher and grounded theory mentor supervised the data collection and analysis process and provided debriefing during and after the study.

Strengths

The women who participated in the study and lent their words and experiences for the purpose of a greater understanding of homebirth access were its most important strengths. In-depth interviewing allowed for the stories of the women to provide insight into the concepts of home birth decision-making. The process of decision-making may not otherwise come to be known through methods such as insurance data analysis, vital statistics records collection, and survey results.

Another strength of the research lies in its ability to describe the experiences of the participants within their own frame of reference (Corbin & Strauss, 2008). Grounded theory methodology allowed for the context and perspective of the participants to be explored. Qualitative methodology acknowledges the participants' view of reality and accepts it as evidence that enables the researcher to consider the meaning that the participant reveals through this evidence (Taylor et al., 2015). This qualitative study described the larger picture of the participants' lives in relation to home birth decision-making.

Conclusion

This chapter detailed the methodology for a grounded theory study examining the decision-making process for women who choose home birth. Grounded theory is composed of very specific tenets, including theoretical sampling, constant comparison method, and the goal of a substantive theoretical explanation grounded in the data. The following chapter discusses the results of the study.

CHAPTER 4 : RESULTS

Chapter 4 is a grounded theory study of the decision to plan a home birth in the U.S. It is formatted as a complete manuscript in the style of the *Journal of Midwifery and Women's Health*, the target journal for publication, and contains its own abstract, purpose, and set of references specific to this manuscript. It begins by describing the context of home birth in the U.S., followed by a description of the grounded theory methodology. Next, the results of the grounded theory study are described. The results are then discussed in terms of their relationship to the U.S. qualitative home birth literature, and future research is considered.

Abstract

Introduction: The purpose of this study was to explore the decision-making process for women who choose home birth and generate a substantive theoretical explanation for the decision-making process. The number of women who are choosing home birth is increasing, despite conflicting safety evidence and differing opinions from professional organizations. There is a lack of qualitative research examining the decision-making process for choosing home birth.

Methods: This study was designed using grounded theory. Eleven adult women who had planned a home birth within the last 10 years with a Certified Nurse Midwife participated. Semi-structured, in-depth interviews were conducted, and constant comparison method was used to analyze the data.

Results: The Basic Social Process for choosing a home birth is *Deciding to Call the Shots*. The decision-making process was depicted in the theoretical model as having three parts: *Realizing an Alternative*, *Deciding to Call the Shots*, and *Building a Shelter*.

Discussion: This study suggests that women who choose home birth value personal agency during perinatal care. Further research is needed to explore the association between personal agency and perinatal outcomes.

Keywords: home birth, grounded theory, decision-making, agency, women

Deciding on Home Birth: A Grounded Theory Study

The percentage of home births in the United States increased by 71 percent between 2004 and 2014 (MacDorman & Declercq, 2016b). The increase persists despite conflicting evidence for the safety of home birth. Snowden, Dhingra, Keyes, and Anderson (2010) found that perinatal death rates were higher for planned home birth at 3.9 per 1000 births, compared to 1.8 per 1000 births in a planned hospital setting. However, Cheyney, Bovbjerg, et al. (2014) found that the risk of perinatal death was similar between planned home birth and planned hospital birth, at 1.30 per 1000 births for the intrapartum period, 0.41 per 1000 births for the early neonatal period, and 0.35 per 1000 births for the late neonatal period.

The methodologies employed in studying perinatal death in home birth continues to be debated in the literature. (Cheyney, Bovbjerg, et al., 2014) utilized voluntarily reported home birth outcomes data, primarily submitted by Certified Professional Midwives (CPMs). Snowden et al. (2010) utilized birth certificate data from Oregon, a state that includes intended place of birth in its vital statistics records. Overall, the general focus of the quantitative home birth safety literature in the U.S. is intrapartum and neonatal mortality rather than maternal outcomes.

Professional guidelines for home birth by the American College of Nurse-Midwives (ACNM) and the American College of Obstetricians and Gynecologists (ACOG) emphasize the right of the woman to choose where she gives birth (ACNM, 2016; ACOG, 2017). ACOG (2017) states that hospitals and accredited birth centers are the safest places to give birth and also lists several absolute contraindications for home birth: fetal malpresentation, multiple gestations, and prior caesarean section. ACOG makes a recommendation for midwifery educational standards, mainly that they meet the Confederation of Midwives' Global Standards for Midwifery Education. The ACNM publishes a more extensive list of conditions that may be

indications for a hospital birth, which includes the three conditions listed as contraindications by ACOG (ACNM, 2016). It goes on to discuss the evidence for midwifery care at home births, engaging in shared decision-making, maintaining informed consent, and providing ongoing assessments in order to ensure an appropriate risk profile for choosing home birth. Both sets of clinical guidelines aim to improve home birth outcomes.

Less is known about the decision-making process for home birth in the U.S. within the context of the perinatal outcomes research and clinical guidelines. American women also have social and economic barriers to home birth, with most women self-paying for home birth (MacDorman & Declercq, 2016). The gap in the home birth literature is the lack of women's voices discussing decision-making for home birth. The purpose of this study was to explore the process of choosing a home birth and to develop a substantive theoretical explanation of the decision-making process.

Methods

The study was designed using grounded theory methods, which draws on symbolic interactionism (Corbin & Strauss, 2008). Semi-structured, in-depth interviews were conducted in three phases with women who have planned or are currently planning a home birth for first and/or subsequent pregnancies. Theoretical sampling was used to guide the recruitment of participants.

Procedure

The proposal and design of this study was evaluated and approved (see Appendix C) by the Institutional Review Board of the University of Wisconsin – Milwaukee (IRB#18.017) prior to the commencement of participant recruitment. Participant informed consent was obtained in person by the researcher before beginning the interview process. Written and verbal explanation

of informed consent included a description of confidentiality procedures, including the use of pseudonyms, de-identification of interview transcripts, and the secure storage of electronic and paper materials for the study. All participants are identified with pseudonyms throughout this paper.

Data were collected by the author between 28 October 2017 and 5 January 2018 using semi-structured, in-depth interviews and a demographic questionnaire. Interview guides (see Appendix F) were employed in each of the three phases, evolving with the data analysis to achieve theoretical saturation. All of the interviews opened with the initial question, “Can you tell me about the births of each of your children?”. Subsequent questions were designed to elicit descriptions of the decision-making process as well as build the substantive theory. The interviews ranged in duration from 26 to 70 minutes and were carried out at a site that was convenient to the participant. Nine interviews were conducted at the participants’ homes, one took place at a coffee shop, and one took place at a shared office space.

The demographic questionnaire asked about (a) age, (b) race, (c) income, (d) relationship status, (e) caregiving status, (f) education, and (g) health insurance. The demographic questionnaire was optional for the participants, but all chose to complete it. Interviews were recorded using primary and back-up data recording devices. The primary recording device was an Olympus MP3 digital recorder and the back-up recording device was an iPhone 6 Plus. After each interview, field notes were recorded as voice memos on the iPhone.

Interviews were uploaded onto the researcher’s computer from the MP3 recorder within 24 hours of the interview and transcribed verbatim by a professional transcription service. Once the recordings were uploaded, the back-up recording was deleted. Upon return from the transcription service, interview transcripts were verified with the recordings by the researcher

before the primary recordings were erased. Field notes were transcribed from voice memos within 24 hours of the interview. Demographic data collected on paper forms were entered into an electronic format for reference (see Figure 3).

Data Analysis

Data were analyzed by the researcher on an ongoing basis during data collection, beginning with the first interview and concluding with the formalization of the theoretical model after the conclusion of the final interview. Each interview was initially coded using an open coding strategy (Corbin and Strauss, 1998). The researcher performed a line-by-line analysis of key words and phrases, which were then summarized and organized in a Microsoft Word document table. Strauss and Corbin's constant comparison method was utilized by the research throughout the analysis process to compare and contrast incidents within the data. Thus, new data was compared with existing data in order to continually refine the concepts described therein.

Constant comparison allowed for more precise concepts to be identified (Strauss and Corbin, 2008). It also facilitated theoretical sampling during the recruitment of participants, in which participants were sought who could provide information about the emerging concepts and theory. The selective codes and their attributes, such as the conditions under which they occur, were analyzed further for possible relationships, antecedents, and outcomes. The analyses, theoretical sampling, and hypotheses that emerged from exploring these relationships led to the development of the theoretical explanation for the decision to have a home birth.

Techniques to enhance trustworthiness included reflexivity journaling, regular reflection and debriefing with a research mentor, transcription rigor, and an outside audit of all study documentation. The outside audit included original verbatim transcripts, field notes, research

journal, and documentation of all stages of coding, theoretical diagramming, and theoretical explanation development. In addition, the theory diagram was presented to two additional women who had chosen home birth. The two women, acting as member-checks, signed consent forms to participate in the study, but did not answer interview questions. Rather, they independently confirmed the validity of the theoretical explanation.

Results

Sample

Participants (n = 11) were recruited from a Certified Nurse Midwife (CNM) home birth practice using theoretical sampling (Glaser and Strauss, 1967). Inclusion criteria consisted of (a) women who were age 18 or older, (b) fluent in English, (c) who were currently planning a home birth or had planned a home birth within the last 10 years in the U.S., and (d) had a CNM as the home birth provider. Following Institutional Review Board (IRB) approval, a flyer describing the study was delivered to a CNM with a home birth midwifery practice. The study was explained in detail to the CNM at that time. The CNM distributed the flyer to potential participants within her community of current and former patients. Initial sampling was open to all participants who met the study criteria. As the study progressed, the researcher theoretically sampled for participants based on the ongoing analysis and constant comparison of the data (Glaser and Strauss, 1967). Thus, subsequent sampling included participants whose experiences with home birth decision-making could complete the gaps in the emerging grounded theory. Theoretical sampling concluded after three rounds of participant recruitment, at which time theoretical saturation was attained (Glaser and Strauss, 1967).

Basic Social Process

The theoretical explanation generated by this study reflects the process of how women decide to have a home birth. The explanation centers around the Basic Social Process (BSP) of *Deciding to Call the Shots* (see Figure 2). *Deciding to Call the Shots* includes three phases: *Realizing an Alternative*, *Deciding to Call the Shots*, and *Building a Shelter*. The three core categories compose the theoretical explanation that answers the main research question, “How do women decide to have a home birth?”

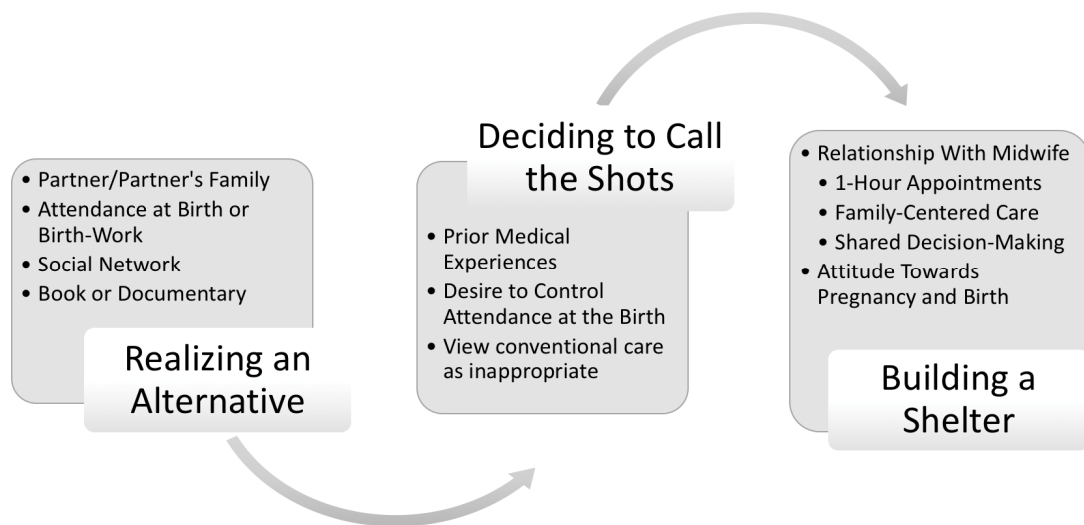


Figure 2 Substantive Theoretical Explanation: *Deciding to Call the Shots*

Realizing an Alternative

The first step in the decision-making process was becoming aware of home birth. In the United States, nearly 99 percent of all births occur in the hospital (MacDorman et al, 2016), and, therefore, many women have limited knowledge of home birth. In addition, media portrayal of birth as an emergency situation requiring a high level of medical intervention shapes the public’s perception (Luce et al, 2016). For some homebirth women, the realization of an alternative way to think about birth began with a hospital birth:

I think [seeing my younger brother born when I was 13 years old] started my interest in birth and in the belief that this is normal- and I don't know, maybe a little bit of sense of- of like, "Wow, that was so simple," in a way it had been hidden from me, you know?

