ALTERNATIVES TO THE MEDICAL MODEL OF CHILDBIRTH: A QUALITATIVE STUDY OF USER-CENTRED MATERNITY CARE

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THESIS SUMMARY

This thesis sets out to explore some important gaps in the sociological and feminist understanding of the provision of maternity care and of women's health needs.

The research was concerned with an exploration of the implementation of proposals for the provision of user-centred maternity care which emerged from the critiques of current medicalised provision. It evaluates the effects of an attempt to provide user-centred maternity care within the Primary Health Care sector (PHC) from both the women's and workers' perspectives and experience.

The central questions addressed within the research have been: Firstly, to assess the degree to which such models of service delivery provide a user centred approach. Secondly, to identify the form of the relationship between the women users and providers from the practices and to develop an understanding of the mechanisms of interaction between them. Thirdly, to explore the extent to which the provision of such care is appropriate to match women users' self identified needs. Finally, to assess the potential of female health workers to adopt a form of provider and user relationship where the balance of power is altered in the users' favour.

The main body of the research consisted of a qualitative study conducted in two general practices. These were chosen as specific examples of innovative practices attempting to provide a genuinely user-centred maternity service. The fieldwork consisted of three methodological components:
Firstly, unstructured interviews were conducted with women users and workers. A sample of 30 women who were pregnant for the first time were interviewed on three occasions during their pregnancy and in the immediate post-natal period. In addition, 10 second time mothers were also interviewed post-natally. In terms of the workers', in-depth interviews were conducted with midwives, GPs and practice nurses within the PHC setting.
Secondly, observations were undertaken on the interactions between the women and workers and between members of the PHC team during the course of the women's ante-natal and post-natal care.
Finally, a structured questionnaire was used with a sample of women from one of the practice's well woman clinic.

The research findings indicate the existence of a user-centred frame of reference held by female health workers - especially the midwives - for the provision of health care to women, which was opposed to the medical model. It explores the translation into practice of this model of maternity care and identifies the way that it functioned to enable women to exercise greater control over their health care and experience of pregnancy. Within this model the traditional 'with woman' role of the midwife was found to be central. Considerable convergence was found between the models held by the main parties in the interaction - issues concerned with choice, control and the provision of information were all found to be central to the care provided and to women's and workers' models.
However, constraints on the effective implementation of the model were found in terms of the influence of professionalism (particularly on the GPs) and the dominance of the hospital system. These resulted in limits to the women workers' ability to meet the needs of women users.

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CHAPTER ONE - INTRODUCTION

This thesis set out to address some important gaps in the sociological and feminist understanding of the provision of maternity care and of women's health needs.

During the first half of the 1980's feminist work was undertaken notably by Oakley (1980, 1984a, 1984b) and Graham and Oakley (1981) which identified the divergence between medical and maternal perspectives towards reproduction and the most appropriate management of childbirth.

Feminist debate within the sociology of reproduction has during the past five years, predominantly moved into new areas, particularly those concerned with the impact of changes within reproductive technology (for example see Stanworth 1987). However feminist research has not addressed certain key theoretical and empirical questions which the findings of the earlier studies raised.

In the United States studies which evaluated the impact of lay-midwifery and alternative forms of provision to the medical model were undertaken (Peterson 1983, Rothman 1983, Weitz and Sullivan 1985). However in the UK analysis of the role women users and women providers and particularly female dominated professions play in the possible construction of an alternative form of relationship where the balance of power is altered in the users' favour remained a notable gap in the sociology of childbirth and maternity care. While feminist analysis had clearly identified the patriarchal nature of organisations and the mechanisms which prevent women from exercising power, no adequate analysis has been undertaken of women's role as 'constructors' of health knowledge or the impact of their active participation in the health domain (Lewin and Olesen 1985). Thus the potential of women workers to change and direct policy initiatives within organisations has been previously neglected.

> "Regrettably absent are descriptive case studies and interpretative analyses of the roles women play as creators or innovators of organisations." (Gould 1980:237)

The research undertaken for this thesis aimed to address this gap, by using the frameworks developed in the early 1980's as a basis for analysing an alternative form of community-based maternity provision. The research explored, from a feminist perspective, the implementation of proposals for the provision of user-centred maternity care which emerged from the critiques of medicalised provision. The work is primarily concerned with the effects of an attempt to provide user-centred maternity care within the Primary Health Care sector from both the women's and workers' perspectives and experience. Thus the research aimed to provide a further understanding of maternity care which was orginally raised by the studies undertaken in the early part of the 1980's by placing the women providers' views along side those of service users' and evaluating the

entirety of their care. Thus broadly the thesis is located within feminist theory which aims to place women's definitions at the centre of research as Stanworth (1987) states, in talking about reproductive technologies, the feminist critique is about enabling women 'to shape the experience of reproduction according to their own definitions.'

The next section of this chapter details the critiques of the medical model which emerged during the 1980's and the alternative models which developed from such critiques. The final sections of the chapter details, the research questions addressed.

THE CRITIQUE OF THE MEDICAL MODEL

Within the sociology of reproduction, one of the central features of the analysis to date has been the identification of the manner in which the medical profession fails to respond to the reproductive health needs of women, but instead acts to create and sustain patriarchal power relationships (Roberts 1981).

> "In matters such as contraception and abortion the medical profession has exercised a degree of power over women which is disproportionate to the importance of the technical expertise on which this influence is supposedly based, ... medicine is not only an institution of social control, but a particularly male dominated one." (Barrett and Roberts 1978:41/2)

An area where medical control has been under increasing criticism during the last decade is that of maternity care (Garcia 1984, Maternity Services Advisory Committee 1982:1a[1], Flint 1982a). Features of the criticisms include women's dissatisfaction with increasing levels of intervention, the depersonalising nature of care, poor patterns of worker-user communication and fragmented care (Cartwright 1979, Macintyre 1982, Walker 1985). The critique of maternity care has not solely been concerned with identifying the inadequacies of certain components of care but has indicated that, for example, poor communication, long waiting times and task-orientated care are symptomatic of the medicalisation of maternity provision. It is the system within which care is provided that creates the problem, as the findings of the National Childbirth Trust working party on ante-natal care indicates,

> "The expectant mother is treated as the passive object of management, who is fed into the system and whose progress through it from point to point is controlled as if she had no wishes or preferences of her own." (Kitzinger, NCT 1982)

Such criticisms have served to highlight the manner in which pregnancy and childbirth have been expropriated from women to the point where women are no longer seen to deliver the child but are delivered by professionals (Oakley 1980).

> "The medicalisation of childbirth has meant placing doctors in the active role and women in the passive position of a patient, a recipient of services

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1. First Report - Part 1 - Ante-natal Care.

> rather than the controller of birth. When childbirth became a medical event women lost control over their experiences." (Rothman 1987)

However, demands from women for equal participation in the decision-making process and choice over the management of their care have, with only a few exceptions (Huntingford 1978, Savage 1986) been received with hostility and concern over the loss of professional prestige and power (Arney 1982, Dale and Foster 1986). This conflict between providers and users has been highlighted in research within the sociology of childbearing and reproduction, (Fluery 1967, Graham and Oakley 1981, Oakley 1981, Romalis 1985). Graham and Oakley (1981) documented marked differences between the ideological framework concerning pregnancy and childbirth held by the medical profession and the framework held by the women. This went beyond different opinions over the management of maternity care, to the point where the two groups were identified as possessing diametrically opposed models concerning the nature of reproduction, and the role of women. In practice, the effect of these opposing models was to generate fundamentally different perceptions of the most appropriate management of reproduction. These differences were found to be so great that any interaction between the two during maternity care provision was bound to be antagonistic.

> "Conflict rather than being a peripheral issue is in fact a fundamental feature of the relationship between providers and users of the maternity service" (Graham and Oakley 1981)

Finally, feminist and sociological theoretical analysis in this area has not only identified the patriarchal and male dominated nature of the maternity system, but has tended to concur with lay pressure groups and some of the more radical professional associations as to the most appropriate responses to the high levels of dissatisfaction that women have expressed with the medicalised nature of their maternity care. As a result radical proposals for change have been advocated, from which models of an user-centred maternity service for women could be constructed, (Oakley 1980, Graham and Oakley 1981, ARM 1986, Page 1988, Flint 1982b, 1988). In terms of enabling women to exercise increased control over their experience of pregnancy and labour, previous research and the alternative birth movement have identified specific changes which would need to be implemented within both maternity care and health care provision generally in order to achieve a form of maternity care which would respond to the full range of women's needs. However, a recognition of the need for improvement within the provision of maternity services is not exclusive to feminist and radical critiques which aimed to enable women to exercise more control over the management of their care. Changes within the provision of maternity care have been advocated which are not orientated to alter the nature of the division of power between user and provider, but instead aim to humanise the current medicalisation of care (Haire 1972; Oakley 1981).

Thus the difference between such definitions and the proposals for change are discussed in the next sub-section.

PROPOSALS FOR USER-CENTRED MODELS OF MATERNITY CARE

It is useful to distinguish between two types of aims which can be found contained within such solutions for change. These were identified by Graham and Oakley (1981:70) as consisting of changes *in* the existing organisation of care and changes *of* the system.

1. Changes in the existing organisation of care. These can be considered as changes which focus on humanising the face of medicalised care, such as allowing partners to be present during childbirth, changing the organisation of the clinics to be more user-friendly, and altering attitudes of professionals so that for example, 'doctors become less dogmatic about the needs of maternity patients.' (Graham and Oakley 1981:70). However, as Graham and Oakley allude to, humanised care does not automatically equate with the change in the power relationships and as a result the balance of power remains with the professionals (Haire 1972). Stacey (1988:243) provides a useful illustration of this. In the 1960's the Association for the Improvement in Maternity Services (AIMS) advocated that women should have a companion of their choice with them during labour. However this was translated often unthinkingly into practice to mean exclusively male partners, and invariably husbands thereby excluding many of the sources from which different women may draw support, female partners, friends, and mothers, (a WHO lecture by Doctor R Caldeyro-Barcia (1980) provides an illustration of this). However, in certain cases this has been advocated more as consideration of the fathers rights or the need for family bonding, than for any consideration of the woman's need for support in labour. In common with other changes such as open visiting to children, demand feeding and babies remaining with mothers on post-natal wards implementation of these changes has not been particularly as a result of any attempt to gain increased control for women or even for patients as a whole, but have frequently been implemented as part of a response to a 'vogue' for theories such as maternal bonding (Critical Social Policy editorial 1982), and as a result such privileges can be taken away if the theory becomes discredited, (Stacey 1988). Furthermore, implementation of such changes have tended to be seen as isolated improvements uncoordinated from any overall attempt to improve services. Finally, humanising care has been seen as a means of diluting and negating the more radical demands from women. As Oakley (1981) notes in an analysis of the role of the consumer in Government reports, the Short report (1980) anticipated that women's demands for home birth and GP unit deliveries would be eradicated if consultant units were 'humanised' and mothers 'educated' concerning the need for intervention.

The problem with changes which operate only within the system is not so much the changes in themselves, but the limited nature of the changes; having made a

concession to women's criticisms the priorities of the institution remain undisrupted (Oakley 1985). An evaluation of change towards user-centred[2] care within the provision of maternity care would need to consider changes which not only attempt at humanise care but which also are orientated to increase women's control over the management of their care. These are what Oakley and Graham refer to as 'Alternative patterns of care'. These are discussed in more detail in the remainder of the subsection.

2. Alternative patterns of care. These "constitute changes of the system itself rather than changes in the system" (Graham and Oakley 1981:71). Discussion here will focus on seven key elements of such proposals:
Although recognizing that there are divergences between the differing models of how maternity care is to be improved, as the proposals come from a wide range of sources, representing different perspectives and professional interests; it is the striking number of similarities they possess in terms of their core components and major recommendations coupled with a unifying opposition to the current medicalisation of maternity care that enables them to be discussed collectively.

The following sub-headings constitute summaries of the main elements of the majority of the proposals for change:

2.1 Women in control

> "It is time that the control of childbirth returned to its rightful place the mother." (Beverly Beech, AIMS 1982)

> "The parturient woman is the central person in the process of care." (Flint 1986:114)

This constitutes not only a proposal but also an objective of the proposals discussed below, as Oakley stated with reference to her proposals for improvements in the nature of maternity provision.

> "The motive behind these proposals is to enable women to look upon childbirth as a genuine human achievement: One moreover that is able to endow a lasting legacy of self respect and belief in self-determination. " (Oakley 1980:300)

A user-defined and controlled model of good practice is a factor which has been seen to be essential for the evolution of change within service delivery (Roberts 1985). Thus the assertion that the aim of improvements in maternity services should empower the user by enabling her to exercise a greater level of control over the management of her maternity

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2. The definition of this term is provided at the end of the chapter.

care forms a key principle underpinning the direction of the majority of the proposed changes.

2.2 User provider relationship. Concern with the form and quality of the interaction between providers and women is a central element of the critique of medicalised maternity care. Communications between providers and users has been identified as problematic for a number of reasons, of which the following section can only provide a brief sketch to highlight the main issues:

A primary goal has been identified to develop ways to involve women as equal partners in their care rather than being treated as passive recipients of medical care, (Webb 1986). The main change required has been seen as the need to achieve an alteration in the unequal nature of the relationship between user and provider so that shared decision-making occurs (Wagner 1986:19). Certainly a change in the view professionals have over their responsibilities in the management of care has been seen as requiring a major shift;

> "Many obstetricians regard themselves as being responsible **for** women and by assuming this position totally sidestep their responsibilities towards **those** women." (Squire 1986)

The hierarchy of the health care system which separates user and provider has been seen as requiring alteration to enable women to become members of the decision-making team and achieve a sharing of the management of maternity care (Houd and Oakley 1986). Thus the development of new form of relationship between provider and user based on a partnership has been seen as central to the improvement of maternity services (Macintyre 1982, Beech and Claxton 1984, ARM 1986).