(B.134-135;137-139)

For this participant, witnessing the birth of her brother as a “*really amazing*” (B.125) event prompted her to think that “...*everyone should know about this.*” (B.143). Several participants expressed similar views - that despite childbirth classes and other traditional preparations, they felt very naïve going into their first hospital birth (N.9;C.118).

Introduction to the existence of home birth was related to several facilitating factors, the most common being family and friend connections (L.269-270;K.606-608;Ky218-222;S18-19;C.409-410J.99-101). Some women had partners who introduced them to the concept: “...*but then I heard enough about the midwives in his community and his mom's birth stories...*”(L.50-51). However, the first impressions of family members' home births were not met with universal acceptance, even from women who would go on to have a home birth themselves:

[My sister-in-law] opted for a home birth for her fourth. She had had three hospital births and she opted for a home birth. And I at the time, I was almost mad at her for doing it. I was like, "That is so irresponsible. I can't believe you would worry everyone like that. And, who knows ...that's reckless." And you know, I didn't know anything about [home birth]. (Ky.218-222).

Others learned about home birth through friends and acquaintances, such as this example from Charlotte: “*I had known people who had home births in [this city], I had just kind of absorbed it through the soup...*”(183-185). ‘The soup’ concisely describes the process of the dissemination of information about home birth within a community. Participants described

becoming aware of home birth, but the requisite for them to move from intrigue to action-taking was the close proximity to others with favorable experiences and opinions of home birth.

Three of the participants were employed in professions directly related to birth, which gave them a more specific awareness of its realities. For Nell, a birth photographer, her professional experience allowed her additional insight into the differences between home and hospital birth, both of which she has photographed. The realization, she describes, came from her observation of a photography subject:

“Seeing her labor where she wanted and then sitting on the couch after and eating a donut was like, wow, that's really cool... and she was so much of a part of her birth, like you should be.”(360-361;367)

Awareness of home birth was augmented by two main sources, mentioned repeatedly throughout data collection. Ina May Gaskin's book, *Spiritual Midwifery*, and Ricki Lake and Abby Epstein's documentary, *The Business of Being Born*, served as either initial points of awareness of homebirth or sources of validation during and after the pregnancy. Some participants were initially intrigued by one or both of these materials, and then went on to gather more information through social networks. Others who were first made aware of home birth by relatives or friends then found these resources during their research on home birth. This bi-directional relationship, coupled with the aforementioned factors such as family influence and birth-related work, contributed to the BSP of *Deciding to Call the Shots*.

Deciding to Call the Shots

Deciding to Call the Shots is the point at which the woman departs from the conventional perinatal model - either mentally, physically, or both. Central to this core concept is the agency of the woman within the decision-making process of her care. *Deciding to Call the Shots*

generally occurred in response to one or more of the following factors: (a) previous hospital birth experience, (b) negative experience with prenatal appointments (c) desire to control attendance at the labor and birth, and (d) specific prior medical experiences. In addition, the participants regarded birth as primarily a family event rather than a medical event.

Previous hospital birth experience. Several participants had previously given birth in a hospital setting and had varying degrees of satisfaction with the experience. Nell recalled her physician's positive support her during labor, "*And [my primary care doctor] was like, "You're doing great!", "You can do this!" And I remember her crouching down and like looking at me in the face and being like, "You can do this." And that stuck out to me so much (88-90).* Karen, whose first birth took place in a hospital with CNMs, said of the birth, "*...I definitely felt it was a great experience, and I loved the birth tub and I really felt very strongly [positive] about the water birth*" (K.101-102). However, she expressed mixed feelings about other aspects of her care, including the process of being admitted to the labor and delivery unit:

"...when I got to the hospital, I was put in the triage room and that was horrible. That was absolutely horrible because all of the shift nurses were coming in, it felt like, every five minutes, and it was a different one and they went through this barrage of questions... and the questions were ridiculous like, "Are you still taking your pre-natal vitamin?" And I've been taking five supplements like fiber and probiotics, and so they would go through each one as I'm barfing into a bag... I was being barraged by all of these people I didn't know that were shouting stupid questions at me that couldn't be less relevant to the fact that I'm imminently going to give birth (K.44-48;50-52;62-63)

Irritation at the policies and protocols of the hospital was echoed by other participants, who were subject to similar rigidity:

“...it was frustrating because [I felt like] I was like chained to the bed, I couldn't walk around. (Laughs)...Some saint came and saved me...”[this nurse said] if you would like to stand in the shower for a few minutes, I'm going to unhook you. Stand in the shower, and then you can come back. And I'll monitor again.” I was like, "Thank you, thank you so much." (Laughs). I'm sure that got me through” (S.53-54;59;60-64).

Postpartum care in the hospital was described as another instance that influenced the decision to choose a home birth for subsequent pregnancies:

“Post birth, just the time in the hospital after birth, I found exhausting, and ... not nurturing (laughs). The care was good, it was just - it was loud and there were lights and noises and then throughout the night the people that were coming to check vitals weren't coordinating to check the mom and the baby at the same time ... It felt like every hour we were getting woken up. ... it was just exhausting” (C. 33-34;36-39;43-44)

The lack of personal agency described by the participants during their hospital births contributed to a desire to have more autonomy for subsequent births. Their observations at the time of the interview had the additional perspective of experiencing a home birth, potentially sharpening the contrast between institution and home.

Negative experience with prenatal appointments. Dissatisfaction with conventional prenatal appointments was another factor mentioned frequently in the data set. Sarah described her impression of the hospital's prenatal clinic as *“...this humongous clinic and the parking lot looks like an airport parking lot and I was like, "Oh, gosh." No, I don't want that. It's too big”* (156-158). In many cases, the scale of the institutional setting was seen as outsized in comparison to the woman's needs, which were mainly time for thoughtful discussion, question-asking, and emotional support.

Participants described the depersonalization of appointments, which were short and focused on physical - rather than mental or socio-emotional - well-being. The short length of the appointments left little time for building a relationship, “*And [the OB] was very in and out. Half the time, I would be still asking questions and she would literally be halfway out the door. And I wasn't okay with that. (laughs) I needed someone that could give me a little more time*” (N.303-305). In contrast to women who have only experienced conventional perinatal care, home birth women have a model for comparison. Women who choose home birth see their appointments as a highlight of their pregnancy care and directly connected to their labor/birth environment.

Desire to control attendance. Women in this sample expressed a deep desire to control attendance at their labors and births, not only in their choice of provider, but in the assistants or other personnel. Charlotte observed that at the hospital, “*there are just many, many more individuals you'll be dealing with (C.670-671). Apprehension about “people that don't really know you coming in [to your room]” (J.299) led this sample of women to seek care in which they could approve each person involved in the care. For women who choose home birth, controlling attendance was another factor that reduced or eliminated points of tension in the labor environment, as described by Kay:*

“...I think that's just so important to know who's going to be at your birth, at least for me. You know, I've had complete strangers ruin an entire day for me. Just a bad server at a restaurant on a date night, on our anniversary or something like that... I don't really want to take the chances of having to, you know, fight for my decisions at a hospital. Not knowing who [the staff] are. They don't know anything about me” (324-331).

Charlotte added to this point, “*...when it's a home birth, you're dealing with fewer people, and you know every single one that you're inviting into your house... So, there is a level of comfort*”

(673-678). As she notes, home birth requires permission for the provider and assistants to enter the space, which influences the power dynamic between the woman and her birth team.

Specific Prior Event. For two of the participants, a specific negative event directly led to the switch from conventional perinatal care to home birth care. For Beth, the routine 20-week ultrasound indicated an abnormality in one fetal measurement. She goes on to describe:

“And the doctor came in, and so this person we've never met sits down with us and starts to tell us, "Oh, this measurement's a little off" ...and it felt very offensive, as somebody who's trained in science. I was like, "Okay, so what are we talking about here? Point three whats? And point three three whats?" How far outside of normal is this; what's this unit of measurement ... And they didn't tell me, and they also told me to not try and look it up. And I was like, "Excuse me?" (347-349;368-377)

Several participants echoed Beth’s sentiment of being considered by their providers to be unable to understand medical or scientific explanations. However, the participants in this sample made a point to discuss the information-seeking that they did on prenatal testing, home birth safety, and fetal and infant morbidity and mortality in both home and institutional settings of care.

For Karen, the hospital’s withdrawal of permission to have a water birth resulted in her switching to home birth care at the very end of her pregnancy. Karen understood that she had to abide by this rule, *“...because otherwise, the hospital will take away water birth [for everyone]”* (411). Nonetheless, water birth was important to her, *“I was, you know, in tears basically, I'm crying when I left the appointment at the clinic because I was so upset about that”* (372-374). She went on to describe her reaction: *“I got home from that appointment and I immediately called [the home birth CNM] (144).* In both of these cases, a perinatal clinical recommendation

that ordinarily would have prompted increased medical interventions instead led to an exit from conventional perinatal care.

All of the women in this study had contact with the conventional healthcare system at some point before or during their pregnancy. Many were able to describe the moment when they *Decided to Call the Shots*, departing from conventional perinatal care and embarking on collaborative care with a home birth CNM. Once the decision was made, the priority became *Building a Shelter* for the labor and birth.

Building a Shelter

Women's agency is strengthened by activities related to shelter-building in the final phase of the home birth decision-making process. Shelter-building activities include (a) developing a close relationship with the midwife, (b) negotiating support from social networks, and (c) shaping the attitude towards pregnancy and birth.

Relationship with the Midwife. The relationship with the midwife was the most significant element of shelter-building, and consisted of 1-hour appointment times, family-centered care, and shared decision-making. One-hour appointments with the home birth CNM were central to building the relationship between the midwife, the woman, and the woman's family. One participant described her prenatal appointments, "*I would go to her house, and you walk in and she gives you a hug and you get your tea. (laughs) And you sit down for an hour and just talk*" (N.130-133). Hour-long appointments were specifically cited by all participants as crucial to their prenatal care, "*I would have never wanted to miss any of those visits. I so looked forward to that hour with [the home birth CNM], and it felt so much like self-care and preparation for my baby and my family*" (S.192-194). In addition, "...*it was nice to be able to spend a lot of time just connecting with [the home birth CNM] and I think that helped set the*

right mental space for going into labor” (L.232-234). Participants also referred to the content of their prenatal appointments as, “*whole person care*” (C.516) and a “*whole family approach*” (C.542).

Family-centered care was noted as a major factor in the facilitation of the relationship with the midwife during prenatal care. One participant described the positive aspects of family-centered care as, “...*just the way that she really just loves on your whole family*” (S.607). Prenatal care included involvement of children as well, and many participants cited this as another benefit of home birth care that strengthened the bonds between the family members in preparation for the birth.

The process of shared decision-making incorporated inquisition by the woman and midwife. Participants in this sample actively sought out evidence and examples to discuss with the midwife at prenatal appointments. This took the form of ‘what if’ questions from the woman as well as her partner, and, occasionally, others such as the woman’s mother. One woman described her mother’s interrogation of the midwife on safety, “*[my mother, a labor and delivery nurse] asked more questions than my husband did. (Laughs). [the CNM] was un-phased*” (S.239-240). It was through these thoughtful conversations that questions were answered in a meaningful way and the process of shared decision-making occurred. For this set of home birth women, all decisions for pregnancy care were made after discussion of the risks and benefits, even for such routine interventions as ultrasounds. For their part, the women and their partners were expected to be an active and informed part of the decision-making process.

Negotiating Support. Support for the decision to have a home birth was negotiated with partners, extended family, and the woman’s social circle. Because the decision to have a home birth is socially and medically unconventional, the women in this sample undertook a delicate

process of sharing the decision with some and not sharing it with others. For example, Karen said, “...we elected not to tell [my partner’s] parents because we thought that that would just cause undue worry for them” (520-522). Beth described the approach she and her husband took with acquaintances and extended family:

“...at that point we were making a lot of decisions that weren't kind of very conventional; we weren't making a nursery, we had decided that we were going to co-sleep...So kind of a lot of those. We didn't know the sexes of our kids before they were, so a lot that kind of normal chatter that happens when you're pregnant ...I think both my husband and I learned how to kind of redirect into like safe waters (laughs). Just to avoid conflict” (566-569;571-572;574).

Conflict and disagreement occurred at times about the decision to have a home birth, especially with extended family. Several of the participants had family members who were medical professionals and voiced their disagreement with the decision. Tension between Sarah and her mother was described as, “...we had a few strained conversations and then she'd just would randomly tell me all the people she asked to pray for me” (234-235).

Sharing and not sharing was a bi-directional relationship, with many women’s family members telling them at a later time that they had misgivings about the decision. Karen summed it up as, “...I'm sure that [my mother] had some anxiety in her own mind that she just didn't want to share with me” (546-547). Gretchen described her extended family’s consideration of her feelings, “So, [my father-in-law] had some pretty strong opinions about it, but [he and his family] did a good job keeping them to themselves, keeping them away from me, especially” (146-150). She went on to recount her family’s dinner-table discussion of home birth:

“And the one time [my father-in-law] really tried to get into it with me, we were in a family setting, and my husband's grandma was there, and he was asking all these questions. And [Grandma] finally said “Well, I was born at home.” And he paused, and he was like, “Huh. I guess my parents were born at home, too.””

Social support for the women in this sample came from their partners, other home birth women, their midwife, and other members of the home birth community. Participants expressed comfort in the fact that their area had a robust support system for women who choose home birth, so assistance was not difficult to find.

Attitude Towards Pregnancy and Birth. The women in this study viewed pregnancy and birth as a normal physiological event. In the words of one participant, *“[pregnancy] is not an illness, at least not until, you know, proven otherwise”* (B.195-196). Betty describes her pregnancy care as, *“...I did not want anti-nausea medication, or any of those things that a medical setting could give me. I just felt like I wanted (laughs) assistance and reassurance...and just congruence with the idea that this might be hard, but it's normal”* (B.552-555). Participants also sought to align their care with a non-fear-based approach, as *“...there's so much in our culture around pregnancy that's all fear-based”* (L.364-365). In short, participants recognized the need for collaborative care, but also considered themselves experts on their bodies and their pregnancies. Because of their expertise, it was expected that the perinatal care provider would collaborate with them as an equal.

The birth itself was seen as an important developmental milestone for both the woman and her family. One participant stated, *“[the family] gets born almost out of the process as much as the baby does”* (B.322-323). Thus, the family's role during the birth – especially the partner's role – was of the utmost importance. During a home birth, the partner was not seen as a

bystander in the process. The partner had ownership over the birth space and a relationship with the midwife independent of the birthing woman. In addition, the woman's family had meaningful tasks to perform during the birth and were a vital part of birth care.

The women in this sample expressed a strong positive opinion of hospital care for high-risk pregnancies or complications during birth. Gretchen stated, "...I'll go to the hospital if I need to, and it's wonderful to have hospitals when you need them...This isn't have the baby at home or have no baby at all" (497-498;576). However, it is important to home birth women to know that hospital transfer and hospital interventions such as caesarean section are medically necessary. What this meant in practical terms was that through the process of relationship-building with the midwife, trust was gained for making the determination of medical necessity. During the ongoing inquisition of the midwife during hour-long prenatal appointments, home birth women established trust in the fact that their midwife would not recommend transfer to hospital care for nonessential reasons. This allowed the women to comfortably hand over that decision during labor.

Discussion

The purpose of this grounded theory study was to explore the decision-making process for women who choose home birth and generate a substantive theoretical explanation. From the data analysis, the Basic Social Process of *Deciding to Call the Shots* emerged. *Deciding to Call the Shots* is how the women solved the problem of decreased personal agency during their perinatal care. There were three steps in the sequence of *Deciding to Call the Shots* related to *Awareness, Agency, and Shelter-building*.

Many of the women in this sample did not set out to exit the conventional perinatal system but felt that their agency had been or was about to be curtailed by policies and procedures

of the conventional perinatal care model. The institutionalized setting served to reinforce the decrease in agency. In exercising their personal agency, the women began to build a shelter that would support their labor and birth, utilizing the relationship with the home birth CNM as one component. Family-centered care, typically including the woman's partner and her other children at appointments and cultivating an alternative attitude about pregnancy and birth were other elements of shelter-building.

Attitudes toward pregnancy and birth were cultivated before, during, and after pregnancy and as part of shelter-building. These attitudes were an important part of facilitating the decision to plan a home birth and were also utilized to justify their unconventional choice of home birth to outsiders. For example, there was a strong belief by the participants that most caesarean sections are not medically indicated and that giving birth in the hospital greatly increased the chances of having an unnecessary caesarean section. The women in this study expressed that if they transferred to the hospital and had a caesarean section, it would be for a "good reason". There was a distinct difference in the minds of the participants between a necessary and unnecessary caesarean section, and the participants were not convinced that conventional care providers would make that distinction.

In addition, the participants contrasted hospital interventions and home birth interventions. Participants had a negative opinion of hospital interventions, and even considered entering the hospital an intervention. The data suggested that the reason for the negative opinion was that hospital interventions often take the form of high technology, such as monitors and medications. Home birth interventions, on the other hand, were viewed as acceptable and even desirable. For example, when participants were asked by the home birth CNM to get into an uncomfortable position called 'mountain climber' in order to cause more intense contractions,

they expressed dislike for the intervention, but also ownership over the augmentation of their own labor through low-technology, reversible interventions.

This study supports the findings of other qualitative studies on home birth in terms of the role of agency in the decision-making process. Control and safety are two aspects of home birth that are cited regularly as reasons for choosing home birth (Boucher et al., 2009). Safety, as it is seen in other home birth literature, is comparable to shelter-building insofar as it requires the cultivation of emotional security and trust. This is conceptually different from the safety that is discussed in quantitative outcomes studies.

Implications

This study and its theoretical explanation contributes to research, practice, and policy in healthcare. First, it adds to the body of evidence about women who plan home births in the U.S. Women who choose home birth have many more reasons – medical, social, and economic - not to choose home birth. Nevertheless, they persist. Understanding the determination of women who choose home birth to make such an unconventional choice can increase what is known about patient agency in healthcare. In terms of practice, the results of this study can be used to increase understanding of other unconventional healthcare choices as well as the choice to have a home birth. Each woman in this study interfaced with the conventional medical system during one or more of her pregnancies, and at times was treated with skepticism. This study can further the communication and collaboration between the conventional perinatal system and home birth, which is also important for improving birth outcomes. For policy, this is especially important. Planned home birth to hospital transfers require collaboration between these entities, while providing safe and non-judgmental healthcare.

Limitations

This study has several limitations. The participants were self-selected, which may have resulted in bias toward positive home birth experiences. There may have been question bias even though the interview questionnaire evolved with the constant comparison of grounded theory method. Another limitation was the homogeneity of the participant sample; women of color were not represented in this sample, nor were un-partnered women. Recruitment of women of color and un-partnered women would have improved the theory generation. In addition, one nurse researcher conducted the interviews, coded the data, and generated the theory, although the researcher was closely mentored by an experienced researcher. The study would be greatly strengthened by a team of researchers engaged with data collection and analysis.

Conclusion

This study examines the processes involved in the decision to plan a home birth in the U.S. According to the theoretical explanation in this grounded theory study, planning a home birth requires a raising of awareness that home birth exists, followed by a decision to prioritize personal agency within the perinatal care environment, and concludes with a process of establishing a sheltered atmosphere for labor and birth. These findings have implications for expanding trust between the home birth community and the conventional perinatal care setting.

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Conflicts of Interest

This study was carried out as part of a doctoral dissertation. No conflict of interest has been declared by the author.

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Age	Race/Ethnicity	Income	Relationship	Caregiver	Education	Insurance	Interview Length
40	White	Very Comfortable	Married	2 Children	Graduate	Private	39 minutes
29	White	More Than Comfortable	Partnered	1 Child and Pregnant	Bachelor's	Private	55 minutes
29	White	Less Than Comfortable	Married	2 Children	Bachelor's	Medicaid	34 minutes
40	White	Comfortable	Partnered	1 Child, 2 Stepchildren	Graduate	Private	70 minutes
38	White	Very Comfortable	Married	2 Children, 2 Stepchildren 50% of the time	Graduate	Private	62 minutes
39	White	More Than Comfortable	Married	2 Children	Graduate	Private	54 minutes
32	White	Very Comfortable	Married	Did Not Answer (1 Child)	Graduate	Private	39 minutes
34	White	Less Than Comfortable to Comfortable	Married	3 Children	Graduate	Private	51 minutes
28	White	Comfortable	Married	1 Child	Bachelor's	Medicaid	44 minutes
35	White	Comfortable	Married	2 Children	Graduate	Private	33 minutes
38	White	More Than Comfortable	Married	2 Children	Graduate	Private	26 minutes

Birth Characteristics

	Pregnant	Total Births	Home Births	Hospital-Midwife	Hospital-Other
Louise	No	2	2	0	0
Rachel	Yes	1	0	1	0
Nell	No	2	1	0	1 (GP)
Betty	No	1	0	1	0
Karen	No	2	1	1	0
Beth	No	2	2	0	0
Kay	No	1	1	0	0
Sarah	No	3	2	1	0
Gretchen	No	1	1	0	0
Charlotte	No	2*	1	1*	0
Jane	No	2	2	0	0

Figure 3 Demographic Information

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CHAPTER 5 : DISCUSSION MANUSCRIPT

Chapter 5 is a case study and policy discussion of planned home birth to hospital transfer in the U.S. It is formatted as a complete manuscript in the style of the *Journal of Midwifery and Women's Health*, the target journal for publication, and contains its own abstract, purpose, and set of references specific to this manuscript. It begins by describing the context of planned home birth to hospital transfer in the U.S., followed by a case study of three home-to-hospital transfers that were described during the data collection for the grounded theory study on the decision-making process for planning a home birth that is contained in this dissertation. The three cases are compared with the current best practice guidelines for home-to-hospital transfer in the U.S. The results are then discussed in terms of implications for future research.

Abstract

Introduction: Planned home birth results in an intrapartum transfer of care between home birth between 11 and 16 percent of the time. The main reason for home-to-hospital transfer is failure to progress. The integration of care between these two settings has an effect on the quality of patient care for women who plan a home birth and then transfer to the hospital. There is a lack of research on the patient perspective of home birth to hospital transfer.

Methods: A case study sub-analysis was conducted on interview data collected from adult women (n=3) who planned a home birth in the United States between 2008-2018 and transferred to the hospital during the intrapartum period. The cases were compared to current best practice guidelines (n=5) for home-to-hospital transfer.

Results: Two of the participants transferred before the birth, and one participant transferred in the immediately postpartum. The case study revealed five critical areas for maintaining a successful home-to-hospital transfer: (a) planning for the possibility of transfer, (b) making the decision to transfer, (c) arrival at the hospital, (d) the birth, and (e) postpartum care.

Discussion: Successful transfers depend on professional trust and collaboration between providers and systems of care. Women plan for the possibility of transfer to the hospital during the prenatal period as part of the shared decision-making process with their home birth midwife. Best practice for home-to-hospital transfers include inter-professional collaboration, open communication, and a non-judgmental attitude toward transferring patients. Nurses have a key role in inter-professional collaboration for home birth to hospital transfers, both as Certified Nurse Midwives and Registered Nurses.