Furthermore a necessary pre-requisite for a more equal relationship to occur, is likely to include the provision of a full and informed choice[3] to women, based on greater access to information. Research has also identified that the patterns of communication normally employed by health care providers reinforces user passivity and effectively bars women from participating in the decision-making process. (Oakley 1980, Kirkham 1987)

Thus for women to be able to access the information they require, the pattern of communication employed by providers needs to be altered. In particular, Kirkham (1986) identified that the language used by birth attendants needs to move away from speech patterns which serve to block women's attempts to gain information from workers. The provision of information which enables women to increase their control over the management of their care is also a feature of critiques of the medical model which have emerged from within health services professions, (Savage 1986, ARMS 1986).

> "What I have learnt from Patients is that women are individuals and they should have control over their own fertility. Informed choice is a

3. Informed choice in this context constitutes full access to knowledge ie. fully informed.

> prerequisite for that control and professional advisers who are prepared to share information and decision making with the woman are essential." (Savage 1986:7)

2.3 Female Health workers

In answer to the expropriation of pregnancy and childbirth from women by the male dominated medical profession[4], some user groups, academics and feminists have recommended that for women to gain conscious control over their own experience and become active participants in their own maternity care, maternity care should be provided by female practitioners (Kitzinger 1988b, Houd 1986). An increase in the numbers of women in the medical profession for example, has been seen as a factor which could make the currently male-dominated nature of the health care system less sustainable (Stacey 1988:191). Women health workers, it has been argued, would be more likely to provide an equal dialogue with women than male health workers (Leeson and Gray 1978, Oakley 1980, Romalis 1982).

> "We believe that women health workers are more likely to see the need for transforming the relationship between doctor and nurse, between nurse and ancillary and between health worker and patient." (Leeson and Gray 1978:32)

In fact, something approaching a popular consensus has emerged in recent years which suggests that improvements in women's health could be better achieved by women health workers, particularly in the areas of reproductive and preventive health. Certainly there is a common perception that women users prefer women health workers

> "The message which is coming back to me from women of all ages and all backgrounds, Tory women as well as Labour women, is, 'we prefer to be looked after by a woman thanks very much.' " (Edwina Currie 1987:23).

Women workers have been identified as being more likely to produce a more sympathetic response, (Oakley 1980:298) and of being capable of expressing a greater degree of empathy by virtue of a shared biology and shared experiences within patriarchy (Jordon 1978). Therefore they are seen as more likely to contribute to the development of user-centred maternity care.

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4. Historical analysis of this process can be found in: Donnison (1977), Ehrenreich and English (1979) and Wertz and Wertz (1981).

2.4 Midwives versus Medical profession.

Previous researchers have not simply suggested the need for a change in the gender balance among health workers, but also a transfer of responsibility away from the male-dominated medical profession to the female professions such as nursing or midwifery (Oakley 1980; Graham and Oakley 1981). Thus in relation to reproductive and maternal health care, the theory that women workers are more likely to be responsive to the needs of women user has been associated with a call for female dominated professions notably midwives, to be the main providers of care.

> "When childbirth became a medical event, women lost control over their own birth experiences. The medicalisation began with the eradication of midwifery as a profession." (Rothman 1982a:161)

It has been argued that such groups of workers are more likely to develop an equal dialogue with users, by virtue of both their lesser claim to professional dominance and authority compared to the medical profession and as a result of the predominance of women within their ranks (Arney 1982). Midwives, it has been argued, are more likely to demedicalise care (Reid 1983b, Weitz and Sullivan 1985)

> "Are midwives necessary? Yes, if we want normal births and a non-interventionist approach. Low intervention rates, lower perinatal mortality and midwives seem to be connected." (Houd 1986:131)

Furthermore, women workers may possess knowledge and skills which do not originate within the biomedical tradition (Martin 1989:143-144). These skills may have an impact on the form of health care they provide. Midwives may retain a substantial store of non-technological knowledge that comes from their experience of working with women and listening to women which could serve to produce a more woman-centred approach to care provision. Supportive evidence that midwives could provide a user-centred form of care comes from analysis of their traditional role. Page (1988:253) identifies 5 principles of traditional midwifery care;

> "1) Continuity of care
> 2) Respect for the normal
> 3) Enabling informed choices
> 4) Recognition of birth as more than a medical event
> 5) Family centred care"

The principles of good quality midwifery, put forward by Page, is an inversion of the components of the medical frame of reference identified by Oakley, forming almost the exact opposite of the ideological framework of medical maternity care. In addition, it is the female dominated professions or occupational groupings such as midwives and nurses which have in recent years increasingly challenged their role as handmaidens to the medical profession (Salvage 1985, ARM 1986, Stillwell 1984). Members of the nursing-associated professions have additionally argued that what is required in order to improve

women's health care and in particular preventive care within the Primary Health Care Sector is a recognition and incorporation into general practice of the skills which are unique and specific to nursing, (Stillwell 1984, Turton 1985). Midwives in particular have been active in promoting and reasserting the traditional role of the midwife in the provision of maternity care (Towler 1982).

Thus user-centred perspectives on maternity care are usually therefore also concerned with a recognition and reassertion of the traditional role of the midwife: a role which is perceived as being fundamentally allied with women (AIMS 1981, ARM 1986, Oakley 1980).

2.5 Normal versus pathological. A further issue which forms a background to many of the alternative approaches to maternity care is that, within the medical model, birth and pregnancy are defined as a pathological process akin to an illness rather than a normal physiological processes (Romalis 1985:184). Thus proposals for change have identified a need for an ideological and philosophical change in the approach of professionals to defining pregnancy and childbirth and an acceptance of the fact that the majority of pregnancies fall into the category of normal births.

One implication of the definition of pregnancy as pathological has been increased intervention. For, if pregnancy is defined as pathological and akin to an illness the management of prenancy is automatically defined according to the medical management of any other illness, ie treatment through intervention. This has led medicalised care in the hospital to have been characterised as a '*chronicle of interferences*' (Arms, 1975:23) Instead, some commentators have indicated that a *'midwifery model'* is a more appropriate basis, because of a perceived greater emphasis and expertise within a midwifery model based on normality and as a result an emphasis on non-intervention (Kitzinger 1988a, Page 1988).

> "We challenge the assumption widely held today that pregnancy is a medical condition which therefore requires a doctor." (NCT Working Party, 1982)

2.6 The place of birth. A prominent feature of the recommendations for change has been the argument that women need to be in control of the situational context of birth in which they labour and deliver (Willmott 1980; Tew 1985). Part of the critique of medicalised care has been to identify the manner in which birth in hospital is an inappropriate environment for the majority of women to use as a place of birth. If birth is identified as an event akin to any other normal physiological process then a hospital concerned with the treatment of disease appears to be an incongruous choice for the place of birth.

> "We have to learn that women don't live in hospitals, they don't socialise in hospitals and they certainly don't make love in hospital, so why do we expect them to give birth there?" (Caroline Flint, Address given at Association of Radical Midwives Conference 1985)

Thus a recommendation for a transfer from the hospital as the normal place of birth to the primary health care sector and the woman's own home has been an important feature of many of the proposed changes, for example Oakley (1980: 296-297) argues for the:

> "... re-domestication of birth, that birth should be returned to the home."

In addition, Graham (1984b) has illustrated the the need for localised care which is not only situated within the woman's own geographical environment but which is accessible by women, and working class women in particular. Within the provision of maternity, care this could involve initiatives such as locally based ante-natal classes.

2.7 The focus of care - Task or user orientated care

A fundamental shift in the focus of ante-natal provision has also been identified as a key component of the changes needed to provide a user centred maternity care. Oakley and Graham (1981) have argued that the priorities of care provision needs to be changed to become less task-orientated and concerned with clinical routine and more patient or woman-centred in order to respond to women's individual needs. Continuity of care has also been identified by research (Micklethwait, Beard and Shaw 1978) as an aspect of care which women perceived as a priority goal for quality maternity care and which may facilitate the development of a more user-centred approach .

A final example of the common themes in the models can been seen in the following summaries of the key elements of the proposals for change put forward by Graham and Oakley and by The Association of Radical Midwives.

User-centred practice: Graham and Oakley (1981:71)

1. The development of neighbourhood maternity centres.
2. A move back towards home delivery.
3. Transfer of medical responsibility from doctors to female workers such as midwives.
4. Less task orientated and more patient orientated maternity care.

The Association of Radical Midwives: (ARMS 1986, Flint 1988)

1. Decentralisation of ante-natal care into neighbourhood clinics.
2. Flexible working arrangements which ensure continuity of care.
3. Midwives should be given total responsibility for all normal expectant labouring and newly delivered mothers up to 28 days after the birth.
4. That women have a real and fully informed choice concerning all aspects of their care.

RESEARCHING THE ALTERNATIVES - OBJECTIVES OF THE THESIS

This research examined the possible implementation of proposals for the provision of user-centred maternity care which have emerged from the critiques of medicalised maternity care. This was addressed by analysing an attempt to implement a system of maternity care which was intended to correspond as closely as possible to the models of user-centred care previously discussed. The research presented in this thesis is an exploration of the structures and mechanisms by which an alternative to the medical model of maternity care could be provided within the established organisation of Primary Health Care (PHC) services. In addition, this work aims to provide a discussion of the degree to which professionals, especially female health workers, can adopt the same frame of reference towards reproduction and maternity care as the users of the service. The thesis discusses some of the aspects of care provision which could constitute a prerequisite both for women users to have control of their health care and pregnancies and for women workers to exercise greater autonomy within the PHC team without that resulting increase in power coming from gaining power over users.

Assessing the contribution of women providers

The major weight of sociological research in the area has tended to focus on the alienating relationship between women patients and the male members of the medical profession by virtue of their dominant role in the provision of care. However, in doing so such research has tended to overlook the potential contribution of women providers despite frequently advocating their increased involvement in the provision of care to women (Reid 1983:89).

Two different perspectives of women as providers are worthy of consideration.

1. The impact of any collective role women could have as providers of care. As already noted, women workers are frequently perceived as being likely to provide a more user-centred approach, yet the nature of the dialogue between women providers and users remains under evaluated.

2. Secondly, in concentrating on the relationship between women and members of the medical profession, previous research has reinforced the notion that the doctor is the key practitioner for providing health care, while failing to actually evaluate the contribution and practice of other health workers, in particular those groups of predominantly female workers, such as midwives. As Reissman (1986) suggests in the title of a review article, there is a need within medical sociology to move beyond "a bad doctor's" scenario. Although some work has been conducted on the contribution of such health workers (Comaroff 1977, Kirkham 1987), there is still a need to develop a deeper understanding of the role female health workers play in the construction of health care for women

particularly within attempts to challenge medicalised care from within the health care system. However, as already noted, above interactions and relationships between women workers and users may be key determinants in affecting an altering in the nature of maternity care. Oakley (1980) analysed the impact of male dominated medicine in the creation and reinforcement of cultural ideologies concerning women and reproduction, while noting that the role of midwives may be crucial in effecting a change in the management of reproductive health.

> "Midwives' attitudes and responsibility have historically been tremendously important and continue to be so. An expansion of their function in the future is likely to be one direction of change in the cultural manipulation of childbirth." (Oakley 1980:10)

In addition, despite an erosion of their role, midwives have been identified as increasingly challenging the subordination of their practice to that of the medical professions (Brooks, Long and Rathwell 1987). The impact at the grass-roots level of these developments on individual women workers, their resistance to male power and domination within the context of the health system, is an important but previously under-evaluated issue. While the impact of midwives in demedicalising care and providing care which aims to empower women has been the focus of detailed sociological work conducted on lay midwifery in the United States (Peterson 1983, Rothman 1983, Weitz and Sullivan 1985), the role of midwives in the UK in providing such alternative care remains under-evaluated.

One of the questions of the research was, therefore, to address the potential of female health workers, particularly midwives, to effect a change in the management of maternity care and to provide an alternative form of relationship between provider and user where the balance of power is altered in the users' favour. In addition, it was noted in the beginning of this chapter, that a gap, in feminist analysis, is that of the role women play as innovators within organisations (Gould 1980) ; this research aims to address this issue through a descriptive study of the role both women users and women workers have in the construction of alternative care to that of the medical model of maternity care.

Constraints on women health workers

However, there may be important constraints which have an impact on women workers within the health system. To assume that a female-dominated profession would automatically provide care where users would be equal partners ignores the structural and situational context with which women workers provide care. The dominance of NHS hierarchies and the sexual division of labour within nursing, coupled with the manner in which nurses and midwives have been trained to passively assent to authority

(Garminikow 1978, Salvage 1985), all serve to constrain workers to conform to the system and to prevent autonomy (Newson 1984b).

> "Demands of the institutions of medicine and the health system and medical culture has a powerful system of socialization which exacts conformity as the price of participation ... there are no individual villains" (Martin 1989 :13)

The studies mentioned earlier concerned with licensed lay midwifery in the USA raise questions concerning the dominance of the medical model which relates back to the earlier discussion concerning humanised care. These studies identified the manner in which the dominance of the medical model influences the care provided by midwives through a process of co-optation or increasing acquiescence to medical definitions. These studies beg the question; could midwifery-based care actually only ever provide a more humanised care without any change in the unequal power relationship between women and providers or would midwifery-based care result in a more radical change? Thus for example could midwfery-based care result in an acquiescence among the women to the demands of the medical model, such as accepting and conforming to hospital policy on ultra-sound scans or being transferred for breech or twin deliveries, because the midwife has recommended that course of action?

The professional literature (see Chapter 2) illustrates some of the tensions surrounding this issue, which apply to all the nursing related groups, that is between, on the one hand adopting a caring role and identifying with the users of the services and on the other, presenting a professional technological orientated approach which places them on an equal footing with the medical profession. Within midwifery, this tension is exhibited in the debate over the most appropriate role for the midwife; either, that of a traditional *with-woman role,* or being the professional expert on reproduction and an equal partner to the obstetrician (see Flint 1982b for an illustration of these debates). Although the professional status of the midwife occupies much of the professional literature at a micro level, this tension could easily affect the construction of their working practice and their relationship with women users. Thus there could be a conflict in the practice of female health workers between enabling women to exercise control as active agents in their health care and in needing women's passive acceptance of their care in order to justify and extend professional authority. If women workers have internalised the view that only professional authority can possess any validity, they may be involved as a consequence in replicating the power relationships found between male practitioners and female users. Dale and Foster (1986) argue that this situation is an unavoidable consequence of a welfare or health system based on professionalism and professional authority. Within such a system, despite supportive staff, user power becomes an impossible goal.

> "Even welfare professionals who are sympathetic to the feminist demands cannot by the very nature of their position fully support the most radical demands for women themselves to have complete control over a range of welfare resources. As professionals working within professionally dominated institutions they can not totally escape either the ideology of professionalism which gives them sole right to define patients needs or the material and legal reality of their power over clients." (Dale and Foster (1986:104)

Thus, as a result, several questions are worthy of consideration: How does the pressure for professionalism interact with the socially constructed and patriarchal low status of women? What impact does this have on women workers clinical practice?

Furthermore the pressures of nursing hierarchical structures in addition to occupying the subordinate positions in the professional hierarchy in the hospitals and PHC team, intersect with gender based-inequalities to constrain the autonomy and clinical practice of the nursing professions. In turn, this position of powerlessness within the hierarchical power structure of the health system will affect the provision of care to users. As Sheahan (1972) noted in an analysis of American nursing:

> "If power corrupts so much more so does powerlessness. It corrupts by changing our perceptions of ourselves ... being too subordinate, too alienated or too weak to effect change." (Sheahan 1972)

A further impact of this is that those in senior positions of power may be reluctant to relinquish their power and fully promote an equal relationship either between users or workers.

In addition, the degree of identification women health workers have with women users may not be as clear cut as previously indicated - in that there have been indications that such workers may have internalised the medical and patriarchal frame of reference when dealing with women, especially women whose socio-economic position or ethnic origin is radically different from their own background (Reid, Gutteridge and McIlwaine 1983 provide an illustration of this in relation to women from working class backgrounds). A review of the nursing literature suggests that a negative view of women is not simply confined to the medical profession, as within the nursing literature professional attitudes also reflect a devaluing of both women and women's abilities. For example, Gillett (1985), in an article on ante-natal care, advocates a paternalistic role for the midwife based on a perception that women are unlikely to absorb information.

> "However great the efforts of hospital staff to give kind care to a pregnant mother, advice given and purposeful resolutions may be forgotten by the time the mother reaches home." (Gillett 1985)

Thus it seems likely that, if female workers are in fact better placed to provide user-centred care to women, it will be dependant on their ability to transcend the traditional

power relationships which are generated within the medical model of health care provision. Finally then, if such workers hold the key to change in the cultural manipulation of childbirth, (Oakley 1980) then the forces involved in the construction of their view and approach towards women's health care will be critical factors in any alteration in the provision of maternity services to women.

In practice, midwives could therefore be operating with the same set of values concerning maternity care as the medical profession and supporting the medicalised conception of maternity care. Alternatively they could be providing a form of health care which operates to protect and expand the interests of the midwifery profession - producing *midwifery maternity cases* as opposed to medical maternity cases. Or would care provided by female health workers and an expansion of the role of the midwife actually result in a change in the *'cultural manipulation of reproduction'* ? (Graham and Oakley 1981) by placing pregnant women in control of their health care. An area requiring analysis is the degree to which the approach of health workers towards providing health care to women is determined, not so much by the gender of the worker, but by either professional status or are based upon predetermined judgements derived from the socio-economic characteristics of the user.

Community based maternity care and the PHC Team

Proposals for change and research concerned with maternity care and women's experience of pregnancy and childbirth, have tended to concentrate on the medicalised system of maternity care based in the hospitals and has largely excluded from the analysis the provision of care in the Primary Health Care sector (a notable exception being Reid, Gutteridge & MacIlwaine 1983). Although accepting that the, concentration on hospital-based care has occurred in part because of the dominance of the hospital system within the provision of care, analysis of the impact of the work being undertaken in the PHC sector is also likely to be important given the recent tendency for predominantly female health workers such as midwives, practice nurses and health visitors to undertake a more autonomous role within the community (Stilwell 1982; WHO 1985; Long & Mercer 1987:202) which may have an important impact on the provision of care.

However, the development of an equal PHC team is far from universally accepted. GPs may be threatened by the expansion of the role of workers who have in the past been assistants to the medical profession (Bowling 1981). On the other hand, members of such professions as nursing and midwifery may find the increased demands and responsibility implicit in autonomous practice too challenging.

In addition, consideration needs to be given to the impact of the sexual division of labour and established power relationship within the NHS working practices which may have an effect on the evolution of an equal partnership between the members of the PHC

team (McIntosh and Dingwall 1978). Thus an analysis of workers' relationship with each other, and the extent to which the power relationships within the PHC team affect the mode of service delivery will be explored. In addition, the form that the interface between the community and hospital takes and the degree to which it affects the construction of user-centred care is an area worthy of comment.

> "The interface between hospital and community based care of pregnant women is the meeting point between two professional organisations; the woman is at that interface and if there is friction, she is the one most likely to be hurt." (Taylor 1984a)

Users' Views

Following from this an important area of analysis will be to evaluate women users' own perceptions of the care provided by these groups of workers. An exploration of the extent to which the women's perceptions of the care provided corresponds with the PHC workers' evaluation of standards of care is likely to be the key indicator in assessing the extent to which a user-centred model of care has been provided. It will also be a central question of the study to determine the model of service women users would find most appropriate to fit with the requirements they have from such a service, which they themselves have identified. Furthermore, a useful area to explore in terms of the practices' ability to meet women's need would be a consideration of any areas of mismatch between the needs from a service as defined by women users and the priorities and aims of that service as defined by the professionals. Finally, the potential impact of any attempt to provide user-centred care on the women is worthy of consideration - in particular the degree to which the care provided can be considered to empower women to exercise greater control over the management of their maternity care. As Reismann (1986:200) argues, it is important for feminist analysis to move beyond seeing women solely as "passive victims of medical ascendancy".

Summary of Research Objectives

The thesis is primarily an exploratory study of an approach to providing user-centred care. The aim is, to explore the features of such care and highlight the issues which were likely to influence the nature of such care, from both the women users and workers' perspectives.(see the next subsection for the details of the study) Some of these issues include the patterns of communication and interaction which occurred between providers and women users in that setting or the nature of the relationship between women user and women providers from different professions. However, as Macintyre notes (1979:758) the distinction between, '*exploratory work, descriptive work and hypothesis-testing work*,' is frequently blurred in social research. Thus the research was also concerned to

describe the possible nature of user-centred care and as far as possible within the limits of the scale of the project, 'test out' the proposals for a model of user-centred care.

The Research Questions:

The research questions are not presented in any order of priority but instead largely follow the order of presentation in the thesis.

1. To identify the workers' frame of reference within a user-centred approach.
2. To describe and outline the nature of the care provided.

   a) To comment on the extent to which the frame of reference of the groups of workers studied consisted of an ideological shift away from the medical model. Could that frame of reference be considered to have led to a different form of care?

   b) To explore the extent to which the care provided conforms to 'humanised care' or provides an alternative pattern of care. Could the care provided be said to be user-centred in nature?
3. To identify the form of the relationship between the groups of women users and providers from the practices and to develop an understanding of the mechanisms of interaction between them.

   a) To comment on the interplay between professionalism and gender in influencing the nature of care provision. An exploration will be conducted on the degree to which relationships between women users and women health workers are affected or constrained by factors such as the workers' professional status and the patriarchal institutions within which they deliver health care.

   b) To explore the potential of female health workers to achieve a change in the management of childbirth, in so far as they are able to adopt a form of provider and user relationship where the balance of power was altered in the user's favour. In addition, the analysis of this potential for change will be addressed from the point of view of relationships among women health workers' in the PHC team. Thus this will be addressed in terms of two perspectives: Firstly the effect of the women health workers' gender identity, the influence of being women: Secondly the effect of women as workers within female-dominated professions.
4. To comment on the communication patterns between providers and users within a user-centred approach.

   a) To identify the nature of these patterns.

   b) To address the extent to which an altered frame of reference creates a more equal dialogue between provider and user.
5. To explore the extent to which this alternative model of care provision met the women's self defined needs: For example, would women users find such a model appropriate to match their needs? This issue will be addressed through the women's own perceptions and experience.
6. Finally, the factors which support or constrain the implementation of user-centred maternity care will be commented upon.

THE RESEARCH - THE FIELDWORK AND METHODOLOGY

The research findings presented in this thesis are based on a qualitative study conducted in two general practices in inner city areas of a northern industrial town. The patient composition of the practices and the women sampled were predominantly, although not exclusively, working class.

These areas were also identified by the local DHA as being areas of particularly high morbidity (eg high incidence of cervical cancer, etc). The practices were also chosen because of their reputation for possessing a well-integrated PHC team approach to service provision, especially in the area of women's health, and for developing innovative approaches to health care. These type of practices, were chosen specifically as examples of practice approaching an ideal type of user-centred maternity provision, as a means of commenting on the theory concerned with the ideal model for PHC and women's health care. This provided a means of identifying if such models for health care provision actually function in practice, and if they correspond with women's requirements of the service.

Both practices had adopted an explicit policy of aiming to provide women with a real and informed choice concerning all aspects of their care but particularly in the area of reproductive health and maternity care. In the main they could be identified as *radical practices*, in that they aimed to provide a radical alternative to the established mode of health care delivery. The fieldwork was therefore concerned with an evaluation of an ideal situation rather than the usual type of care received by the majority of women. Furthermore the practices were chosen on the basis of criteria which as closely as possible corresponded to the models and recommendations advocated by previous researchers in the field as well as lay pressure groups. (The criteria are detailed in chapter 2).

In terms of evaluating the maternity care at the practices, it was decided that this could be best approached through a study which explored both the women's experience of care at the practices and the workers' experience of providing that care. This was addressed by interviewing a sample of women throughout their pregnancy, supported by observational material on both them and other women at the clinics as well as home visits. In addition, a series of interviews with all the staff at the practices were conducted - supplemented by interviews with other Radical Midwives. The fieldwork was conducted over a two year period from 1986-1988.

Sample of Pregnant Women

The main body of the fieldwork concentrated on the experience of a sample of predominantly working class women who were pregnant for the first time (primagravida) in the community maternity care system. This was not intended as a study of the pregnancy careers of the women, the aim was not to document their progress through a system but instead to identify their perceptions and experience of the system as a whole. There are several reasons for adopting such a sample as the basis of the fieldwork. Pregnancy brings women into contact with the major components of the PHC team and a wide range of women workers, thus obtaining a means of evaluating the care of the complete PHC team concerned. The provision of maternity care also represents an aspect of health care delivery which is dealing with normality rather than ill-health. Pregnant women are individuals who are going through an important life event, but a normal event. Thus an evaluation of maternity care provides an opportunity to assess the health care system's response to "health care" rather than "disease care". Furthermore, by looking at maternity care, the research will be addressing an area, in which there has been extensive debate between doctors, other health care professionals and users over who should determine, direct and control the nature of care provided (Brooks and Long 1986, Newson 1982, Kitzinger 1985, Newson 1982).

Pregnancy and childbirth also represents an experience unique to women; an evaluation of an approach to providing user-centred maternity care could be a valuable indicator of the basis for a model of health care which responded appropriately to women's reproductive health needs in a wider context than just maternity care.

The reason for sampling a predominantly working class sample of women is that previous sociological studies concerned with the sociology of childbirth have concentrated on eliciting the perceptions of predominantly middle class women (Reid 1983). Thus this study aims to partly redress that imbalance. Furthermore there is a perception by health workers, sociologists and the media that it is only middle class women who are dissatisfied with pregnancy and childbirth being an experience of high technology medicine and occurring only in hospital. The aim being to comment on the degree to which an attempt to respond to women's critiques would meet the need of working class women. However this study was not oriented to provide a comprehensive analysis of class-based differences between women's perceptions and needs of maternity care. Instead, the intention of the study was to focus on the identification of any fundamental needs for care which could potentially be common to all women. In addition, to supplement the data from the main sample of women, interviews with ten second-time mothers were conducted and women user's views of the well woman clinic was explored by means of a structured questionnaire.

PRESENTATION AND OVERVIEW

The Structure of the thesis

Chapters 1-3 form the background to the presentation of the findings from the fieldwork. Therefore the first section of the thesis is concerned with identifying the research questions, the review of relevant literature and the presentation of the methodology used. The remaining chapters are concerned with a presentation of the findings from the fieldwork. These examine the workers' view of their philosophy of care and the model they identified as constituting the basis of their care. The implementation and translation into practice of this model is then examined over two chapters. The final field work chapter draws together the extent to which the form of care provided conformed to the women users' needs for maternity care. The thesis then concludes with an overview of the main findings and a discussion of the theoretical and policy related implications of the research.

Chapter Summaries

Chapter One : Introduction

This presents the background to the research via the critique of medicalised maternity care and the proposals for a more user-centred approach identified by previous research and pressure groups. The main research questions addressed in the thesis are then identified.

Chapter Two : Literature Review

The literature review chapter provides an overview of some of the key issues which underpin the research objectives. Two main areas of literature are discussed. Firstly, the academic literature. This includes a discussion of feminist models of women's health care and the debate surrounding the primary health care team. Secondly, the professional literature is examined. This section includes issues such as: the debate over the erosion of the midwifes' role; the contribution of radical midwifery; and questions concerning professional status.

Chapter Three : Methods

The methodology employed in the study is discussed situating the methods in the traditions of ethnography and feminist research.

Chapter Four : The Workers' Frame of Reference

This chapter is concerned with the philosophy of care held by the providers of maternity care. Following from the model of the medical frame of reference developed by Graham and Oakley (1981), the women workers' frame of reference concerning care provision for women is identified. The chapter is structured around the key components of the workers' frame of reference. The following elements were found to form the basis for the workers' frame of reference:

1. A rejection of professionalism - this consisted of a rejection of the status and power base which distances provider from the user of services. In addition, the midwives felt that the role of the midwife should be based on a traditional *with-woman role.* The workers' function was to support and empower women to exercise a greater degree of control over their health care.
2. The standards of care are not medically defined. Primacy in care was given to the quality of the relationship between provider and user.
3. Belief in the naturalness of pregnancy. Pregnancy is perceived as a natural event in which their role as care providers should be to act as facilitators supporting and assisting the natural process of birth and labour, and where intervention should be kept to a minimum. The workers' role is to prevent abnormality from occurring in a natural physiological process. The midwives expressed a belief in women's ability to labour naturally.
4. Identification with the users of the service. Working within the field of women's health was ascribed a high status by the workers' at the practices.
5. Their role should be founded on the transference of information and knowledge to the women.
6. Commitment to certain key aspects of care as being an essential requirement to meet women's needs, the provision of holistic care and continuity of care.
7. Control and ultimate sanction over the decision-making process should rest with the pregnant woman.