Keywords: planned home birth, qualitative, transfers, inter-professional collaboration

In the United States, between 11 and 16.5 percent of women who plan a home birth are transferred to the hospital during the intrapartum period (Cheyney, Bovbjerg, et al., 2014; Snowden et al., 2015). The most common reason for home-to-hospital transfer is failure to progress (Cheyney, Bovbjerg, et al., 2014). Transfer protocol and integration of home birth into the conventional perinatal care model is one of the main safety mechanisms by which home birth can be measured (Comeau et al., 2018). It has been suggested that countries and territories with increased integration of home birth and conventional perinatal care, such as England or Washington State, have a higher rate of transfer due to the ease with which home birth care providers can move a patient into conventional care if transfer is medically indicated (Shah, 2015).

Collaboration for home to hospital transfers in the intrapartum period is often hampered by a lack of respect, trust, and understanding from both types of care providers (Cheyney, Everson, et al., 2014; Rainey et al., 2017). One consequence of this lack of professional and systems integration may be decreased quality of care for the patient, although this relationship is under-researched (Comeau et al., 2018). Quality of care includes many factors, such as respect, individualized care, and waiting time (Novick, 2009). Research on these aspects of quality of care is needed in the U.S., as one of the primary indicators of negative maternal outcomes – maternal mortality – has risen from 7.2 maternal deaths per 100,000 births in 1987 to 17.3 deaths per 100,000 births in 2013 (Centers for Disease Control, 2017). Exploring individual and health systems influences on maternal outcomes contributes to an increased understanding of the factors that put women at risk. The purpose of this paper is to explore the patient perspective of home-

to-hospital transfer in the intrapartum period and compare the experiences to best practice patient safety guidelines.

Methods

This paper is a case study analysis of a subset of interviews (n=3) with women who planned a home birth and then transferred to the hospital during their intrapartum care. After institutional review board approval (UWM IRB# 18.071), in-person, in-depth interviews were conducted with women who have planned a home birth within the last ten years as part of a grounded theory study on the decision-making process for home birth. Within the sample of women (n=11) there was a subset of women (n=3) who had been transferred to a hospital setting during labor or after the birth, as well as a number of instances where women in the sample discussed the possibility of home-to-hospital transfer. This paper is a sub-analysis of the topic of planned home birth to hospital transfer, privileging the voices of the three participants who described the process of transferring to the hospital in their original interview.

This case study analysis focused on the phenomenon of transferring from a home birth setting to the hospital during the intrapartum period. The analysis examined transfers within a real-world setting for the purpose of exploring its context (Yin, 2014). This analysis sought to answer the research question, “What was the experience of planned home birth to hospital transfer as it relates to current best practice guidelines?” Best practices documents (n=5) were compared with the interview data. Best practice guidelines from the American College of Nurse-Midwives (ACNM), the Association of Women’s Health, Obstetric, and Neonatal Nurses (AWHONN), the American College of Obstetricians and Gynecologists (ACOG), the Home Birth Summit, and the Washington State Perinatal Advisory Committee (WSPAC) were examined. Five critical areas for home-to-hospital transfer emerged from the case study

analysis: (a) planning for the possibility of transfer, (b) making the decision to transfer, (c) arrival at the hospital, (d) the birth, and (e) postpartum care. All names used in this paper are pseudonyms. In addition, references to personal communications on practice setting with the key informant are cited as Anonymous/Protected in order to preserve anonymity of place, practitioner, and participants.

Results

Planning for the Possibility of Transfer

All of the women in this sample prepared for the possibility of transfer to the hospital from the planned home birth. The women emphasized the fact that they were well aware that they may need to transfer to the hospital if indicated. They disputed the perception by outsiders that planning a home birth means never going to the hospital. As Gretchen underscored, *“This isn’t have the baby at home or have no baby at all”* (576). Women discussed the process of thinking about the possibility of having to go to the hospital as one of many mental preparations that took place during the prenatal period. Stated Louise, *“I mean, I tried to go into it very prepared like, “There’s a chance I’m going to transfer and... I need to understand that reality.”* (317-319). The women didn’t necessarily like to think about transferring, but they forced themselves to confront that possibility, so as to be prepared.

This sample of women were also highly aware of the sometimes-strained relationship between home birth care providers and hospital staff who receive home birth transfers. However, they also had confidence that nearby hospitals were more accepting of home birth. Beth discussed this, saying, *“I’ve heard of situations where there’s a lot of tension if you start with a home birth and you end up in a hospital, how that can be really difficult and, I got this sense, that ... That’s not what it’s like here”* (464-467). Many participants pointed to the positive

relationships with hospitals and other providers that had been cultivated by their midwife over many years. Rachel described going to a local hospital for ultrasounds, “*But everyone knows [the home birth CNM] ...all my ultrasound techs are like: Oh, [the home birth CNM]! Great!*” (896;898).

Despite mental preparation and planning with the midwife for a possible transfer to the hospital, there was still a great deal of emotion attached to the idea of transfer. The abstract ‘what-if’ scenarios often clashed with disappointment when participants were faced with the reality of the transfer situation. As Kay describes it, “...[*transferring*] had never even crossed my mind before that point, and I was so upset. I was really upset. I was so unprepared and I had no idea [what to expect]” (11-13).

Making the Decision to Transfer

The women in this sample who transferred to the hospital were not transported as an emergency intervention. Betty described the medical reason for her transfer as, “...*my water broke and labor didn't begin*” (B.35-36). Rachel spent many hours in labor at home and describes the moment when she made the decision to transfer, “*And then finally at 6 AM I said, I feel like I've been in the same place for six hours. And, I think I'm done. I'm done here*”. So, we transferred to the hospital around 6 AM” (172-173,177-178). Kay transferred after the birth for a significant perineal tear that needed extensive stitching. She had already given birth at home and had this to say about the decision to transfer, “...*I'm fine, and [the baby] is fine and this is not that big of a deal. I mean I know that it is not an ideal situation to have that kind of tear but, I felt okay with [the transfer] and I was just happy that [the baby] was here, and healthy, and everything [else] went well.*” (200-203). All of the situations were non-emergent, and both of the women in labor had time to consider their plans to transfer. They explained that their

conclusion came after spending time discussing it with their midwife, family members, and themselves.

In contrast to Rachel, Betty describes this process of deliberation with herself as difficult. Betty reflected, “...when I think back to that time, I think I was really focused on this idea that if we waited enough, then [the baby] would come. But I think that next [part of the day] was kind of all about me trying to come to terms with the idea that she might not just come [on her own]” (678-683). Betty questioned herself about the situation, asking “*Why did my cervix not soften and release this baby, you know?*” (B.713). She describes frustration with her body and with the change of plans for the birth, stating, “...we might need to get another layer of help, and there was a little bit of just, a sense of failure in that” (685-686). Although her home birth CNM was mindful of the time constraints for transferring a patient with ruptured membranes, Betty wavered until the last moment, finally consulting with a colleague who was also a CNM, “...and [my CNM colleague] was like, ‘Bett, fuck it. You have to go to the hospital. You need something they have there. I don't know what it is, but you need something they have there.’ And her saying that, I think, gave me all kinds of permission.” (726-728).

After the decision had been made, Betty described her new focus, which included thoughts about the hospital, “*What if I need to take antibiotics? Will I say no? Will I say yes? You know, or what if they're grumpy that I'm a home birther...And so it shifted the project into a new place*” (742-747).

Arrival at the Hospital

The arrival at the hospital called for a renewed sense of purpose in labor. Betty described this change, “*I was upset that we had to transfer, but once we did it and I was there, there was a shift into a sense of like, “Okay, well this is okay too. I'm going to do this here,” and meet my*

baby here, and then it was okay again” (B.24-26;28). The adjustment – both mental and physical – to a new location was facilitated by the anticipation of the birth.

The home birth midwife smoothed the transition to the hospital by alerting the hospital staff ahead of time and offering a verbal report. Rachel recounted her positive experience, “*And of course [the midwife] had called ahead so I literally got like wheeled off the elevator into a room... it was really great” (184-187). Her home birth midwife accompanied her to the hospital room and continued to provide labor support. Rachel recalled the home birth midwife counseling her on pain medication, “[The home birth midwife]’s like, Rachel, I want you to be prepared. It could take a while to get an epidural. So, I know at this point you’re ready to give up, but you can’t quite yet” (185-187). Once Rachel had been administered epidural anesthesia, she was able to take a moment to rest. However, she described her realizations at that time, “And like, I’m suddenly processing the decision that I’ve made, where I’m at, and having really no idea what’s next” (213-215).*

Both women were expecting negative judgement from the hospital staff for their decision to plan a home birth but found none. Overall, they described a caring and professional atmosphere, “*...[the hospital staff] expected me when I got there. I didn’t feel any judgment for having a home birth, which was something I was kind of expecting (R.651-653). This atmosphere of welcome promoted a collaborative setting, as described by Betty“...but then the physicians came in who were familiar to me from pregnancy. I’d seen one a couple of times and we made a plan...that was lighter or more friendly to me than I expected” (749-752). Kay, who transferred postpartum stated, “The nurses wanted to hear about [the home birth], and they were really kind of excited and proud...they were just like, ‘Sorry you had to come here, we’re going to try to get you out [quickly] because obviously we know you don’t want to be here”’ (440-447).*

The Birth

Both labor transfers in this sample ended with vaginal births. One of the women specifically credits the team of nurses and midwives at the hospital for her birth outcome. Rachel states “...not having a c-section I think speaks a lot to the [hospital] midwives and probably me coming in as a home birth transfer and everyone kind of knowing the extreme of my desires” (647-649). She goes on to describe the encouragement and patience of the CNMs:

“...the nurses and the midwives - there's a great group of midwives - and they were wonderful. They were absolutely wonderful. I mean, I was pushing for three and a half hours. Like, those women were in there for three and a half hours and they had a mirror down by my vagina so I could see him coming out and they were very encouraging. [A photographer] was actually there, so you can see the midwives' faces. They are like, gleeful, while I'm pushing” (656-663).

In addition to the hospital staff, both women also had the home birth CNM there for support at the hospital. In Betty's case, the home birth CNM was joined by another CNM colleague in addition to the woman's partner and hospital staff. Betty described the scene with two home birth CNMs and the hospital healthcare providers supporting her towards the end of her labor:

“...the [hospital] nurse kept flitting in and flitting out and really worried that my labor had progressed to the point where I was just going to have that baby in the tub, which is not approved or whatever at their hospital. And so [the hospital nurse] went and got the resident... [my CNM colleague], she was kneeling by the tub and she kind of looked at the resident and she just said really forthrightly in that quiet moment, 'Are you concerned? Because I don't think [Betty] wants a water birth and, you know, I think we're good. I think [Betty] will get out [of the tub]; we're going to get out. But just so you know

in case we do have a water birth - and she's pointing at herself and [the home birth CNM]- 'We have a lot of water birth experience; it's going to be okay.' (laughing) And the resident was like, 'That's true.' And he left" (B.802-805; 806-809;811-815)

The home birth CNM communicated the patient's information prior to arrival at the hospital, accompanied the patient into the hospital setting, and provided support throughout the birth process. While it is not possible to tell from the interview data how the transfer was perceived from the home birth CNM's perspective, the participants described a positive collaborative atmosphere. As Rachel stated, *"I think as far as a home birth transfer to the hospital, it was a great experience. I don't think that there is anything overtly terrible"* (693-696).

Postpartum Care

In contrast to the descriptions of postpartum care in the home, women who transferred to the hospital described the postpartum care as difficult. Women cited the hospital protocols and routines to be the main drivers of mediocre care. As Rachel observed, *"That [support] kind of felt like it maybe dwindled away after the labor, but that was fine. Just because I think I kind of went into the normal... [hospital] stream of events"* (671-673). She goes on to describe that 'stream of events':

"So, there were a lot of things not helping the situation that made it a challenging experience. But then he was like, 9 pounds, 6 ounces and they pricked his foot every two hours because they were worried about him being too big. And it just ... ugh. Like, the whole thing. I was like, get me out of the hospital. They're like, it's 10 PM. Are you sure you don't want to just sleep? And I'm like, fine, we'll sleep. Can I have my baby? They're

like, no you can't have your baby. He actually has to be here. And I'm just like, this is stupid" (246-252).

Despite this, Rachel emphasized, *"I still had like, a great deal of empathy and gratitude for [the hospital staff]"* (688).

Even in ideal transfer circumstances, women discussed the negative feelings they worked through after the transfer. It was especially difficult for the women to tell friends and family members about the transfer and subsequent hospital birth, *"So, me telling people [about the transfer] felt terrible and felt like a failure"* (R.800). Betty described making peace with the hospital transfer, *"I think I mostly kind of got over [the disappointment], especially after time went on and it almost felt like we had a home birth and nothing changed in my community and nobody was like banning me, (laughing) or shunning me because she hadn't been born at home. I really let it go"* (B.866-870). The same social support that the women had relied on during the pregnancy was relied upon again after the birth.

Betty articulated one of the most important aspects of her transfer, and one that made it easier to transition from home to hospital, *"...the idea that we were in embedded and home throughout the pregnancy was so real and present all the way through the birth that even though we weren't at home, physically at home, I felt at home"* (B.14-15;17-18). Betty was able to bring her sense of shelter (Chapter 4) with her to the hospital, facilitating an emotional atmosphere that felt to her like home.

Implications for Nursing

Both of these home-birth-to-hospital transfers illustrate the type of circumstances recommended by best practice guidelines for a transfer. Trust and collaboration between the

home providers and hospital providers allowed for a more seamless transition between care settings and a high quality of care as described by the patients.

The nursing profession - and Certified Nurse-Midwives in particular - has collaborated with other professions involved in providing perinatal care to formulate guidelines related to the transfer of home birth patients to the hospital during intrapartum care. The Home Birth Summit, which took place in 2011, 2013, and 2014 in the U.S., brought together perinatal care providers from different practice settings in order to “address their shared responsibility for care of women who plan home births in the United States (p.1)” (Home Birth Summit, 2018). One of the documents to come out of this collaboration was *Best Practice Guidelines: Transfer from Planned Home Birth to Hospital* (2014). This set of guidelines was developed from other inter-professional groups’ recommendations on home to hospital transfer. For example, the MD/LM Workgroup, a subcommittee of the Washington State Perinatal Advisory Committee, is composed of members of the Washington State American College of Obstetricians and Gynecologists, the Midwives’ Association of Washington State, the Washington State Obstetrics Association, Public Health, and health systems representatives.

According to best practice recommendations, nurses have an important role in facilitating transfers from planned home birth to hospital. Protocols for non-life-threatening out-of-hospital transfers call for the obstetrical charge nurse or nursing supervisor to be the first person notified by the home birth care provider when the decision is made to transfer. This nurse, being the first member of the hospital staff to be notified, has the first chance to guide the collaboration across settings.

Collaboration across settings for women who have planned a home birth and then transfer to the hospital has suffered from misunderstanding, distrust, and bias against home birth (Rainey

et al., 2017). The American College of Obstetricians and Gynecologists [ACOG] addresses this unfortunate aspect of home to hospital transfer in its statement on home birth:

“When antepartum, intrapartum, or postpartum transfer of a woman from home to a hospital occurs, the receiving health care provider should maintain a nonjudgmental demeanor with regard to the woman and those individuals accompanying her to the hospital” (ACOG, 2017).

This statement indicates that not only have patients been subject to healthcare providers’ judgement, but the midwives and family members have been subjected to it as well. In this case, nurses have an opportunity to facilitate trust and open communication between the patient, her family, her home caregivers, and her hospital caregivers.

Discussion

The participants in this case study analysis described positive experiences with home-to-hospital transfers. The experiences illustrated the types of patient experiences that home-to-hospital transfer guidelines are designed to support. It was necessary for professional medical organizations to codify non-judgement in their best practice guidelines. In addition, both of the labor transfers were able to remain within the CNM scope of practice once the patient had transferred to the hospital. Keeping women who transfer from a home birth within the CNM model in the hospital, when possible, may be another way to facilitate communication and transfers. According to the home birth CNM in this study, data is being collected to investigate the number of transfers to this particular hospital, as well as the outcomes and incidences of CNM-led care (Anonymous/Protected, 2018).

Planned home birth to hospital transfers are a healthcare scenario in which patient agency interacts with healthcare system protocol. Communication and respect between home birth and

hospital providers was crucial to offering optimal patient care. It could be suggested that communication was enhanced in the cases presented here due to the home birth provider's credentials as a CNM who has worked in a hospital setting and is familiar with the policies and protocols there, as well as the cultural nuances of the medical environment. In other words, the CNM's social capital may have allowed her to more easily facilitate the transfer. The reason this matters is that most home birth midwives are not CNMs who have trained or worked in a hospital setting. Non-nurse midwives may not have the social capital to gain or maintain entry into the medical setting and facilitate optimal home-to-hospital transfers. This is an area for further research.

Patients' social capital in the medical setting is another area for further research, especially its relationship to maternal outcomes. Maternal outcomes have been under scrutiny in the U.S., as maternal mortality has risen in the past 30 years and there is a large racial disparity (CDC, 2017). To place this in context, the overall U.S. maternal mortality rate was 17.3 deaths per 100,000 births in 2013 (CDC, 2017). However, the rate was 12.7 deaths per 100,000 for white women and 43.5 deaths per 100,000 for black women (CDC, 2017). Recent studies have examined the link between this disparity and prenatal care utilization, including factors such as social context and racism in the conventional perinatal care system (Baudry, Gusman, Strang, Thomas, & Villarreal, 2018; Gadson, Akpovi, & Mehta, 2017). Social context and social capital was important for the white women in this study, but it is an important concern for women of color in the U.S. who are dying at a much higher rate within the maternal care system.

Conclusion

This paper describes planned home birth to hospital transfer from the perspective of women who chose home birth. The observations that they articulate illustrate a successful

collaborative transfer, as well as the challenges of changing the birth setting during the intrapartum period. Nurses are in an important role for facilitating home to hospital transfers and increasing respectful perinatal care.

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CHAPTER 6 : DISCUSSION AND SYNTHESIS

The grounded theory study that forms the basis of this dissertation describes the theoretical model and basic social process for choosing a home birth, *Deciding to Call the Shots*. *Deciding to Call the Shots* explained how women solved the problem of lack of agency in their perinatal care. The outcome of *Calling the Shots* was *Building a Shelter* for the birth. *Calling the Shots* was precipitated by awareness of an alternative perinatal care framework such as home birth. The confluence of *Awareness, Agency, and Shelter-Building* is the origin of *Deciding to Call the Shots*.

In this chapter, the study results will be discussed in terms of their relationship to and placement within the current home birth literature. The three manuscripts of the dissertation will be synthesized and their contribution to nursing science explained. Next, the findings will be examined alongside the theoretical framework of Emancipated Decision Making (Wittmann-Price, 2004; Wittmann-Price & Bhattacharya, 2008). Following that, the practice, policy, and research implications of this study will be explored. Finally, limitations of the study will be discussed.

Findings

The decision to plan a home birth is conceptualized as a three-part process that begins with *Awareness*, proceeds to *Agency*, and concludes with *Shelter-Building*. This section of the discussion will compare and contrast this conceptualization with the current home birth literature in order to demonstrate the integration of this study within the home birth literature.

Awareness. The concept of awareness in this study supports previous findings in the literature regarding the limited information available on birthing choices. Bernhard et al. (2014) found that many women were unaware of home birth before or during a first pregnancy, and that

the hospital was less of a choice than a default setting for birth. The catalyst for awareness of home birth was sometimes negative birth experiences, either the woman's own or those close to her (Boucher et al., 2009; Cheyney, 2008). Displeasure with institutionalized perinatal care, or, as Cheyney (2008) frames it, 'redefining authoritative knowledge', contributed to the information-seeking that led to realization of an alternative model.

Since this study focused on the decision-making process for choosing home birth, there was more evidence in the data of awareness as a separate category of decision-making, differentiating it from the previous literature (Boucher et al., 2009; Cheyney, 2008). In some cases, the moment of awareness was specifically described by the participants. For example, Betty picked up a copy of *Spiritual Midwifery* at a bookstore during her time as an undergraduate nursing student and realized that home birth existed (B.91-96). This moment of realization affected the rest of her nursing education as well as her decision to choose a home birth. For other participants, awareness came about later, even during a pregnancy. In all cases, the realization of home birth as a choice for perinatal care resonated with the woman.

Dissatisfaction with the conventional model of perinatal care was a primary motivating factor in awareness of an alternative model such as home birth. Lothian (2013) noted this finding, explaining that early negative experiences with conventional providers and settings led to the search for an alternative. Participants in this study had similar experiences with dissatisfaction. Both conventional and alternative perinatal care providers may be interested in exploring this finding further, as it seems to place the decision to choose home birth for some women as a reactionary decision rather than a pro-active decision. As such, home birth as a reactionary decision may have implications for quality improvement in conventional perinatal settings.

For the participants in this study, awareness of an alternative model of perinatal care was critical to the decision-making process. The socio-cultural norm for birth in the United States is hospital birth. Although there is a general cultural script for American birth - shaped by personal stories, books and other media, and the hospitals themselves through prenatal birthing classes – women also seem to be aware that there are deviations to this cultural script. For example, women are aware that there are choices within this model, such as whether or not to be induced for labor, whether or not to request pain relief, and whether or not to request a caesarean section. However, this is often where the awareness ends.

Awareness of the power structures that influence perinatal care is more difficult to cultivate amongst patients. Attanasio, Hardeman, Kozhimanni, and Kjerulff (2017) found that first-time mothers' opinions of vaginal birth were not associated with race or socioeconomic status. However, the opinions of white, highly educated, and privately insured women were the only opinions that translated directly to fewer caesarean sections. In other words, women with higher socio-cultural status seemed to benefit from increased agency in birth. The ability to influence birth outcomes is a component of social capital that the participants in this dissertation study were able to recognize and access through increased agency and shelter-building.

Awareness, as a concept, is not limited to an understanding that an alternative model of care exists. Awareness, as a more robust conceptualization in perinatal care, includes the acknowledgment that there are inherent structural barriers to agency in conventional perinatal care. These structural barriers include paternalism, racism, sexism, and other biases that shape conventional perinatal care (Rothman, 1991). Awareness for the women in this study seemed to arise from a realization that they had reached a point at which their agency in their perinatal care would end, or at least be severely curtailed.

Agency. Previous qualitative literature has conceptualized agency in home birth as empowerment, control, ‘resisting the system’, and ‘governing my birth’ (Bernhard et al., 2014; Boucher et al., 2009; Cheyney, 2008; Fleming, et al., 2017; Lothian, 2013). This study supports these previous findings and builds upon them by conceptualizing agency as having a defined antecedent, *Awareness*, and an outcome, *Shelter-Building*. In addition, a specific component of agency that was important in this group of participants was the desire to control attendance at the birth.

Other qualitative studies have discussed the phenomenon of controlling attendance, but this study found that it is a core concept of agency in birth (Chapter 4). Desire to control attendance at the birth is not just limited to the main provider but extends to all persons present at the birth. Women in this study specifically discussed the importance of weak social bonds and the possibility of the threat to their agency at the birth. For example, Karen explained, “...*you’ve maybe seen a midwife once or twice before, and you’ve never met any of the shift nurses on the [labor and delivery] floor.*” (772-775). While commonplace in institutional medical settings, the presence of ‘strangers’ at the labor and birth was one factor cited by participants in this study as a point of concern. This concern was important enough to prompt exit from the conventional care setting by some participants (Chapter 4), and therefore should be studied in further depth.