Chapter Five : Women and Workers - Care provided

This chapter documents the findings concerning the implementation into practice of the philosophy of care provision identified in the preceding chapters. This is mainly based on the presentation of observational data. Findings from the observations on interactions between women and workers' include:

1. The starting point of the analysis is a consideration of the workers' attempt to construct the environment of the clinic so that they constitute jointly-owned territory.
2. Women users in their interactions with workers' were found to be incorporated into the decision making team and were health workers (Stacey 1988:6) in the sense that they were acknowledged by the workers' as having an important contribution to make both to the provision of care and to the development of the midwives' clinical practice.
3. Overall the care provided at the practices was observed to facilitate and support a culture of access to information.
4. One of the key features of the model of care identified was the degree to which the midwives were of central importance to the provision of care. The midwives were found to be involved with the women - the role and status of the midwife in the interaction came not from a professionally based power over women users - but from the women themselves.
5. Clear limits were found on the extent to which the GPs were able to adopt a user-centred approach - constraints which are not encountered to the same degree by the midwives and practice nurses.
6. However, overall, conflict can be interpreted as a peripheral rather than an intrinsic feature of the relationship between provider and user. Women health workers have a major contribution to make in this area.

Chapter Six : Implementing a user-centred philosophy: Supports and constraints. This chapter identifies the factors which influence the form of maternity care provided at the research practices. The focus of the chapter are the factors which either support or constrain the workers' from implementing a user-orientated approach and innovative practices. The chapter examines issues such the influence of hospital system and the relationships within the primary health care team. In addition, the chapter draws together the findings concerned with the influence on the workers' practice of such issues as feminism and radicalism and the significance of being women workers.

Chapter Seven : The Women's View

In this chapter, the women users' definitions and perceptions of need are identified. While the supportive findings of the survey of the well woman clinic indicate that such a model has present implications for the delivery of health care to women beyond maternity care provision. The chapter's examination of the women's views of the care provided can be summarised as follows:

1. The findings indicate that women users felt that women workers possessed, by virtue of both a shared biology and shared experiences as women, a more empathetic approach to the provision of care than male workers.
2. In terms of the professional qualifications of workers, the women felt that midwives possessed the skills, expertise and importantly, the right approach to constitute the main providers of care. Thus the definition of appropriate maternity care held by the women was quite restrictive in terms of the appropriate parameters of the doctors' role.
3. The women felt that the form of care provided at the practices gave them considerable confidence and reassurance. They felt that the components of the care provided, such as holistic care and continuity of care, was a key factor in achieving their goals and objectives
4. Contrasts are identified between the women's views and experiences of maternity care at the practices and their encounters with the hospital system.
5. Finally the supportive findings from the well woman survey indicate the extent to which the model of care provided at the practices has a relevance for the provision of reproductive health care to women in general.

Chapter Eight : Conclusion

The conclusion to the thesis has two elements: An overview of the findings and a discussion of areas for future research.

Appendix : The three appendices cover the following: 1. The questions asked during the interviews with both women and workers' including the themes and typical phrasing. 2. The respondents, lists of the women and workers' who took part in the study and relevant biographical details. 3. The well woman questionnaire.

Terminology

1. User-centred maternity care: Throughout the thesis, the term 'user-centred' or 'woman-centred' will be used to describe the ideal model of maternity care which has been advocated in previous research and to describe the form of care which the two research practices were aiming to achieve. Although other terms such as 'innovative' or 'radical' were considered, they were felt to be open to far too wide an interpretation of meaning to be helpful. Use of the term, 'midwifery-model' as opposed to 'medical model' was also considered (used by Weitz and Sullivan 1985, by Rothman 1982) this could have been useful and is used to refer to the midwifes' view of part of their care and role. However, as the analysis was also concerned with the role of the GP, it seemed sensible not to appear to impose on their view of their role a model which may not be applicable. In addition, it seemed that the central element of an alteration in the provision of maternity and reproductive care would be concerned with placing the woman user at the centre and therefore a term using a professional title would not reflect that. In the end a variation on the term 'patient-orientated' used by Oakley and Graham (1981:71) was adopted. Oakley and Graham used 'patient-orientated' to distinguish their proposed form of care from the task-centred nature of care within the medical model, although in the context of this thesis it should be taken to encompass more than a rejection of task-orientated care alone.

2. The women: References to 'the women' in the thesis refers to the pregnant women who used the maternity care at the practices and were interviewed as part of this study. It refers to both first and second time samples. It does not include the sample of women from the well woman clinics which is treated separately. (Even though some of the women attended this clinic for pre-conception care and pregnancy testing).

3. The workers': The term 'the workers' refers to the midwives, GPs and practice nurses at the practices. In situations where only certain workers are being referred to, this will be noted.

4. The practices: The two practices are identified as North and Park. However, as both practices stated an expressed commitment to providing user-centred care according to the same definition and as no significant difference was found in the frame of reference held by the workers' at the practices, the findings from the two practices have therefore been joined for the purposes of this thesis. However, some areas of difference are noted where these were found to have had an impact on the care - this mainly relates to the effect of the difference in the two buildings housing the practices.

In addition, a high degree of interaction existed between the practices: for example, the two midwives whose practices were observed were part of the same community midwifery team and frequently covered for each other. Furthermore the GPs were all members of the same home birth support group.

Presentation of Data

The data from the interviews are presented according to the following conventions. After a quotation the women's or workers' name is provided. For the workers, a job title is also given. For the women users unmarked excerpts are from ante-natal interviews and interactions. All names have been changed to preserve anonymity. Normally the data are also presented with the question that was asked. Observation data are presented as interactions between the women and the health workers'.

CHAPTER TWO - MEDICAL CONTROL AND MATERNITY PROVISION

The literature relating to reproduction covers a vast wide ranging area. Even the literature relating solely to to childbirth and maternity care could not be comprehensively covered in an overview of this nature. As a result this overview will be focused in terms of its scope, largely concerned with some of the effects of medical dominance and the medicalisation of maternity care. In doing so, the chapter will reiterate and expand some of the issues highlighted in chapter one. The chapter only aims to provide a background for some of the key issues which are discussed in the thesis. Discussion of the literature is not confined to the analysis provided in this chapter. The issues which are raised by the literature and which either illustrate or provide an explanation for some of the findings are discussed throughout the main body of the thesis.

The literature reviewed is not confined to sociological contributions - it also covers some of the professional literature and the most relevant government reports.

In terms of the professional literature, all of the key health professions have established journals which apart from reporting health *news*, policy initiatives and clinical developments claim to be the *voice* of the profession and to represent their interests. By analysing the *'published voice'* of midwifery the aim is to provide a guide to professional attitudes and opinions towards the midwives' role and the provision of maternity care. Furthermore the manner in which each professional body perceives their role in providing care to women is likely to provide an indication of both the standards which the profession considers to be the norm, and of any conflict within the profession over the standards and values which should form the basis for the provision of care.

SECTION ONE - CONTROL AND CHILDBIRTH

This section provides an overview of some of the issues and implications raised by the medical control of childbirth. This is not intended as a comprehensive analysis of these issues and further exploration occurs in the body of the thesis.

Risk and the Place of birth

The debate over the place of birth is perhaps one of the most significant illustrations of the many tensions and debates surrounding the provision of maternity care. Although many commentators have documented the historical reasons for the transfer of birth from the home to the hospital (Wertz and Wertz 1979, Romalis 1981) the starting point of this discussion and of much of the debate over birth, is the widely held contention that a hospital is the safest place to have a baby.

Consideration of the approach towards the place of birth in government reports during the last 20 years provides an indication of the influence of medical definitions of childbirth, particularly of the medical view of childbirth as a pathological event.

> "We consider that the resources of modern medicine should be available to all mothers and babies and we think that sufficient facilities should be provided to allow 100% hospital delivery. The greater the safety of hospital confinement for mother and child justifies this objective." (Peel Committee 1970 para 277)

Both the Peel report (1970) and even more markedly the later Short Report (1980) subordinated the preferences of women to the demands of medicalisation (Oakley 1984:220). However the government's reply to the Short report (in recognition of the control being given to obstetricians by the report) stated that health workers could not ultimately make decisions for women.

> "Where a mother wishes to have a home confinement, despite the medical arguments against, health authorities are expected to provide a domiciliary confinement service that is as safe as circumstances permit. Doctors and midwives can help ensure that she makes an informed choice, but they cannot make that choice for her." (Government reply to the Short Report HMSO 3 December 1980)

One result of the Short Report was the establishment of the Maternity Services Advisory Committee to the Secretaries of State for Social Services, it was identified as being set in part as a response to:

> "... the groundswell of consumer complainants which alleged that the service was in the grip of technological advance, the victim of excessive pressure on hospitals and in dire need of humanising. " (Munro, Chair of the committee, 1985)

The aim of the committee was to identify ways of raising standards within maternity services. The aim was only to reduce consumer criticism and to find ways of humanising the service within existing resources, (Munro 1985). Enhancing user control and actively developing strategies for increased participation in the decision making process did not appear to be on the agenda.

The committee reported on care in labour in 1984. Although the tone within this committee's report has shifted away from the enforced compliance advocated within the Short report, the message essentially remains the same. "Maternity care in action" (1984, part II Care during childbirth) which is the Second report of three completed by the committee devotes an entire chapter to home births. Although the negative tone towards home confinements seems to be set with the positioning of the chapter on home births immediately after the chapter concerned with complications instead of next to the discussion on labour and birth. This tone is continued in the text of the chapter, thus the Committee's policy statement tacitly accepts the medical definition of every birth as only being normal only in retrospect (Romalis 1981:21). The report states:

> "As unforeseen complications can occur in birth, every mother **should be encouraged** to have her baby in a maternity unit where emergency facilities as readily available ... " (my emphasis 1984:23)

Thus as Rothman (1981) argues it is the distinction between low and high risk pregnancies and births which is seen as the justification for the medical authority over childbirth. Rothman argues that this distinction results in an inherent emphasis on risk, which then moves to encompass more and more births as high risk.

> "That is, normal births may exist and be only low risk but there are many factors which will make any given labour high risk." (Rothman 1981:177)

Furthermore the definition of what constitutes a high or low risk is, within the medical model, only open to medical definition. Alternative definitions such as those constructed by the woman herself are defined as unscientific, being ungrounded in medical knowledge. This division between acceptable professional opinion and unacceptable women's preference is made explicit in the Maternity Services Committee report:

> "Some mothers might prefer to have their babies at home despite the possible risks, feeling that these are outweighed by the benefits **they perceive** to themselves and their families. Doctors and midwives should discuss the reasons for each mother's preference, so that her final decision is an informed one." (1984:23, my emphasis)

The reports recommendation that professionals "*discuss*" with the woman her reasons for a home birth, can be taken to infer, professional persuasion against having a home birth as presumably she is to be informed of the risks, as perceived by the professionals, that are associated with a home birth. No such recommendation to discuss the woman's

reasons is included in the advice to providers in the chapter concerned with hospital deliveries. The next few sections of the report continues with this theme; thus mothers and (the report adds fathers) who persist with the notion of home birth:

> "... should be encouraged to visit the local maternity unit" (1984:23)

As Oakley noted (1981) there has as been a tendency in Government reports (notably the Peel and Short reports) to adopt the view that women, need only to be adequately educated or informed to appreciate the undoubted benefits of hospital deliveries and the value of technological intervention. This is a tendency which appears to be continuing. Although the authoritarian tone of the Short report has been replaced by more subtle recommendations concerning the power of professional persuasion, thus finally the Advisory Committee recommends where there is an indication of 'any' medical reason against a home delivery:

> "Doctors and midwives would feel it their duty to try and persuade the mother to change her mind but they must recognise that the final decision is hers." (1984:23)

Such reports appear to acknowledge a situation of conflict between women and providers and between their definitions of childbirth. However it is with the medical model that such reports have situated themselves.

A further feature worthy of note is the inclusion of the midwife as a perceived ally to the medical definition and defender of hospital deliveries (the role of the midwife is discussed in later sections of this chapter).

However, evidence has been put forward which indicates that the assertion that hospital deliveries are invariably safer than home has little or no grounding in any scientifically generated evidence. Both the Short report and the more recent Advisory Committee report (1984) were published in or after a period in which systematic evidence had emerged demonstrating home births to be as safe or even safer than hospital deliveries, (Hazell 1975, Mehl 1977, Dewitt 1977 and Tew 1978). As Chalmers and Richards (1977) argue, supposedly scientific decisions are frequently grounded in medical fashion and institutional customs rather than being based on considered evaluation of controlled research findings.

Thus it could be possible to conclude that the emphasis on hospital confinement says more about the current dominance of obstetrics than it does about the actual safety of either hospital or home. This dominance of medical definitions of normality and safety have had important implications for the nature of midwifery and for the involvement in maternity care by GPs. Furthermore it seems possible to infer that any attempt to orientate the management of maternity care towards user control, will involve a

redefinition of the risks which have been attached to pregnancy and childbirth within the medical model.

Having highlighted the impact of the dominance of the medical model on the approach towards maternity care within government reports the next section considers a specific example of the involvement of obstetrics in the management of labour.

Intervention and the role of obstetrics

Once pregnancy is defined as pathological, then the most appropriate response within the biomedical model is medical intervention - as would occur in the treatment of any disease. This as Arney notes, in a historical analysis of obstetrics, a shift has occurred in which the focus has moved from identifying pathology to obstetric monitoring and surveillance in all births.

> "Under this new regime no distinction between normal and abnormal exists. Instead of births being categorised for the sake of obstetrical intervention, interventions like induction of labour become part of integrated systems of control arrayed around a new conceptualisation of pregnancy and childbirth." (Arney 1982:85)

This situation is not without its critics, as the Director General of W.H.O. (1975) wrote of obstetrics:

> "It might appear that some doctors consider that the 'best' health care is one where everything known to medicine is applied to every individual by the highest trained medical scientist in the most specialised institution."