Understanding the role of unfamiliar persons’ attendance at women’s births and its effect on women’s agency could provide insight into power dynamics in the conventional perinatal care model. As Jane stated in this study, even if there is a stranger that you form a rapport with at your birth, “...*you have no choice over that [person’s attendance]*” (233). In addition, the social construct at a hospital birth is the birthing woman as a guest in an unfamiliar environment,

subject to the institutional social expectations and the social hierarchy of the institution. Barbara Katz Rothman (1991) describes this social hierarchy:

The hospital patient is in no position to be an equal participant in her birthing. She is outnumbered and overpowered. She may be allowed to act as if she were an equal participant, even bringing a patient advocate (husband, coach) with her, but should she stop playing by the rules and become disagreeable, difficult, or disruptive, as defined by the birth attendants, her true powerlessness is made clear. Her “advocate” is there only as long as the hospital attendants allow him to be there, only so long as he continues to coach the woman in accord with institutional rules. (p.176).

Feeling powerless and feeling as though there is a lack of choices to be made in perinatal care has been addressed in the home birth literature. Bernhard et al. (2014) conceptualized the lack of choice as the difference between ‘real choices’ and ‘perceived choices’ in the home and hospital care settings, respectively. ‘Perceived choices’ were described as care decisions that women were ‘allowed’ to make in the institutional setting, but which were actually a set of hospital protocols that one could either conform to or not. Whether or not the woman conformed to the protocols was unimportant – because either ‘choice’ left her feeling disempowered (Bernhard et al., 2014). Boucher et al. (2009) noted women’s desire for control over their treatment and care. Cheyney (2008) describes agency in detail, noting the subthemes of knowledge as power, empowerment in birth, and healing power. Fleming et al. (2017) describe perinatal agency as the ability to govern one’s own body during perinatal care.

Agency in perinatal care, like agency in any type of patient care, is an ethical imperative that is codified in section 1.4 of the American Nurses Association’s Code of Ethics (ANA, 2015). Specifically, the Code of Ethics indicates “[Patients] also have the right to accept, refuse, or

terminate treatment without deceit, undue influence, duress, coercion, or prejudice, and to be given necessary support throughout the decision-making and treatment process” (Provision 1.4, paragraph 1, lines 7-10). In this study, undue influence, duress, and lack of support were all cited as reasons for seeking an exit from conventional perinatal care (Chapter 4). In addition, the U.S. has a maternal mortality rate of 17.3/100,000 live births, which is higher than other high-income countries, which have rates of 3.8-9.2/100,000 live births (Centers for Disease Control, 2017; Kassebaum, 2016). Future research should explore the concept of patient agency as it relates to maternal outcomes in the U.S. healthcare system. In particular, research should focus on the agency of low income women, and women of color within the perinatal care system. Findings indicate that these two groups, when faced with negative interactions with conventional perinatal care providers, may opt out of perinatal care entirely (Baudry et al., 2018) rather than seeking an alternative model of care like the participants in this study. Gadson et al. (2017) state, “While distrust of the health care system has not been studied in the prenatal or obstetric context, it may be an important additional mediator in the relationship between utilization and outcomes for those at risk of disparities” (p.312). Distrust of the healthcare system was described by the women in this study (Chapter 4), but they possessed the necessary social capital to exercise their agency by moving to an alternative care setting. For those with less social capital, there may not be an alternative path to perinatal care, and some women may choose to exercise their agency by choosing to disengage with perinatal care. Exploration of the phenomenon of missed care due to conventional perinatal system exit related to distrust should be a topic of future research.

Obvious examples of patriarchal biomedical opinion related to agency continue to be published in major medical journals such as the American Journal of Obstetrics and Gynecology (AJOG). One such example debates the limits of women’s agency within perinatal care.

Chervenak, McCullough, and Brent (2011) suggest that prioritizing either the rights of the mother or fetus is too simplistic and propose a model of ‘professional responsibility’ for perinatal care that rejects either the woman or the fetus as having primary ethical consideration. Instead, they suggest a model that foregrounds medical science and professional clinical care.

Chervenak, McCullough, and Brent (2011) state “The result is that responsible medical care overrides the extremes of clashing rights” (p.315.e1). Having the right to patient autonomy overridden by the medical profession is exactly what the women in this study were attempting to avoid when they exited the conventional perinatal care system.

The same authors were part of a group that wrote an additional opinion piece in ACOG (Chervenak, McCullough, Brent, Levene, & Arabin, 2013) specifically citing planned home birth as an example where the ‘professional responsibility model’ should be employed: “In summary, from the perspective of the professional responsibility model, insistence on implementing the unconstrained rights of the pregnant woman to control the birth location is an ethical error and therefore has no place in professional perinatal medicine.” (p.35). The piece also encourages physicians not to participate or recommend patients to randomized controlled trials on home birth safety because “...fetal and neonatal patients are vulnerable subjects of research because they are incapable of consent and therefore cannot protect themselves.” (p.36). The implications of this rationale underscore the patriarchal attitudes that continue to pervade the medical model.

Shelter-Building. This study found that social and emotional shelter-building were the sequela of deciding to call the shots. Some of the primary components of shelter-building were 1-hour prenatal appointments, family-centered care, shared decision-making, favorable attitudes towards pregnancy and birth, and support through social networks. All of the components of building a shelter were related to the relationship between the woman with her midwife. This

supports other findings in the qualitative literature about home birth that describe the process in which women establish a trusting relationship with their home birth midwife. Bernhard et al. (2014) note this in their study as ‘connection’ with the provider, from which the home birth women derived comfort and security for pregnancy and birth. Connection is cultivated over the duration of the pregnancy. Cheyney (2008) explores intimacy and trust as prerequisites for women to feel emotionally safe through the work of labor, and Fleming et al. (2017) use the description ‘building a nest’ to discuss the process of preparing for a home birth. Lothian (2013) found that having a socially and emotionally sheltered place to give birth offered protection, privacy, and safety, which was the overarching goal for the women in her study.

Role of Manuscripts

The three manuscripts in this dissertation contribute to the body of literature on home birth and the study of patient decision-making by addressing several gaps in knowledge. The qualitative synthesis manuscript takes a critical view of the current literature in the U.S. There is an absence of high-quality and rigorous qualitative literature on home birth, and the state of the science has not recently been updated. Home birth is an extremely small, specialized, and highly nuanced component of the perinatal care system in the U.S. and therefore is especially suited to qualitative research methods.

The grounded theory study on home birth in Chapter four of this dissertation is an example of the type of research that has not yet been conducted. This study addresses the decision-making process and has implications for understanding the motivation for choosing home birth in the U.S. It serves to link home birth and conventional perinatal care resources in understanding the rationale behind the decision to have a home birth. Increased understanding is integral to improving communication, safety outcomes, and overall perinatal care.

Improvement in care is the goal of the case study policy manuscript. There is a lack of understanding and a negative impression of home birth in the conventional setting, mostly based on ‘horror stories’ about home birth transfers rather than actual experiences with home-to-hospital transfers (Rainey et al., 2017). The last decade has seen perinatal care providers come together and address home-to-hospital transfer safety through the development of best practice guidelines (Vedam et al., 2014). Building on this literature, the case study policy manuscript serves to examine the best practice guidelines within the context of three home-to-hospital transfers that adhered to the guidelines. This manuscript is an illustration of how home-to-hospital transfers can transpire within the U.S. setting – non-emergent and within the scope of CNMs.

Theoretical Framework

The results of this study offer a way to interpret the Wittmann-Price Theory of Emancipated Decision-Making (EDM) in terms of choosing home birth care for the perinatal period. The decision to have a home birth could be considered an example of an emancipated decision in women’s healthcare. In particular, EDM (Wittmann-Price & Price, 2014) posits that oppression must first be acknowledged as an influence on decision-making insofar as “one option is socially sanctioned as superior to the remainder of the options, thereby imposing personal and social implications if an alternative route is chosen” (p.362). Participants discussed the social sanctions placed upon them in the form of disapproval and lack of insurance coverage for home birth.

EDM identifies three criteria that contribute to an emancipated decision: awareness of social norms, flexible environment, and personal knowledge. The participants in this study were aware that planned hospital birth was the choice that was most socially acceptable. Participants

discussed their strategies for avoiding conversations with those who would express social condemnation of home birth. Part of *Deciding to Call the Shots* was confronting that awareness and inhabiting a flexible environment – creating one if no such environment existed. New and existing social networks, carefully vetted for a non-judgmental attitude toward home birth, were cultivated during pregnancy. EDM theory considers the flexible environment vital to being able to enact a choice – in this case, home birth. Personal knowledge was highly valued by the participants in this study and valued by the home birth midwife. As stated earlier, the woman and her home birth midwife both considered the woman an expert on herself. This expertise not only allows for emancipated decision-making, but as a legitimized source of information in the home birth perinatal care setting.

Home birth decision-making departs from EDM in terms of the economic sanctions placed upon it by the healthcare insurance system in most parts of the U.S. As it is an economic choice, it is not entirely free of oppression. Many participants in the study cited the cost of home birth as a factor, even though all of the participants carried public or private health insurance. In contrast with other examples of women's healthcare decisions that have been evaluated under EDM, such as infant feeding decisions or pain management in labor, home birth requires an additional economic consideration. In other areas of the country where home birth is more widely covered by insurance, such as the Pacific Northwest, it may be more appropriate to apply EDM to home birth as a social decision.

Implications

Practice

This study has several implications for practice, both for nurses and other healthcare providers seeking to understand the decision-making process for women who choose home birth.

The women in this study described specific examples of instances in conventional perinatal care where their needs as patients were not met. Providers of conventional perinatal healthcare can utilize the results of this study to form a better understanding of the rejection of conventional perinatal care. For example, Stoll, Fairbrother, and Thordarson (2018) found that women who planned home births reported a higher fear of medical interventions during birth, including caesarean sections, than an overall fear of giving birth. Fear of medical interventions and the desire to avoid medical interventions is consistent with the findings of this study and other qualitative studies of women who choose home birth (Boucher et al., 2009).

Women in this sample expressed a desire for shared decision-making in perinatal care, including an active role in information-gathering and investigation of alternatives to conventional care. Perinatal care providers should consider the benefits of shared decision-making, not only as an exercise in patient education, but as a trust-building activity that could lead to a more meaningful dialogue with patients. In home birth, the patient is recognized as a creator of knowledge as well as an expert on their own experience.

Research

Future research should include the exploration of why home birth resonates so strongly with some women and not at all in others. Researchers have determined that some women are more fearful of medical interventions during birth than the birth itself (Stoll et al., 2018). It is possible that this group who fears medical interventions may gravitate towards hospital midwifery or home birth midwifery care, but this will require further research.

The role of trust and respect in perinatal care must be explored in much greater detail, especially in vulnerable populations in the U.S. Racial disparities in maternal and infant mortality rates demand more research on institutional variables - including provider biases and

power differentials - that may influence birth outcomes for mothers and babies. While this study did not examine race as an aspect of care, the overall absence of women of color in home birth settings indicates a possible disparity in the opportunity to choose home birth. The increase in the percentage of home births from 2004-2014 is overwhelmingly due to an increase in home birth by non-Hispanic white women – an 88 percent increase versus a 20 percent increase for non-Hispanic black women (MacDorman & Declercq, 2016).

Limitations

Sample

The sample for this study was small (n=11) and homogenous. It was composed exclusively of women who identified racially as white and had at least a bachelor's degree. Nine of the 11 women had private health insurance. All of the women were married or partnered. The combination of these demographic factors placed this sample of women within the highest of socioeconomic categories in the United States hierarchy. This is acknowledged as a limitation of the study due to the absence of women of color and women who are differently abled, and a low percentage of economically disadvantaged women. Self-selection increased the possibility that some groups of women who choose home birth would not be reached due to structural barriers, individual barriers, and personal preferences. Self-selection may have also increased the number of women with very positive home birth experiences.

One Midwifery Practice

The sample for this study was recruited from a single CNM home birth midwifery practice. Although the participants had experienced care both with other home birth midwives and hospital-based providers, they all had one CNM in common. This is acknowledged as a limitation of the study due to the similar experiences that the women had with the CNM who

provided at least one aspect of their total history of perinatal care. Future studies would seek to recruit women with other home birth CNMs, as well as other categories of home birth perinatal care providers.