Dunn (1976) an obstetrician, in pointing to the iatrogenic nature of much of the current intervention, argued for a reconsideration of the reasons for intervention by obstetricians. In particular, Dunn argued that obstetricians need to gain confidence in the normal processes of reproduction. However, O'Driscoll, Carroll and Coughlan (1975) have identified the difficulties for obstetrics in aiming for non-intervention: the issue which lies behind much of the explanation for intervention in labour, and the problem at the core of heroic interventionist medicine; a process which,

> "... operates to absolve a doctor who intervenes in the course of a normal pregnancy and which by implication, exposes his conservative colleague to censure for inactivity when an infant is born dead." (O'Driscoll, Carroll and Coughlan 1975)

This illustrates some of the difficulties and contradictions in the role medical practitioners may face in trying to adopt a non-interventionist policy. However, in arguing for obstetricians to recognise the normal, Dunn may be at odds with other commentators who have also argued for a reduction in the levels of intervention. Traditionally obstetricians have not had an expertise in normal birth, their expertise is concerned with the management of abnormality. As already noted, their role in normal birth has evolved

through a reinterpretation of birth as pathological. In the past, the obstetrician was not required to recognise normality because they were not responsible for defining the boundaries of normality and abnormality. This was the responsibility of the midwife (Arney 1982). Commentators from within the field of midwifery have tended to argue that as the midwife is the expert in terms of normal maternity care, a full use of her skills would result in a reduction in the required input from obstetricians (Newson 1982:528).

Cartwright (1979) identified differences between midwifes and obstetricians views on induction, finding midwives more 'sceptical' about the advantages of such technological intervention. Cartwright proposed two explanations, both of which she states are likely to contribute to the identified difference. The first relates to the fact that midwives may identify with the women and attached importance to the negative reactions of women to induction. The other relates to the further subordination to the medical profession technological intervention may mean for midwifery.

> "Induction and other technological changes may be seen as shifting the balance of power to greater medical dominance. Midwives may resent this and prefer more home births and a greater emphasis on natural childbirth because they would be more powerful in those situations." (Cartwright 1979:155)

The relationship between women providers and women users

Dazinger (1978) identified the nature of doctor and woman interaction during pregnancy as, being in the majority of instances, categorised by an asymmetry in which the doctor holds the power base and therefore controls the direction and rules of the interaction. This control is established through the exclusivity of medical knowledge held by the doctor (Friedson 1970, Dazinger 1978). Friedson argued that the division of labour creates a hierarchy of institutional expertise, which "can have the same effect on the experience of the client as bureaucracy is said to have" (1970:137), which results in the exclusion of the user of the service from participation in the decision making process. As the subject of the interaction is solely medically defined, the patient or user of the service is invariably at a disadvantage in the interaction, because they lack the skills and knowledge which would enable them to participate. Thus compliance and passivity in the face of medical expertise become the norms of behaviour for the users of health services:

> "Doctor and patient normally agree that the doctor defines the situation and defines what is and is not acceptable as appropriate for the patient to talk about." (Roberts 1985:24)

In addition to the issue of the professionally constructed relationship between providers and users there is also the issue of gender which adds a further dimension to nature of the interaction between the two. Romalis (1982) argues that interactions between women users and male doctors are particularly hampered by the fact that male doctors "generally

don't understand or share the culture of women." (Romalis 1981:8). As already noted in chapter one, Graham and Oakley (1981) have characterised the nature of interactions between women as being grounded in a situation of conflict. However Oakley (1980) does identify an element which is likely to be an indicator of a more symmetrical interaction between user and provider;

> "The less social distance there is between doctor and patient the greater the chance of a satisfying and relatively equal communication between them." (Oakley 1984)

Support for Oakley's assertion can be found in linguistic research which provides evidence of the mechanism whereby communication between males and female reinforces and reproduces inequalities. For example research has identified that interruptions when a person is speaking by another, communicates and displays dominance, and is a key mechanism through which control of the interaction is maintained between the powerful and the powerless, (Spender 1980, West 1984). In interactions between male medical practitioners and female patients interruptions in the woman patients speech by the doctor were found to be a consistent feature of the interaction affecting the amount of information the woman was able to convey.

> "Insofar as the over arching conversational topic is in the medical exchange the state of the patients health, interruptions in these encounters may have far more serious consequences than in casual conversation." (West 1984:97)

Linguistic research conducted by West (1984) on communications between female physicians and women users indicated a pattern of interaction which differed markedly from that between male physicians and women users. West found that such interactions tended to be more symmetrical in terms of listening time and in terms of the distribution of interruptions. Perhaps even more significantly for addressing inequalities in health care, this tendency remained constant irrespective of the race or age of the woman patient.[1]

An ability of women to empathise with other women, was found by Jordon (1981) to be a cross-cultural phenomenon characteristic of women's relationship with each other during childbirth. However this situation is dependant, as Jordon (1981) notes, on the local system of maternity care allowing a relationship based on empathy to develop. Thus the cultural manipulation of childbirth as manifested through the maternity care system determines women's relationship with each other as user and health care provider. For user centred care to develop the support women can provide to each other would need to be valued and the localised maternity care system must allow a positive

1. Class was not a variable in West's study.

relationship to develop. The point made by previous researchers is that, within a patriarchal and medicalised system of maternity care provision neither of these two characteristics are normally valued.

SECTION TWO - THE MIDWIVES

This next section considers the specific case of midwifery, and the degree to which the practice of midwifery has been influenced and controlled by obstetrics.

The nature of midwifery

The idea that the development of a positive relationship between women and midwives is a fundamental feature of good quality midwifery practice forms the base line for many of the commentators definition of midwifery (Methvan 1982, Walker 1976). The original meaning of midwife "with-woman" is frequently cited as the key to the interpretation and understanding of the function of the midwife.
Reid (1983b), in an analysis of lay midwifery in the USA reports that, the midwives' relationship with their clients,

> "... is characterised by an informality and a closeness which sets them apart from a number of occupational groups in the health field." (Reid 1982:130)

Control of midwifery practice

The structures within the health service reflect and reinforce patriarchal structures which impact on female workers affecting the nature of their interaction with users and other health workers (Manikiem 1979). Thus although female health workers, notably midwives, may deliver 85% of the babies and the obstetrician is unlikely to be actually present at the birth, the obstetrician has control over the direction and formulation of policy, thereby dictating the nature of the work of all other other health workers. The profession of obstetrics, as Arney (1982) argues, exercises control in the same tradition as Foucoults machine of power,

> "It does not express power ostentatiously as a prince does, nor does it create a relationship through a reign of terror the panopticon creates a structure of power through it's design." Arney (1982)

The implications of this exercising of power, as a process of control over midwives, was observed by Kirkham (1987) in her study of women's experiences in labour, Kirkham found that in the consultant unit she studied, the midwives were almost entirely responsible for the processing of women as patients, according to the perceived wishes of the doctor and the custom of the unit. Henderson (1984) in a study of the factors determining midwives' decisions to rupture a woman's membranes identified that the midwives were unaware of their compliance to medical policy but acted in the belief that they were using their own initiative.

> "They were not aware of why they did things and imagined that they had more autonomy than they do. So whilst thinking they were using their own judgement in practice they unwittingly followed a routine." Henderson (1984:68)

Thus it is not uncommon for midwives within the hospital setting to intervene not because they perceived such intervention as strictly necessary but because they are following what they believe to be the consultants' policy, (Flint 1988:31).

Task orientated care has also been identified as being perpetuated by midwives within the hospital setting. Macintyre (1978) through observing the structuring of interactions around the booking form, identified the manner in which the control of the interaction between midwife and woman is maintained according to a medical definition,

> "... the midwives who collect the data do not design the record sheets. It is the medical staff who dictate what data are to be collected for their own purpose." (Macintyre 1978:610)

Methven (1983) also noted in a study of midwives' behaviour during the woman's first encounter with ante-natal care the 'booking visit' that midwives constructed the initial interview entirely according to the demands of obstetrics. The midwives therefore directed the interaction towards medical priorities, while failing to illicit information relating to the women's perceptions, expectations and subjective experience of pregnancy. Thus valuable information which could have supported the devlopment of user-centred care was not collected as the interaction operated entirely within the boundaries of the medical frame of reference.

Furthermore, Methven identified that the priorities of the institution also affect the quality of the interaction, in that if communicating with women is perceived as a low status task then little energy will be devoted to establishing a good rapport. Within the institution of the hospital the hierarchy of priorities of the majority of staff tend to become structured towards meeting the needs of the medical profession and towards fulfilling the demands of the administration and bureaucracy.

Thus Methven (1983) found that booking women was a task ascribed to non-permanent staff and to students while the permanent qualified staff, the very ones who were also more continuously available to develop a positive relationship with the women, concentrated on managing the organisation of the clinic or chaperoning the doctors. This process of apparent acquiescence to medical definitions by midwives led Cartwright to conclude that:

> "The extent to which midwives can be seen as identifying with mothers is limited in the sense that many accepted apparently uncritically the doctor's power to make decisions about induction without taking into account mothers' views and preferences." (Cartwright 1979:156)

Comaroff (1977) found that in the hospitals she studied midwives perpetuated and reinforced medical definitions for the management of pregnancy and childbirth while being at the same time overtly hostile to the pregnancy as 'normality' definition of the physiotherapists teaching relaxation classes. Comaroff concludes that it is the situation of the midwives practice in the hospital and working within the confines of the medical model which generates these competing paradigms:

> "The situation of midwives in the hospital rather than in the community and their opposition to such competing para-medical categories as physiotherapist in the management of childbirth, leads them to stress their orientations towards the medical establishment." (Comaroff 1977:131)

The next sub-sections are concerned with some of the further possible explanations for this situation and the response of midwifery itself.

Medical Knowledge and the Training of midwives

A review of the midwifery textbooks available to student midwives in Sheffield's medical library (Law and Friedman 1972, Hallum 1976, Bailey 1976, Clyne 1980, Myles 1974, &1984) reveals a considerable opposition to home births. In the discussion of birth the textbooks follow a similar pattern, that begins by stressing the dangers inherent in birth and labour and continues with the stricture that the unknown risks associated with deliveries warrant all births occurring in hospital. In addition the majority of the these textbooks tended to devalue the ability of women to determine the management of her pregnancy and to make choices in a rational manner. Instead the texts imply that ultimate responsibility lies with the provider of care and not the pregnant woman.

> "Where ever possible the patient should be allowed to choose her place of confinement. This choice however must never take precedence over the needs for her safety. Thus should she want to be delivered at home this can only be agreed to if she belongs to a category of a patient in whom a normal delivery may be confidently expected." (Law and Friedman 1972).

In all the texts reviewed medical definitions of safety predominate. (The difference between medical and women's definitions of safety is discussed in chapter chapter 5 - limits to control section). Furthermore all of the texts provide strict criteria for the type of women who are to be denied a home birth:

> "It is generally agree that no primigravida should be delivered in her own home." (Clyne 1980:156)

> "Home birth may thus be considered **only** for a healthy woman under 35, expecting her second or third child, if her previous obstetric history is normal, her present pregnancy uncomplicated and her home suitable." (Bailey 1976:406 my emphasis)

None of the textbooks examined provide evidence to support their categorisation of women who were not eligible for a home delivery. None supported their claim that hospital was safer with any evidence, or that home deliveries were any less safe with any evidence. This tendency was noted by Cameron as a feature which occurs throughout midwifery training;

> "The traditional training does not encourage a questioning attitude which is essential for a profession to survive and flourish... Theories may be presented as facts to the student. An accepted practice - particularly where it is medically sanctioned is not questioned. " (Cameron 1985:43)

This provides an illustration of the control by obstetrics over other professionals and workers in the hierarchy of institutional expertise,

> "It is true for other workers as for the patient that the professionally organised division of labour has pathologies similar to those stemming from bureaucracy." (Freidson 1970:145)

One illustration of this dominance of obstetric knowledge over all other knowledge within the system is illustrated through its control of midwifery. Further support for such an influence is provided by the midwifery textbooks reviewed as with the single exception of 'Miles' all the textbooks were written by obstetricians who are experts in the abnormal and not by midwives who are primarily concerned with the normal. Thus through the obstetric body of knowledge, obstetrics is capable of exercising considerable direction of midwifery knowledge. Furthermore, obstetrics as the dominant profession also exercsises considerable control over the development and advancement of knowledge relating to pregnancy and childbirth.

> "In it's control over practice the profession of medicine maintains control over research - research in it's broadest sense. Data is collected both formally and informally to support and develop the medical basis of knowledge. But the data is itself generated by the medical practices. The context in which medical knowledge develops and is used shapes that knowledge ... " (Rothman 1984)

This situation led Kirkham (1987) to conclude that, in order for midwifery to assert a central role in the provision of maternity care, they would need to assert and develop an independent body of knowledge.

Within the midwifery literature the issue of training has also been interpreted in the light of a need for midwives to assert a midwifery rather than an obstetric-midwife based training for midwives. Morrin (1982) for example, argued that midwifery training should be reviewed to produce a more questioning and articulate midwife, who is not just an obstetric nurse, but rather a confident professional who is able to defend midwifery from a further deterioration in status and medical encroachment. A measure of assertiveness

training has been advocated in order for midwives to reassert the significance of their role in the provision of maternity care.

> "We must ask our selves why we are unduly influenced by medical opinion unable to form judgements of our own and insufficiently articulate and confident enough to voice our opinions? Are we products of a training where the emphasis is on covering a syllabus irrespective of understanding. logical thinking and individual development? Should midwifery training be reviewed in relation to the calibre of the midwife we wish to produce? Do we want midwives or obstetric nurses?" (Morrin 1982)

The quality and content of training has also been criticised by the Association of Radical Midwives (ARM) who similarly argue that midwives need to be able to evaluate standards and techniques of care as well as being provided with a broad curriculum which can respond to changes in the social and economic conditions women find themselves in, such as unemployment and poverty (Bolton 1985).

Similarly Newson (1982:528) argued midwifery education should produce midwives who are flexible enough to respond to the individual needs of women, and that it is responding to those needs which should be come central to the training of midwifery in the future.

> "Midwifery education in the future must aim to produce midwives who recognise the importance of listening to the consumer and are able to adapt their skills to women's needs."(Newson 1982:528)

Erosion of the midwives role

One of the key concerns in the literature has been the erosion of the midwives status. Through out the period reviewed (1970-1989) concern has been expressed by the profession over an apparent contraction of the role of the midwife and the erosion of her status (Walker 1972, Donnison 1977, Morrin 1982, Towler 1984).

> "The midwife has been maligned and discredited as a professional and erosion and contraction of her function and under-utilisation of her skills are well documented facts." (Towler 1984)

An erosion which has occurred despite the fact that midwifery is unique among the nursing related professions in having the status of an 'independent practitioner' in cases of normal childbirth (Midwives Act 1902). This erosion is believed to have progressed to the point, where midwives are no longer able to exercise the level of responsibility for which they were trained, midwives have become *"a dying species"* (Towler 1982). With the role of the midwife in the future being perceived as constituting nothing more than that of an obstetric nurse or chaperon to the doctor.

The causes identified by the midwifery profession for this erosion of their role all to a certain degree relate to the dominance of the medical model as a framework for providing care. The fact that most midwives work in the hospital reflects the dominance of the obstetric model, in 1982 some 16, 368 midwives registered their intention to practice in the hospital sector while only 4,235 registered for the community.[2]
Part of the reason is attributed to the definition of pregnancy and childbirth as pathological; as the expert in the normal processes of childbirth,once the birth is defined as an obstetric event the role of the midwife becomes automatically marginal.

> "Perhaps one of the main threats to the execution of the midwifes role is the practical application of the philosophy that childbirth is only normal in in retrospect." (Flint 1985:23)

A further implication of this, is that, the very notion of a midwife and her contribution to maternity care has become increasingly obscured, so that other professionals and women do not comprehend the midwives abilities and skills. Midwifery is therefore caught in a cycle of self-fulfilling prophecies (Brooks, Long and Rathwell 1987)

> "... women have come to expect medical care and hospital admission to be the norm. This may make it difficult for pregnant women to feel safe with the care of midwives when they have no knowledge of midwives' training or expertise" (Cameron 1985:42)

Midwifery is therefore caught in a cycle of self-fulfilling prophecies, because their responsibility and area of practice has been contracted this results in midwifery becoming less significant to women and other professionals which results in a further contraction of their role and status (Brooks, Long and Rathwell 1987). Thus there is a general consensus in the literature that the medicalisation of childbirth and in particular the move of the majority of maternity care provision into the hospitals has resulted in a fragmentation of the role of the midwife,

> "Many midwives find it unsatisfying to see women exclusively ante-natally or during labour and feel that they are working on an assembly line." (Kitzinger 1982)

It may be the that the impact of the co-optation of midwifery to the medical model within the hospital system is the predominant factor in the erosion of the midwives role.

Goldthorpe and Richman (1974a) in a study of increased domiciliary confinements as a result of the hospital strike in 1973, found that, midwives welcomed the opportunity to deliver primagravida women in their own homes because of the

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2. Although the intention to practice register is a fairly crude measure in that doesn't match all those actually working as a midwife, in that 'intention to practice' does not equal the numbers who will actually practice during the year.

improved quality of the relationship this provided. They (1974b) also found that the community midwives held a different frame of reference towards childbirth and maternity care than those midwives working at the hospital. In line with Comaroff's (1977) later findings, midwives within the hospital structure were found by Goldthorpe and Richman (1974b) to adopt a task centred approach to care provision while the community midwives worked within a different paradigm, which was more user-centred in nature.

> "Taken together the work of Comaroff and Goldthorpe and Richman suggests particular paradigms of maternity care are associated with different methods of organising that care." (Hale 1985:25)

Professionalism

One solution to this situation has been for midwifery to reassert its traditional with-woman role, the growth of both the Association of radical midwives and the move towards independent practice undertaken by some midwives are concrete manifestations of this process. (Chapter 6 provides a further discussion of radical midwifery). However there is a contradiction in that, on the one hand, midwifery appears keen to state the naturalness and traditional nature of the midwives role in pregnancy and childbirth, it's with-woman or wisewoman nature (Holmes 1985), while on the other asserting the emergence of midwifery as worthy of professional status. In promoting professional authority and aiming to establish *'consultant midwives'* (Flint, July 1985) or midwives as, *'The clinicians giving antepartum and postpartum care'* (Towler 1982:326) midwifery may lose sight of women's needs. For it is adopting a model for development and establishing it's authority which strongly echoes the path followed by the medical profession in the 17th and 18th Centuries; in asserting that, midwives by virtue of midwifery's special and unique training only can have access to the body of knowledge concerned with pregnancy and childbirth. Therefore other carers, even women, are excluded from participating in fertility control, pregnancy , childbirth and the early post-natal period, (from the literature they seem quite happy for the health visitor to take over when the midwife has finished her statutory 28 days) and in particular those carers who lack the sanction of professional authority, such as the NCT,

> "We are the professionals and it seems absurd that thousands of mothers (in fact couples) go to classes run by hundreds of lay teachers who undertake a long and rigourous training for this role." (Towler 1982; 325)

The concept that women may feel a need for lay involvement in childbirth and at a personal level a de-professionalisation of their experience is not considered to be an issue in the literature. Women's choice over the care they receive and their input into the decision making process may be substantially reduced by such a shift within midwifery. Thus to some extent professional interests of midwifery have been given priority in the

professional literature over consideration of women's actual requirements or of a considered attempt to understand women's needs. The discussion in the midwifery literature raising midwifery's concern over standards of care and the erosion of the traditional role of the midwife needs to be seen in the light of operating to strengthen midwifery's claim, to professional status. Therefore a collaborative based approach to providing care is advocated between doctors and midwives as a partnership of equals; a development which would certainly enhance midwifery's status.

Consideration of the total balance of skills required by women is absent from the discussion beyond the midwife and doctor team. Whether the skills of the physiotherapist or the lay NCT teacher are for women a welcome addition to their ante-natal care is simply not even on the agenda for discussion.

Thus the erosion of the role of the midwife has lead to an attempt within the literature to re-assert what has been perceived as a traditional midwifery role, to enable midwives to practice as *'practitioners in their own right"* with separate skills but equal status to that of the medical profession. However an associated consequence of this drive for equal status with medical practitioners has been a move towards developing professional status for the midwife, (Flint 1988). The concept of a consultant midwife has also been taken on board by the profession as an unproblematic means of enhancing the status of the midwife in relation to the doctor. In contrast the potential for such an increase in professional status to create a power relationship between midwives and women users has not been recognized thus the construction of midwifery maternity cases could become a real eventuality. In order to become a profession midwifery must assert a unique body of knowledge and stake a claim to being the only body of providers who have access to that specific body of knowledge. Childbirth could change from being medically controlled to simply being controlled by midwives, with little change for the woman giving birth the fact that midwifery is a female dominated profession may not be enough on it's own to prevent such a development.

The discussion in the midwifery literature illustrates midwifery's essential dilemma, if they are not to become obstetric nurses they do need to change their status, but whether adopting a medicalised status of a profession is the path they should be taking or seeking an alternative path where their status is user-derived - is one which has not been raised as an issue within the 'published voice of midwifery'.

> "Although attached workers are separately liable, GPs may feel a deep moral responsibility for any act involving their patients and their practice." (Dingwall 1980)

This situation has also arisen due to the dominance of the hospital models of practice. The nature of the training received by health workers has institutionalised the dominance of doctors and the subordination of other health workers, such as nurses. Dingwall (1980) argues that patterns of domination and subordination are experienced and established in the hospital setting where the training of health workers occurs, and are thus continued in the work relationships outside the hospital.

Thus the models for relationships between workers in the community are in fact determined by the hospital power structures so that professions which are traditionally subordinate to the medical profession are in a position of institutionalised subordination in any of their working contexts (McIntosh and Dingwall 1978).

This unequal relationship is also maintained within the PHC team through the mechanisms of interaction and communication between team members. An example of this is what Stein (1978) has termed the doctor-nurse game, which means that, nurses adopt an 'array of manipulative interactions' rather than directly asserting their view to the doctor. Empirical evidence to support this was found by McIntosh and Dingwall (1978) as every nurse interviewed for their study felt that making a direct recommendation to a physician was equivalent to insulting or belittling the doctor.

> "The physician is an omniscient and punitive figure the questioning of his knowledge would be unthinkable." McIntosh and Dingwall (1978:128)

A position which, in the main GPs are unlikely to query as a direct questioning of a medical decision by a nurse would be seen by the GP as an inappropriate action for a worker who is only employed by the GP in order to accept task delegation .

Another force preserving the unequal nature of the relationships between health workers is the gender identity of the team members. Doctors are predominantly male while other health workers are almost exclusively female a situation which reflects the unequal sexual divisions of labour.

> "The highly visable 'miracles' wrought by the predominantly male doctors continue to rest on a pyramid of invisible and pre-dominantly female labour." (Doyal 1979)

An illustration of this is provided through the work of the Pithiviers centre in France. The form of maternity care provided there is invariably accorded to the Obstetrician at the centre Micheal Odent, a feature which consistently ignores the central role the midwives at the centre have played (ARM Report 1981 June).

In terms of interactions within the PHC team, Dingwall (1980) argues that there are elements of the Doctor-nurse game (Stein 1978) which reflect patterns of male

dominance and female passivity: for example some nursing instructors were found to explicitly tell their students that their femininity is an important asset to be used when relating to physicians, although the role tutors felt such students should adopt when interacting with a female physician, Dingwall did not relate.

In addition male GPs were found to support such patterns of interaction. Beales (1976) argues that male GPs have a tendency to establish and define their perceived right to head and direct the PHC team in terms of reference to their gender. Furthermore this situation is reinforced Dingwall (1980) argues by the manner in which female health workers rarely speak at case conferences even when their contribution would be highly appropriate instead they tend to defer to the GP and wait for the GP to initiate questions although Dingwall did not analyse the extent to which the GP interrupted the speech of other health workers or prevented them through controlling the interaction from participating. A gender based division in control of interactions is supported by Spender (1980). She argues that women who do defer to men are denied control over the interaction by being frequently interrupted and being talked over and thus she found no instance where women in mixed sex conversations did not defer to men. This situation which is particularly likely to occur among interactions between GPs and other health workers, where there already exists a formal power relationship beyond a solely gender determined one. As Spender concludes:

> "Those with power and status talk more and interrupt more." (Spender 1980)

SECTION FOUR - ALTERNATIVES

Innovations in maternity care

There are three main areas of research concerned with alternatives in maternity care provision which are worthy of some consideration. The first area is concerned with studies of lay midwives and work on the role of midwives from other cultures. These studies - because of their significance as a basis of comparison with the work of the midwives in this study - are dealt with in the main body of the thesis. These include Rothman (1982a, 1983); Weitz & Sullivan (1985); Peterson (1983). The two remaining areas are: Firstly, studies evaluating systems of provision, such as evaluations of innovative developments of projects within the area of maternity care, and secondly, the implementation of natural childbirth.

1. Schemes

During the last 15 years several notable systematic attempts or pilot schemes aiming to provide an alteration in the system of care provision have been set up. Two of the most well known are Sighthill community based scheme and the hospital based "Know Your Midwife" scheme.

The Sighthill ante-natal care project represents one of a number of similar innovatory projects in ante-natal care which have been undertaken in the last ten years. Sighthill is based on a form of shared care with General Practitioners, Community Midwives and Obstetricians. The aim of the Sighthill project is to operate with a greater degree of inter-professional partnership than is normally the case (Reid, Gutteridge & McIlwaine 1983). All women receive ante-natal care in the health centre and post-natal care from the same staff. The scheme is located in a predominantly working class area of Edinburgh. Overall, the scheme is popular with both users and providers and there appears to have been a marked drop in perinatal mortality among babies born to women in the scheme (McKee 1984).

Within midwifery innovative schemes have tended to focus on addressing the lack of continuity of care. The "Know Your Midwife" scheme (1986) is perhaps the most recent widely known example. The scheme was set up in St Georges Hospital Tooting to address the dissatisfaction that both women and midwives felt at the fragmented nature of care and the lack of continuity of care. The scheme was able to reduce the total number of staff that each woman saw. The scheme was also found to affect the quality of the relationship between the midwives and the women users.

> "Know Your Midwife care fared much more positively than the control group, they enjoyed their ante-natal care more, they felt they were more encouraged to ask questions than women in the control group, they felt that the midwives appeared interested in them as a person." (Flint & Poulengeris 1986)

Unfortunately, while these schemes illustrate the significance of changing certain elements of care such as providing continuity of care or local community base care, they are limited for several reasons. Firstly, they tend to remain as isolated innovations, much hailed and largely successful but little imitated (Frohlich and Edwards 1989). Secondly, they are invariably partial responses to the problems within current maternity care provision. For example, care in labour is not considered in the Sighthill scheme. Thirdly, and most significantly, they do not address the fundamental nature of women's lack of control over the management of their pregnancies.

2. The natural childbirth movement & developments in maternity care

It has already been noted that many of the responses to consumer criticisms have simply resulted in an attempt to make the medical management of birth more acceptable.

> In response to the criticism over the high number of caesarian sections hospital in the USA had started to offer 'humanised cesareans,' often described as family-centred cesareans in which the woman can have a supporter with her (usually considered to automatically mean the father)"Certainly this is progress for the individual woman having a caesarian section. But is warmer, cozier Caesarian section the real issue?" (Rothman 1982b:178)

However as Rothman (1982a) argues, an emphasis on natural childbirth with less active intervention does not necessarily provide a much better response.

> "It is widely held that childbirth practices developed in the 1920's including heavy medication, make up "traditional" childbirth, and childbirth preparation is a revolution against that tradition. This is not what happened. The childbirth preparation movement, far from being a revolution is at most a reformation movement, working within the medical model." (Rothman 1982a:79)

This next sub-section briefly highlights the co-optation and in some some senses construction of definitions surrounding natural childbirth.within the medical model.

Mead (1949) argued that the development of much of what is taken to define natural childbirth rather than emerging out of women's actual experience emerged from male fantasies concerning the nature of childbirth. Rothman similarly identified (1982b) the way such developments as Lamaze (1958) and Leboyer (1977) are more concerned with the management of pain, and the experience of the foetus than with women's control over the birth process.