Amish and Other Rural Home Birth

There is a large population of Amish and Mennonite women in Wisconsin (WI DHS, 2017) who choose home birth and could account for disproportionately rural makeup of the home birth population (DeClercq & Stotland, 2017). This population was not accessible during this study for two reasons. First, Amish women are known to be attended by non-nurse midwives for the majority of births, placing them beyond the scope of this study. Second, the separation afforded by Amish culture makes it a difficult population to access for research purposes. It was beyond the scope of this study to approach this population. However, it is acknowledged that a portion of the home birth population in Wisconsin belongs to a conservative religious sect that was not captured in this study.

United States Literature

It was the intent of this study to examine the decision-making process for home birth in the United States. The U.S. healthcare system has a unique set of factors that make it difficult to compare home birth decision-making with other countries. These factors include (a) health insurance availability and regulation, (b) regional social acceptance or dismissal of home birth, (c) differences in midwifery education, scope of practice, and licensing, (d) regional differences in home-to-hospital transfer integration. For these reasons, the literature utilized for the qualitative analysis and comparison is all U.S.-based research.

It should be noted that the participants in this study, as in other home birth studies, cited safety literature from European countries. There has only recently been research that aims to

form a system of comparison for home-to-hospital transfers across international territories (Comeau et al., 2018). Comeau et al. found that home birth integration is limited to Washington State in the U.S. The goal of standardizing the measurement of home birth integration is to increase the relevance of cross-national home birth outcomes studies. At this time, home birth outcomes studies from other countries are not as applicable to U.S. home birth due mainly to regional differences in home birth integration with conventional perinatal care in the U.S.

Comeau et al. (2018) address the problem of disparate international perinatal care systems, including home birth care, being compared in the literature. One of the main arguments among perinatal care professionals, both opposed to and in favor of home birth, is whether or not home birth safety outcomes from Canadian or European countries are applicable to the U.S. healthcare system. Using criteria such as recognition of home birth providers, training of midwives, ease of transfer from home to hospital, and the legal ability to carry emergency equipment to home births, Comeau et al. sought to create a system of comparison for home birth integration into the larger systems of healthcare, despite variation across countries. Since home births account for such a small percentage of overall births in the U.S. and elsewhere, the ability of this research to provide a common comparison is moving the process of outcomes evidence-gathering forward.

Conclusion

The purpose of this dissertation was to explore the decision-making process for women who plan a home birth. Home is an unconventional setting for birth in the United States, and this dissertation investigated the perceptions of the women and families who chose home birth to develop a substantive theoretical explanation. By examining the process of decision-making for home birth, insight was gained about patient perceptions of exercising agency as well as

perinatal care both at home and in conventional settings. This study may serve as a reference for healthcare providers who wish to gain a deeper understanding of women who choose home birth.

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APPENDIX A: Quality Appraisal Using the CASP Qualitative Research Checklist

	Bernhard <i>et al.</i> (Bernhard <i>et al.</i> , 2014b)	Boucher <i>et al.</i> (Boucher <i>et al.</i> , 2009b)	Cheyney (Cheyney, 2008)	Cheyney (Cheyney, 2011)	Farrish & Robertson (2014)	Fleming <i>et al.</i> (Fleming <i>et al.</i> , 2016)	Klassen (2001)	Lothian (Lothian, 2013b)	Merg & Carmoney (2012)
1. Was there a clear statement of the aims of the research?	Yes.	Yes.	Yes.	Yes.	Yes.	Yes.	Yes.	Yes.	Yes.
2. Is a qualitative methodology appropriate?	Yes.	Yes.	Yes.	Yes.	Yes.	Yes.	Yes.	Yes.	Yes.
3. Was the research design appropriate to address the aims of the question?	Yes. Exploratory	Can't tell. Examination of decision. Secondary analysis.	Yes. Examine processes and motivations.	Yes. To describe an experience.	Yes. Investigate and analyze from an Afro/Afri-centric sociological perspective.	Yes. Exploration and meaning construction	Can't tell. Research Design not discussed.	Yes.	Yes.
4. Was the recruitment strategy appropriate to the aims of the research?	Yes. No discussions around recruitment. Purposeful sample may have actually been convenience sample.	Yes.	Yes.	Can't tell. Participant selection and recruitment not discussed.	Yes. Inclusion and exclusion criteria not explicitly discussed.	Yes.	Yes.	Yes.	No. One of the researchers contributed data to the study.
5. Was the data collected in a way that addressed the research issue?	Yes. Setting not justified.	Can't tell. Internet survey and secondary analysis.	Yes. Setting not justified.	Yes. Saturation not discussed.	Can't tell. It is unclear how and where the interviews took place and whether the interviews were recorded and transcribed.	Yes.	Yes. Methods not justified. Data collection occurred in the mid-nineties.	Yes.	No. One of the researchers contributed data to the study.
6. Has the relationship between the researcher and participants been adequately considered?	Can't tell. Biases unexamined.	No.	Can't tell. Author is CPM, but this is not discussed.	Can't tell. Bias not discussed. Author is CPM, but this is only discussed in terms of access to the population.	Can't tell. There was no discussion of the relationship between the researcher and participants. No discussion of bias.	Yes. Roles discussed, but relationship to participants not discussed.	Can't tell. Influence is discussed, but not bias.	Yes.	No. One of the researchers contributed data to the study.
7. Have ethical issues been taken into consideration?	Yes. Data security not addressed.	Yes. Consent not addressed.	Yes. Consent and confidentiality not addressed.	Yes. Consent and confidentiality not discussed.	Can't tell. IRB approval not discussed. Consent procedures not addressed.	Yes. Data security not discussed.	Can't tell. IRB approval not discussed. Consent procedures not discussed.	Yes. Consent procedure not discussed.	No. IRB approval not discussed. One of the researchers contributed data to the study.

8. Was the data analysis sufficiently rigorous?	Can't tell. Description of analysis process is not in-depth. It is not clear how the themes were derived from the data. No discussion of contradictory data. Biases not examined.	Yes.	Can't tell. It is not clear how the themes were derived from the data. No contradictory findings discussed. Potential bias not addressed.	Can't tell. It is unclear how themes were derived. Contradictory evidence not described. Biases not examined.	Can't tell. It is unclear how the themes were derived from the data. Small amount of data presented in the findings. Contradictory evidence not discussed, although it was hinted at in the introduction.	Yes.	Can't tell. Analysis process not described in depth. Bias not examined.	Yes. Contradictory evidence not discussed.	Can't tell.
9. Is there a clear statement of the findings?	Yes. No discussion of contradictory evidence.	Yes.	Yes.	Yes.	Yes. Credibility not discussed.	Yes. Validity discussed abstractly.	Yes. Credibility not addressed.	Yes.	Yes. Credibility in question.
10. How valuable is the research?	+	+/-	+	+	+/-	+	+/-	+	o
Rating	Good	Average	Good	Good	Excluded	Good	Excluded	Good +	Excluded

APPENDIX B: Data Abstraction for Qualitative Synthesis

Authors	Aims/Objectives	Design	Setting and Country	Participants	Data Collection Method	Analysis Strategy	Findings	Strengths & Weaknesses
Bernhard <i>et al.</i> (Bernhard et al., 2014b)	To explore the reasons why these women chose home birth and their perceptions regarding their experiences.	Qualitative descriptive.	Southwestern Michigan, USA	n = 20 women with a hospital birth followed by a home birth in the past 10 years	Focus Groups	Qualitative content analysis. Member checking.	5 themes: choice and empowerment; interventions and interruptions; disrespect and dismissal; birth space; connection	<p>Multiple researchers performed the qualitative analysis for themes and agreed on saturation. Member checking was utilized. Participants had the experience of both home and hospital births.</p> <p>The relationship between the researcher and the participants was not adequately explained and researcher biases were not explored. Lack of description of the qualitative analysis process.</p>
Boucher <i>et al.</i> (Boucher et al., 2009b)	To describe the reasons why women choose home birth.	Qualitative descriptive. Framework: Leninger's cultural care diversity and universality theory	The Internet, USA	n = 160 women who were U.S. residents and planned at least one home birth	Internet Survey Essay Question Response	Qualitative description as described by Sandelowski.	26 themes, 5 most common discussed. Safety and better outcomes; intervention-free; negative previous hospital experience; control; comfortable environment	<p>Multiple researchers engaged in the analysis process, which included 508 separate statements. Tables displayed all 26 themes and frequencies.</p> <p>The conceptual framework had to do with cultural care diversity, but the sample was mostly white. The study was secondary analysis of an essay question, but the placement of this question in the initial survey was not discussed, so it is unknown if this was a thoughtful research design. The relationship</p>

								between the participants and researchers was not discussed. The setting was the internet, and the participants were a self-selected convenience sample.
Cheyney(Cheyney, 2008)	To examine the processes and motivations involved when women in the U.S. choose to have a home birth.	Modified grounded theory.	Phase 1: Pacific Northwest college town Phase 2: Midwestern college town	n = 50 women who received perinatal care with direct-entry midwives	Open-ended, semi-structured interviews and participant observation	Ethnography and member checking.	Three themes with subthemes: redefining authoritative knowledge; embodying personal power/agency; creating connection/intimacy in the birthplace	Large study with many participants for in-depth interviews and observations. Medical anthropology framework. Detailed theoretical underpinnings. The researcher is a CPM, but did not discuss her role and/or biases. Consent and confidentiality are not discussed. There was some ambiguity about theme derivation and data presentation. No contradictory evidence presented.
Cheyney(M. Cheyney, 2011)	To describe the roles ritual plays in the construction, performance, and maintenance of birth at home as a transgressive rite of passage.	Prospective, modified grounded theory.	Northwest and Midwest USA	n = 50 home birthing mothers	Open-ended, semi-structured interviews and participant observation	Thematic and narrative analysis	Home birth is "intentionally manipulated rituals of technocratic subversion designed to reinscribe pregnant bodies and to reterritorialize childbirth spaces and authorities" (p.520)	Large study with many participants and several geographic areas. Author's CPM status allowed for in-depth observation. Medical anthropology framework and theoretical underpinnings. Author biases not discussed, and some details about the collection and analysis of data were not thoroughly explained. Consent and confidentiality only briefly discussed.

<p>Fleming <i>et al.</i> (S. Fleming, Healy, M., Severtsen, B., and Donovan-Batson, C., 2017)</p>	<p>To explore and construct meaning from experiences of planned home births that took place in Washington State</p>	<p>Heideggerian Phenomenology</p>	<p>Washington State, USA</p>	<p>n = 9 childbearing women with at least one home birth between 2010 and 2014</p>	<p>One-to-one in-depth Interviews</p>	<p>Heideggerian Phenomenological Analysis</p>	<p>One pattern: 'Striking a Balance...' and 4 Themes: 'Building a Nest...', 'Providing a Safe Passage...', 'Resisting the System...', and 'Governing My Birth...'</p>	<p>Well-structured study with thorough philosophical framework and analysis techniques. Recruitment and relationships not discussed in detail. Small sample with limited data presented. Data security not discussed. Validity referred to in passing even though credibility was sufficient.</p>
<p>Lothian (Lothian, 2013b)</p>	<p>To describe women's experiences of planning, preparing for, and having a home birth. Research question: How do women in the U.S. make the decision to have a planned home birth within the context of the current U.S. maternity care system and the controversies that swirl around it?</p>	<p>Qualitative ethnographic.</p>	<p>Very Large City in the Northeast, USA</p>	<p>n = 13 women who were planning a home birth</p>	<p>Informal interviews and observations</p>	<p>Codes, categories, and themes (thematic analysis)</p>	<p>Central theme of 'being safe', with four sub-themes: avoiding technological birth interventions, knowing the midwife and the midwife knowing them, feeling comfortable and protected at home, and knowing that backup medical care was available.</p>	<p>Technically superior qualitative methods. Findings are described in detail with lots of supporting evidence. Power dynamics are addressed, and the relationship and biases of the researcher were discussed in-depth. Reflexive journaling utilized. Contradictory data not discussed. Limitations not discussed, such as single researcher analyst.</p>

APPENDIX C: Institutional Review Board Approval Letter



Melissa Spadanuda
IRB Manager
Institutional Review Board
Engelmann 270
P. O. Box 413
Milwaukee, WI 53201-0413
(414) 229-3173 phone
(414) 229-6729 fax

New Study - Notice of IRB Exempt Status

Date: October 11, 2017

To: Jennifer Doering, PhD
Dept: College of Nursing

Cc: Jessica Coburn

IRB #: 18.071
Title: Staying Home for Birth

<http://www.irb.uwm.edu>
spadanud@uwm.edu

After review of your research protocol by the University of Wisconsin – Milwaukee Institutional Review Board, your protocol has been granted Exempt Status under **Category 2** as governed by 45 CFR 46.101(b).