> "Most alternative ways of having babies in our society cannot be regarded as more than reform movements working within the medical model." (Oakley 1982)

In fact maintenance of medical control is not excluded by a commitment to natural childbirth. As Rothman (1982) demonstrates the concept of prepared childbirth involves socialization into a certain form of management of labour which is still a part of the medical model as women are still subject to control;

> "In order to give birth properly these days one must attend classes in it ... to learn how to do it actively." (Oakley 1987)

Although representing a considerable advance in terms of humanising the actual experience of many women, the argument is that the way natural childbirth has been interpreted within the system and in particular the concept of prepared childbirth, demonstrates that natural childbirth has been subject to co-optation by the medical model.

> "The crucial issue is male control of the birth process - regardless of whether that process involves surgical procedures, anaesthesia, or breathing and relaxation exercises." (Bunker - Rohrbourgh 1979:323)

Rothman (1982b) concludes that changes in the provision of maternity care and the ideological framework through which childbirth is perceived cannot be achieved from within by reforming the current system. Thus as noted in chapter one: two forms of reform can be identified; firstly those which humanise care and secondly those which seek to achieve something more ambitious, to return autonomy and control in childbirth to women.

The fundamental issue identified within feminist work is therefore not one of natural childbirth vs intervention, or hospital vs home although changes in the management and policy of such areas may contribute to a change in the control of childbirth. Instead the key issue is the nature of medical dominance over maternity provision. and the question of who is in control of childbirth

> "The home birth movement, incorporating consumers and midwives in a strong coalition, has the potential for returning power and autonomy in childbirth to women as mothers and as midwives. Its effectiveness in creating change in childbirth ideology remains to be seen" (Rothman 1982b)

CHAPTER THREE - RESEARCH DESIGN AND METHODOLOGY

> "Feminist research projects originate primarily not in any old women's experiences but in women's experiences in political struggles." (Harding 1987).

Women's control over their health care and in particular, reproduction has been an area of increasing conflict over the last two decades between providers and women users. At the same time women health workers have also become active in asserting the value of their contribution to health care, midwives for example have campaigned to prevent the complete erosion of their role. Thus the research undertaken was situated within the feminist tradition aiming to understand and document women's experiences, but also to research those areas women had defined as important or valid areas for their concern and energies.

The ethnographic style

The objectives of the research, to explore the nature of a particular type of care provision, with the emphasis on detailing the relationship and mechanisms of interaction between user and provider seemed to be ideally suited to an ethnographic methodology. The adoption of an ethnographic style in the research was felt to be appropriate because of the potential for ethnography to enable detailed explorations of particular settings. As Macintyre (1977) noted, ethnography is ideal to provide a comprehensive analysis of a particular setting.

> "rich detailed accounts of the pattern of activities and social relationships within that setting." (1977:478)

Its strengths lie in the potential to explore the details of the interactions and relationships between participants in an interaction. The use of ethnography has also been usefully applied in previous research concerned to understand the nature of the relationship and form of interactions between providers and users in the provision of maternity care, (Shaw 1974, Comaroff 1977, Macintyre 1979, Kirkham 1987).

As a result this study was felt to be best suited to an ethnographic style of research, away from the experimental style of research founded on the logic of positivism. There are two main justifications for this rejection of positivism, As Chalmers (1982) states, positivism is inherently conservative and provides little scope for breaking out of the dominant paradigm. This is because the scientific model has assumed a value neutrality whereas in fact they incorporate the status quo, as Long argues, what is required,

> "..is a radical critique of the prevailing paradigm which is itself dependant upon the existing structural relations in society." (Long 1984)

This is needed in order to take into account the effects of variables such as power relations, gender and class. Furthermore, the problems of a positivist methodology become intensified with a research design which does not seek to evaluate and generate facts and laws in the sense of say the relationship between ill health and smoking status, but which enquires into perceptions, intentions, communications and relationships between actors in the social setting. In situations where universal laws cannot apply because individuals will perceive and define situations and events differently an ethnographic research style is required to approach these areas.

> "Its emphasis lies not in covering laws but on cultural descriptions, providing explanation and causal understanding. Rules not laws of behaviour are its focus ... How individuals perceive organise and make sense of their situation how they interact, the meanings of health and illness, experiences of illness and social control - all become fitting phenomena for enquiry." (Long 1984)

Within ethnography a researcher aims to capture the *processes of interaction* by this a researcher must understand and evaluate the multiple and even conflicting definitions held by all parties.

In addition, forms of action by respondents will depend on social context and as a result there is a need for interaction to be evaluated where it occurs. Long also argues that it is necessary to see social life and interactions within the general context of the culture or sub-culture of the organisation, thus it is important to evaluate the impact for example of professional authority and professional dominance upon the type and quality of the care provided. Also it is important to incorporate an analysis of wider societal and cultural norms, values, divisions and power relationships which determine and underlie the internal workings of any situation or institution, for example, the manner in which gender based inequalities are reflected in the organisations and delivery of health care services. Finally the ethnographic style aims to understand social action within the respondents' own terms of reference that is for example to evaluate the difference in the perceptions between women's users views and workers' views over such issues as the quality of care provided. The foundation of ethnography is therefore concerned with a subtle exploration of people and their setting, it involves taking on board and interpreting 'their world view,' ethnography is:

> "The work of describing a culture ... Fieldwork then involves the disciplined study of what the world is like to people ... rather than studying people, ethnography means learning from people." (Spradley 1979:3)

Thus, for the reasons outlined above it was the ethnographic style of research with its emphasis on evaluating meanings and perceptions through qualitative data that formed the methodological framework of the study.

However, despite the strengths of qualitative research in enabling a level of understanding of social processes and interaction which would not be possible within a scientific positivist framework, ethnographic research has been charged with being more intrinsically prone to bias than quantitative methodologies. Bias generators have particularly been seen to be a problem caused by the researcher affecting the situation or the respondents in some way, all of which round down to the accusation that the research is unscientific and therefore contains no validity.

> "Some argue that the qualitative researcher being the sole instrument acts like a sieve which selectively collects and analyses non representative data. What these critics often fail to realise is that the researcher acts as a selective sieve in all forms of research." (Bogdan and Taylor 1975)

However one manner in which the qualitative researcher can provide verification of findings is to adopt data triangulation (Long 1984), for example by verifying what people say in an interview situation by obtaining data on actions through observation. Thus Macintosh's (1977) study concerning doctors' information giving to patients was able to identify a marked difference in doctors perception of information given by them and the reality of the situation by using both interviews and observation.

Therefore the choice of empirical methods used in the research was not simply a matter of picking and choosing from a list of methods, interviewing vs questionnaires. Instead the methodology needed to be directly associated with the research questions to be addressed.

Furthermore, in order to achieve as full an understanding as possible of the processes involved in the interaction and to provide verification checks on the data, methodological triangulation was seen as necessary. Thus the research methods employed included longitudinal semi-structured interviews, observations as well as more structured interviews within the setting of the well woman clinic. Following from, this data triangulation was used by employing different methods and contrasting information sources different perspectives were gained on the interaction and relationships.

> "Narrow-mindedness in perspective over appropriate method can only result in extending the number of possible threats to the validity of the study, thus reducing it's ability to generate causal knowledge." (Long 1984)

Furthermore the strength of the qualitative methodology is that it allows for the recognition of bias as an effect, and can therefore account for it.

> "Whatever the problems faced by the qualitative researcher they are faced by other researchers as well. In few other methods, however can the researcher actually weigh the influence of the research situation." (Bogdan and Taylor 1975)

Feminist methodology - Feminist ethnography

In recent years there has been a growth of literature and and increased awareness of feminist research and methodology, (Ferree and Hess 1987, Lupton 1990) While feminist research is not a homogeneous entity (Lupton 1990) certain themes and principles do underlie the conduct and nature of the majority of feminist research. The feminist approach to research begins with the critique of traditional methodologies;

> "Women appear only as they are relevant to a world governed by male principles and interests. To the extent that women sociologists accept that perspective they speak a language, use theories and select methods in which they are excluded or ignored." (Smith 1974)

There is a difference between the application of the ethnographic style and methodological tools within feminist research and the more traditional approaches as evidenced in many textbooks. (see Moser and Kalton 1971, Sjoberg and Nett 1968, Schatzman and Strauss 1973). The difficulty with such texts is that they provide only the most basic outline for the methodological conduct of social research, experience of research shows that it is impossible to apply a research methodology in the rigid cookery book framework that such texts are often written in.

The problem with such textbook methodologies is a failure to acknowledge a distinct feminist approach This is because as Millman and Kantor (1975) argued the theoretical and methodological framework within which sociology operates has been dominated by a masculine paradigm. Thus, as a consequence research within sociology has largely been one of generalising from only one section of society, male. Far from being value-free such research has implicitly been involved in justifying the distribution of advantages which arise from gender based inequalities through a denial of the experience and existence of women.

> "The ideology is pervasive and largely inarticulated but it is expressed within sociology by methodologies which ignore sexual divisions and do not see the experience or situation of women. The symptoms of this are familiar, such as the assumption that statements about social class can be made on the basis of male occupations and that generalisations can be made about all participants from an all male sample." (Roberts 1981)

Their analysis could equally as well apply to the exclusion of black experience and within the sociology of reproduction the exclusion of working class women's experience.

The central message of feminist work in this area is a crucial one for social research in that without an incorporation into the conduct of sociological enquiry and methodological tools a perspective based on women's models and interpretations of the world, then social research is incomplete biased and distorted. Thus what was required was the adoption of a non-sexist methodology, which incorporates women's experience and which does not implicitly support the status quo. The key issue is not only one of choice of method, but to what theoretical framework its application is attached and which

model of the social world is adopted for the research. As a model which incorporates women's perspectives and experience necessitates a methodological framework which is quite different from established methodologies.

A Feminist Methodological Framework - A rejection of the hygienic model

> "We argue that feminist research coming from within a tradition which expressly supports self examination and sharing should reflect these two qualities." (Stanley and Wise 1979)

Traditionally within research reporting it has been the *procedures* of social research which have been documented at the expense of detailing the *processes* involved in conducting research. (Oakley 1981, Bell and Newby 1977 Stanley and Wise 1979). The research process can be taken in part to include the principles or ethics in which the research is grounded, as well as the effect of the research both on researched and researcher and the quality and form of the relationship between the two. To include such issues in methodological reporting, is not to devalue the detailing of procedural aspects, which are obviously an important aspect of accounting for research, but rather to accept that they do not provide the *whole story*. While the inclusion of the process of research is the difference between what Bell and Newby (1977) argued was a descriptive methodology rather than a normative cook-book one.

As Oakley (1981) noted, with regard to interviewing, in research reporting the established custom is to detail the type, number and format of the interviews and to add details only to describe facts such as what prompts were used. Rarely is a presentation given on the process and experience of interviewing itself. However to even provide such a discussion is fairly contentious, in that such aspects of the conduct of research do not fit within the scientific paradigm of *hygienic research* , and thus have not even been seen to be a legitimate area of sociological concern. (Oakley 1981, BSA Equality of the Sexes Committee 1987).

> "Another woman described her experience of having been attacked by the male academics in her department for the kind of qualitative feminist work she was doing. She was told by them that if she wanted to submit for the degree for which she was registered she would have to rewrite her work in a more objective way, as though I was not there." (BSA Equality of the Sexes Committee 1987)

> "As research workers we also become different people through the process. This point is totally and necessarily ignored in the conventional methodology texts." (Bell and Newby 1977)

Although researchers feelings concerning the research situation have been discussed within ethnographic research for sometime (Gans 1968, Hammond 1964 and Vidich 1955) The proper concern of the researcher in such texts is perceived as being one of

avoiding those feelings as bias, is seen as being generated by over-rapport. Involvement with respondents is conceived of as a form of contamination, which a committed professional researcher strives to avoid.

> I had to fight the urge to shed the emotional handcuffs that bind the researcher and to react spontaneously to the situation, to relate to people as a person and to derive pleasure rather than data from the situation. (Gans 1968)[1]

Such contamination is felt to occur, if the researcher becomes a friend of the respondent or so involved in the situation that they can no longer act as a researcher, or their data becomes so skewed as to be worthless.

> "Being friends with people means being open with them and acting as a person rather than as a fieldworker." (Gans 1968)

However are the roles of being researcher and person two mutually exclusive ones? Researchers such as Gans describe the difficulty of divorcing one from the other but completely fail to question whether it is valid or even ethical for social research to maintain such a distinction, let alone if it is actually possible.

In terms of the methodological validity of hygienic research it is feminist research which has provided the most relevant critiques. Stanley and Wise (1979) provide two central critiques in arguing that it is impossible for a researcher to do otherwise than present herself in the research process and to be affected by it. Firstly they argue that the deriving of theory, second-order constructs from experience is not a process that is uniquely the province of social researchers.

> "We reject the idea that only social scientists and not people produce general accounts of social reality in this way In this sense it is possible to argue that all research is grounded, because no researcher can separate herself from personhood and thus from deriving second order constructs from experience." (Stanley and Wise 1979 p361)

Instead it can be assumed to be part of the process of interaction which everyone is involved in, to some degree.

The second is a critique of the view that respondents are simply that, mere data receptacles who speak in quotations. This fails to correspond with social reality as respondents are likely to operate with their own agendas,

> "The researched too are actively involved in the research in hand. They may like, dislike, sexually desire, despise the researcher. They will almost certainly construct their own theory about both the research topic and the theory held by the researcher and supply information accordingly." (Stanley and Wise 1979)

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1. Gans was recently reprinted in a field manual (Burgess 1982) thus is still seen as relevant for guiding research protocol.

Thus as a consequence failing to take the respondent into the research process could equally bias the data as they could develop a false conception of the research aims. Oakley in detailing a feminist methodology for interviewing practice argued that the hygienic approach to social research exemplifies *a lack of fit between the theory and practice* of conducting research. A view which could easily be extended to cover the entirety of social research and qualitative fieldwork in particular.

> "A feminist methodology of social science requires that.. the mythology of hygienic research with its accompanying mystification of the researcher and the researched as objective instruments of data production be replaced by the recognition that personal involvement is more than dangerous bias - it is the condition under which people come to know each other and to admit others into their lives." (Oakley 1981)

Thus unless the researcher places her own personal identity into the research process, data collection will be severely hampered as, a hierarchical relationship based on professional distance and non-involvement will be unlikely to achieve the *goal of finding out about people* (Oakley 1981). Thus one the most significant elements of feminist research is that of the adoption of a 'conscious partiality' (Ferree and Hess 1987) through the rejection of the hygienic model.