This protocol has been approved as exempt for three years and IRB approval will expire on **October 10, 2020**. If you plan to continue any research related activities (e.g., enrollment of subjects, study interventions, data analysis, etc.) past the date of IRB expiration, please respond to the IRB's status request that will be sent by email approximately two weeks before the expiration date. If the study is closed or completed before the IRB expiration date, you may notify the IRB by sending an email to irbinfo@uwm.edu with the study number and the status, so we can keep our study records accurate.

Any proposed changes to the protocol must be reviewed by the IRB before implementation, unless the change is specifically necessary to eliminate apparent immediate hazards to the subjects. The principal investigator is responsible for adhering to the policies and guidelines set forth by the UWM IRB, maintaining proper documentation of study records and promptly reporting to the IRB any adverse events which require reporting. The principal investigator is also responsible for ensuring that all study staff receive appropriate training in the ethical guidelines of conducting human subjects research.

As Principal Investigator, it is also your responsibility to adhere to UWM and UW System Policies, and any applicable state and federal laws governing activities which are independent of IRB review/approval (e.g., [FERPA](#), [Radiation Safety](#), [UWM Data Security](#), [UW System policy on Prizes, Awards and Gifts](#), state gambling laws, etc.). When conducting research at institutions outside of UWM, be sure to obtain permission and/or approval as required by their policies.

Contact the IRB office if you have any further questions. Thank you for your cooperation and best wishes for a successful project

Respectfully,

Melissa C. Spadanuda
IRB Manager

APPENDIX E: Eligibility Determination Script

Thank you so much for your interest in my study about home birth. To make sure that you qualify for the study, I have a couple of questions for you.

1. Are you a woman 18 years or older? **Yes/No**
2. Have you had, or planned to have, a home birth within the past 10 years? **Yes/No**
3. Was your healthcare provider a Certified Nurse Midwife? **Yes/No**

If the potential participant answers 'Yes' to all three questions:

Thank you. You are eligible to be in this study. If you join, you will be asked to fill in a demographic questionnaire and participate in an approximately 90-minute audio-recorded interview in a place that is convenient for you. I will be conducting the interview about the decision to have a home birth. Would you like to hear more about the study? [If yes, discuss consent form over the phone and ask if interested in doing an interview. If yes to interview, consent will be obtained at interview.] I can go over the consent process now, and I will also go over it in more detail when we meet for the interview.

If the participant answers 'No' to any of the questions:

Thank you for your interest in the study. Unfortunately, you do not qualify for this study.

APPENDIX F: Initial Interview Questionnaire

Participant Identification Number/Pseudonym:

Interview Site:

Date:

Start Time:

End Time:

Interview Guide

Thank you so much for meeting with me today and participating in my study. I am doing this research as part of my PhD education as a nurse. Nurses study all the different parts of healthcare and how all those parts affect our patients. One of the things I am interested in is how women seek and use different kinds of healthcare and how women find ways to have a home birth - which is what this study is about. The information that you share with me could help to make pregnancy healthcare better and help nurses to understand more about what women value about healthcare.

In this interview, you will be doing most of the talking. I just want to let you know that at the beginning. The reason I will not talk as much is so that I can give you the chance to express your ideas about seeking and choosing home birth. The interview will take about one and a half hours and I will be recording it so that I don't miss anything. I may take notes while you are talking so that I remember things to listen to later. You do not have to answer any questions that you do not want to answer. Do you have any questions for me? Are you ready to begin?

1. Can you tell me about where you gave birth to each of your children?
2. Can you tell me about the process of deciding on a home birth? What was it like to make that decision?
3. Can you talk about the factors and influences that were important for your pregnancy and birth care? To your partner?
4. What are some of the things that made it difficult to have a home birth?
 - a. (If she did not have a home birth) Can you tell me about the decision not to have a home birth? What was that like? [Skip to Question 8]

5. What are some of the things that made it easy to have a home birth?
6. If you shared your home birth plans with others, can you describe the reactions that you got?
7. Did you share your plans for a home birth with any medical care providers? If so, can you describe what that was like?
8. If you could talk to midwives, doctors, and nurses, hospital administrators, the mayor of [city], the governor of [State], or Congress, what would you tell them about getting pregnancy care? What would your ideas be to make it easier for women like you?
9. "Is there anything else you would like to tell me about planning to have (or having) a home birth?"

That is the end of our interview. I will turn off the recorder now. Thank you so much for talking to me today about these questions. I am so pleased to have you in my study.

APPENDIX G: Demographic Questionnaire

1. What is your age?
 - a. 18-24
 - b. 25-30
 - c. 30-40
 - d. 40-54

2. Racial and/or ethnicity identification:
 - a. American Indian/Alaskan Native
 - b. Asian
 - c. Bi-racial or Multiracial _____
 - d. Black or African-American
 - e. Hispanic or Latino
 - f. Native Hawaiian or Other Pacific Islander
 - g. None/I don't identify with any
 - h. White

3. What is your income level?
 - a. Comfortable
 - b. Less than Comfortable
 - c. More than Comfortable
 - d. Uncomfortable
 - e. Extremely Comfortable

4. What is your relationship status?
 - a. Single
 - b. Married or Partnered
 - c. Divorced or Separated
 - d. Widowed
 - e. Other: _____

5. Are you a caregiver to others?
 - a. Children # _____
 - b. Parent(s)
 - c. Other Family Members
 - d. Friend/Other

6. What is your education level?
 - a. Some High School
 - b. High School or GED
 - c. Some College
 - d. College Graduate
 - e. Graduate Degree (master's degree or doctorate)

7. Do you have health insurance?
 - a. Yes: Public? Private?
 - b. No

APPENDIX H: UW-M Consent to Participate in Interview Research

Study Title: Staying Home for Birth: A Grounded Theory Study
IRB Protocol # 18.071 Expires 10/10/2020

Person Responsible for Research: Dr. Jennifer Doering, PhD, RN and Jessica Coburn MSN, RN, CNL

Study Description: The purpose of this research study is to explore the decision-making process surrounding home birth. Approximately 20 subjects will participate in this study. If you agree to participate, you will be asked to participate in an interview. During this interview, you will be asked questions about the decision-making process for home birth. This will take approximately 1-2 hours of your time. The interview will take place in a private location and it will be audio recorded.

Risks / Benefits: Risks that you may experience from participating are considered minimal. There are no costs for participating. There are no benefits to you other than to further research.

Confidentiality: During the interview your name will not be used. A pseudonym will be used for this study. You can choose a pseudonym or one can be chosen for you. Your responses will be treated as confidential and any use of your name and or identifying information about anyone else will be removed during the transcription process so that the transcript of our conversation is de-identified. All study results will be reported without identifying information so that no one viewing the results will ever be able to match you with your responses. Direct quotes may be used in publications or presentations. Data from this study will be encrypted and saved on a password-protected computer in a locked room for one year. Only the student primary investigator, Jessica Coburn, will have access to your information. However, project sponsor Jennifer Doering, the Institutional Review Board at UW-Milwaukee or appropriate federal agencies like the Office for Human Research Protections may review this study's records. Audio recordings will be destroyed at the conclusion of the study, on or before May 20, 2018.

Voluntary Participation: Your participation in this study is voluntary. You may choose not to take part in this study, or if you decide to take part, you can change your mind later and withdraw from the study. You are free to not answer any questions or withdraw at any time. Your decision will not change any present or future relationships with the University of Wisconsin Milwaukee. The alternatives to participating in this study include. There are no known alternatives available to participating in this research study other than not taking part.

Who do I contact for questions about the study: For more information about the study or study procedures, contact Jessica Coburn at jlcoburn@uwm.edu.

Who do I contact for questions about my rights or complaints towards my treatment as a research subject? Contact the UWM IRB at 414-229-3173 or irbinfo@uwm.edu.

Research Subject's Consent to Participate in Research:

To voluntarily agree to take part in this study, you must be 18 years of age or older. By signing the consent form, you are giving your consent to voluntarily participate in this research project.

Printed Name of Subject/Legally Authorized Representative

Signature of Subject/Legally Authorized Representative

Date

I give permission for my voice to be audio recorded: (initial yes or no) _____ Yes _____ No

Curriculum Vitae

Jessica Coburn

May 2018

EDUCATION

- Ph.D. College of Nursing, University of Wisconsin, Milwaukee, 2018
Dissertation: Deciding to Call the Shots: Awareness, Agency, and Shelter-Building in Home Birth Planning
- M.S.N. College of Nursing, Marquette University, Milwaukee, 2014
- R.N. College of Nursing, Marquette University, Milwaukee, 2011
- M.L.S. Center for 21st Century Studies, University of Wisconsin, Milwaukee, 2006
- B.A. Department of Sociology, University of Wisconsin, Whitewater, 1999

TEACHING EXPERIENCE

2018 UW-Milwaukee Clinical Instructor, Population Health, Aurora Sinai Medical Center

PUBLICATIONS

Submitted to *Birth: Issues in Perinatal Care*

Planned Home Birth in the United States: A Qualitative Synthesis (journal article)

In Preparation

Deciding on Home Birth: A Grounded Theory Study (journal article)

Home to Hospital Transfer: What Can Home Birth Teach Us? (journal article)

AWARDS AND HONORS

- 2016 Chancellor's Graduate Student Award, University of Wisconsin - Milwaukee
- 2015 Chancellor's Graduate Student Award, University of Wisconsin - Milwaukee
- 2014 Chancellor's Graduate Student Award, University of Wisconsin - Milwaukee

PROFESSIONAL TALKS

- 2017 "Introduction: Nursing Legislative Priorities in Wisconsin", Wisconsin Nurses Association, Green Bay, WI, October 20th
- 2014 "A Nurse's Guide to the Affordable Care Act", Wisconsin Public Health Association, Statewide Webinar, March 31st
- 2014 "A Nurse's Guide to the Affordable Care Act", Wisconsin Nurses Association Nurses Day at the Capitol, Madison, WI, March 3rd

- 2014 “Update From Wisconsin on Nurses and the Affordable Care Act”, U.S. Department of Health and Human Services, Nationwide Conference Call, January 23rd
2014 “A Nurse’s Guide to the Affordable Care Act”, Meriter Hospital, Madison, WI, November 27th

CONFERENCE ACTIVITY

Posters Presented

- 2018 “Planned Home Birth in the United States: A Qualitative Synthesis” American College of Nurse-Midwives Annual Meeting and Conference, Savannah, GA, May 20-24

PROFESSIONAL SERVICE

- 2016-present Wisconsin Nurses Association Public Policy Committee
2016-2017 Co-Chair of the Wisconsin Nurses Association Public Policy Committee
2013-2014 Co-Chair of the Wisconsin Nurses Association Affordable Care Act Task Force

RELATED PROFESSIONAL SKILLS

- 2011-present Registered Nurse, Wisconsin State Board of Nursing License 179921-30

INTERNSHIPS

- 2013-2014 Public Policy Intern at the Wisconsin Nurses Association, Madison, WI
2013-2014 Public Health Nurse Administration Intern at the Jefferson County Health Department, Jefferson, WI

PROFESSIONAL MEMBERSHIPS

- American College of Nurse Midwives, 2018-present
Midwest Nursing Research Society, 2015-present
American Public Health Association, 2015-present
Sigma Theta Tau International, 2013-present
Wisconsin Nurses Association, 2011-present
American Nurses Association, 2011-present