It is perhaps surprising that this is not more widely accepted and incorporated into research methodology given that sociology has produced rigourous critiques of the manner in which professionals, are unable to communicate effectively with their clients. One explanation for the continuing acceptance of the hygienic method and its specific negating of the feelings of researcher and researched is that it is part of the dominant masculine paradigm within sociology (Oakley 1981). Thus the emphasis on a scientific removal of bias is due to that fact that sociology has adopted methodological models which are masculine in nature (Ross 1979). As Oakley argued, the hygienic approach to research objectifies the respondents participating in the research and generates a power relationship between researcher and researched. Which is also a reflection of the professionalism in research in that one of the characteristics of professional dominance and authority is that *The client has no choice but to accede to professional authority.* (Greenwood 1957)

Summary

As a result of feminist work in this area it is a premise of this research that to ignore aspects of the process of research which step out side the hygienic model of conducting research is not only part of what Oakley describes as the masculine paradigm in sociology, a paradigm which not only specifically negates the feelings of the researcher and the researched, but is also methodologically invalid.

> "The personal is not only political, it also the frequently invisible yet crucial variable present in any attempt to do research. We emphasize that it should not be absent from doing feminist research." (Stanley and Wise 1979)

Therefore it was with the feminist critiques of the hygienic method in mind that I formed the methodological foundations for the interviews and observations conducted in the research. Thus while this chapter will present the procedures and stages of development of the project, this chapter also aims to partly redress the imbalance in traditional research reporting, by discussing the processes of the research, the ethical considerations and dilemmas it presented as well as issues such as the presentation of self as the researcher.

THE CONDUCT OF THE FIELDWORK

The practices

The selection of the research practices[2] was determined by an interest in evaluating the *ideal* rather than the norm, in terms of both health care provision and structure of the practices. The practices were therefore chosen specifically as examples of *ideal practice*. The aim of such a choice was to provide firstly, a means of identifying if an alternative model to the medical model for maternity care provision could function in practice, and secondly if such a model corresponded with women's requirements of the service or if they are inappropriate constructs imposed by professionals and academics.

The practices were chosen because of their reputation for possessing a well integrated PHC team approach to service provision especially in the area of women's health and for developing innovative approaches to health care. The practices stated they had explicitly adopted a policy of aiming to provide women with a real and informed choice concerning all aspects of their care but particularly in the area of reproductive health and maternity care.

Composition of the areas the practices were located in

The fieldwork was situated in two group practices in predominantly working class areas of a northern industrial town. These were identified by the Local DHA as being areas of average to high morbidity and social deprivation.[3]

In order to provide a context for the fieldwork, a comparison of the two research sites (the names have been changed) from the local census report (1981) had been provided although it is worth noting a few problems with this data, apart from the fact that census material is by its nature out of date. The two major omissions are that break down by ethnicity and gender are not provided in the area analysis, as well as other factors relevant to this analysis such as marital status while also excluding single parents

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2. The names of the practices and the people interviewed have been changed to retain their anonymity.

3. Statistics taken from the local census report 1981. Figures in brackets marked CA refer to city average.

from some of the statistics. However given these flaws, the census data proved to be useful in providing a guide to the areas of the research sites.

The first area (North) is composed of mixed housing with traditional turn of the century terraced houses of which some are privately rented (13%), but increasingly coming under owner occupation, 52% (CA 44%) and some modern council housing 32%. In terms of its social composition, it is closer to the city average in most respects than the second research practice. 54.% of all households do not own a car (CA 52%), Unemployment is at 10% (CA 11%) and over crowding in houses with children under 16 is at 24% (CA 28%).

The other practice (Park) is situated in an area composed almost entirely of council owned 60's high rise, developments 88% compared to a city average of 44.5% In terms of factors which can be termed as indicators of social deprivation, moderate over-crowding is high in households with children under 16, 44.1% (CA 28.3%) along side which 70.4% of all houses do not own a car, 58.6% in households with children under 16 (CA 36%). The unemployment rate is 14.7% which is also well above the city average of 11%.

In terms of the Social class composition of both areas, while recognising the problems associated with using a social class distinction

Table 1.1 Class composition[1] of heads of household with economically active head.

	Class					
	I	II	IIIN	IIIM	IV	V
North	3	15	13	42	22	4
Park	1	9	7	43	31	9
City average	5	20	11	37	19	6

All figures = %

1. (Census 1981) Thus overall North is area which is typical of Local as a whole, and could be considered to be a more traditional working class area in both composition and sense of community structure.
Park is an area of higher social deprivation as well as higher than average mortality and morbidity.

Choice of practices

In order to evaluate the conception of something approaching an ideal form of women's health care provision a criterion for identifying suitable practices was developed. This criterion was drawn from the proposals of ideal practice outlined in chapter one.

The choice of practices was based on as close as possible conformity to the models and recommendations advocated by previous researchers in the field as well as lay pressure groups. In practice this consisted of the following criteria:

1. The operation of a system of shared care for consultant bookings.
2. In addition the chosen practices would have to have a high percentage of home deliveries and GP unit deliveries. The criteria for home deliveries should include first time mothers and women over 30.
3. That the practices should state that the choice over the place of delivery was entirely the woman's. In practice this had to be modified as no practice could be found which stated they would readily book multiple and breech births for home deliveries and such deliveries were not allowed to be conducted in the GP unit.
4. Midwives were responsible for the provision of care to the women and acted as more than obstetric nurses, but instead there was an expectation at the practices that they would work within the definition of a midwifery practice detailed by the World Health Organisation (1966). WHO defines the sphere of practice of the midwife as:

> "She must be able to give the necessary supervision, care and advice to women during pregnancy , labour and postpartum periods, to conduct deliveries on her own responsibility and to care for the newborn and the infant." This care includes preventive measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help. (WHO 1966)

In particular I was concerned to use practices where the midwife provided continuity of care to the women; that is she was responsible for the day to day running and organisation of the ante-natal and post-natal clinics as well as attending the women's deliveries.

5. The practices were to state a commitment to providing continuity of care and to have a well developed system for providing continuity of care.
6. Possession of a full and well integrated PHC team, including Health Visitors and Nurse Practitioners.

Practices within the Postal districts identified for the research were then contacted. These were drawn from the Doctors Postal list and from this practices without female GPs could be eliminated. The GPs were first contacted because lists of GP practices were readily available. Although 5 practices were identified as *radical*, 2 were in middle class areas and the third did not possess a female GP who offered home deliveries at that time for first time mothers. Thus it was decided to concentrate on the remaining two practices. In preliminary discussions with the GPs the remaining two practices identified themselves has having a commitment to a fully integrated PHC team including health visitors and Nurse Practitioners. As well as stating that they had adopted a policy of aiming to provide

women with a real and informed choice concerning all aspects of their care particularly in the area of maternity provision.

The organisation of the practices

The two practices were very different structurally (See chapter 5). One was a modern (North) newly built surgery and the other a 1960's health centre (Park).

Within the north practice there were four GPs. Three men and one woman although only the woman, provided maternity care (although during the last month of the research this was being undertaken by one of the male GPs). In addition the PHC team consisted of 1 midwife, 1 Health visitor, a nurse practitioner, a counsellor and three receptionists.

The Practice consisted of three entirely separate practices. One composed the 'radical practice' which took part in this research, the other two could be defined as more traditional and although had a midwife attached did not offer home or GP unit deliveries. The radical practice consisted of 2 GPs, a midwife a practice nurse. The health visitors and receptionists worked with all the practices. During the course of the research, the GPs at the practice changed. Originally when the fieldwork was started the GPs consisted of one male and one female GP who both provided maternity care. However three months into the project the male GP left and was replaced by a female GP, who was also committed to providing home/GP unit deliveries and it was therefore with this GP (Louise) that the majority of the research was undertaken at the Park practice. the midwives at both practice remained the same throughout the fieldwork.

The GPs included in this study and interviewed were only those who provided maternity care.

Ante-natal appointments were made according to the recommendation in the Midwives Rules:

> "Every four weeks until 28 weeks
> Every two weeks until 36 weeks
> Every week until baby is born."

The majority of women were seen at each visit by the midwife and occasionally if the clinic was busy by the GP instead. The GP was seen by the women once at the beginning of the pregnancy to discuss the booking for delivery and once towards the end. (approx 36-38 weeks).

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The place of birth

Within the city women have four options available as a place of birth (including home birth). There are three hospitals providing obstetric and gynaecological services;

1. **The Infirmary** - Women's hospital with consultant unit which - specialises in abnormal deliveries. In recent years this hospital has made some concessions to the natural childbirth movement with the establishment of a natural childbirth room. However midwives pointed out that this room is not offered to women when they arrive at the hospital, they have to find out about it's existence before hand and actively ask for it.
2. **The General** - Services the northern side of the city - large General Hospital. - none of the women in the sample opted for the General, mostly due to travelling distances involved.
3. **The York** - Has a small consultant unit but also houses the GP unit.

The GP unit - This unit enables women to be booked and cared for during their ante-natal under the community system and to be given continuity of care throughout. Women booked for the GP unit do not normally attend the consultant ante-natal clinics. The midwife attached to the women's own GP practice normally attends the delivery, visiting the woman at home during labour and taking her into the hospital when she is ready.

The policy of both the practices and the other community midwives interviewed is to use the GP unit as a means of providing continuity of care to women, and for women to be delivered by a midwife they have established a relationship with. In most cases the women are looked after in labour for as long as possible in their own home, before going into the hospital. The GP may not even be present for the delivery although the midwife usually will contact him/her during the second stage.

Home birth - The Regional Health Authority's official policy is to *encourage* 100% hospital deliveries. Although the flying squad is still in existence in the city. Ease of access to a home birth depended on the women being registered with a GP who offered such a choice to women, or accessing knowledge of their rights regarding a home birth through books of childbirth and pregnancy.

The fieldwork

As this was to be an in depth ethnographic study, it was felt that following the experience of a sample of women through their pregnancy from two practices would provide a broad sample base, particularly where this would be supported with interviews of staff from other practices. These interviews were to prove to be particularly useful in extending the analysis of a user-centred model held by the midwives model of health care provision. During the course of the research it was found that there existed a core of radical midwives, (the midwives at the participating practices formed a part of this group)

these additional radical midwives were subsequently interviewed. These interviews were undertaken to provide a means of evaluating if the philosophy and approach of the midwives was more universal and formed part of a philosophy held by other midwives working in similar environments.

Although it was felt that these midwives practices were not suitable for the main part of the field work as either the GPs were not as committed to providing the mode of delivery to be evaluated or else they proved to be in predominantly middle class areas.

Access

> "Negotiating access to organisations for the purposes of research is a game of chance not skill." (Buchanan, Boddy, McCalman 1983)

Gaining access for any piece of social research is not simply an issue of gaining entry to a proposed research site or number of respondents. Consideration also needs to be given to developing an awareness of what degree of access to information or interaction was given or withheld.

As a feminist interviewing and observing women during an important life event, I further felt that it was necessary to remain aware that women in agreeing to be involved in the research had not implicitly given access to all aspects of their experience and that access would need to be renegotiated with them at various stages, for example by asking their permission to remain present during a clinic visit where the midwife has decided to do a breast examination, or where the women wished to discuss personal details in private.

However given these considerations, access, never at any stage of the research proved to be a problem, either in terms of gaining initial access or entry to the practices or in terms of graduated access such as access to information, observational settings or respondents. Although exact reasons for this are obviously difficult to validate, but evidence does point to this being in part due to the commitment to the research by the midwives and the women and their feeling from the information I had provided concerning the aims of the research, that the research possessed some value. Thus they would volunteer unasked for information even when it might not conform with their values or views, for example one midwife who was very committed to home births informed me,

> *We thought of you yesterday Fiona as I went to do this delivery for one of the other midwives and it was a home birth but we got the impression that the woman wasn't very keen at all and in fact she wasn't happy having a home birth because she was very anxious but the husband was very keen. And we thought it would be good for you to talk to her, as she wasn't happy. To find out what she really wanted.* (Midwife - Jean with student)

Here again I was able to identify a mismatch between the text-book approach and the reality of conducting research,

> "The researcher who hides his researcher role can enter more easily than the researcher who describes himself as such, and begs admittance on the basis of persuading people that scientific research is useful and desirable." (Gans 1968)

In fact the degree of access was aided by my being explicit about the purpose and aims of the study with the result that the women did feel committed to the study. This situation was certainly helped by the stating of my own stand-point to the practices, the promising of results and the commitment of the practices to publicising the radical nature of their health care provision. However it was not only the professionals who became involved in the research, the women users also demonstrated a degree of involvement and interest. However, unlike Oakley's experience few women contacted me directly, which is perhaps unsurprising given that many of the women did not have access to a phone. Oakley's experience in this respect is perhaps a consequence of having a predominantly middle class sample. But despite this many of the women volunteered extra information or added to comments they had made in the interviews or to tell me of their further experiences, if they saw me passing through the clinic. Thus contrary to Reid's (1983a) assertions, working class women can also possess an appreciation of the research process.

For both of the main practices studied the first approach was made to the GPs who after being interviewed themselves agreed for the research to be conducted in their practices although they, as well as myself, insisted on the right to veto their involvement in the research being given to the midwives and the women themselves.

The majority of women were contacted at their first appointment with the midwife, during each practices' ante-natal clinic, this was after they had seen the GP or the practice nurse to confirm their pregnancy and had discussed their intentions regarding the future of the pregnancy with the GP. The original intention had been to contact the women at home as Graham (1980) had done to enable the women to discuss the research on their own territory and to distance the project from an association with the practices. However this was found to be far too time consuming as few women had phones and the majority who lived in the high rise flats tended to go out for the majority of the day.

Before starting the fieldwork, it was expected that some of the women would refuse to be involved and the midwives or GPs would place limitations on my degree of access to observing their practice. However this never occurred, no woman refused to take part in the study or dropped out at before subsequent interviews. While the midwives and GPs although expressing considerable interest in the findings never expressed any concern over what I was doing with the material or even hinted that they would rather I did not observe any aspect of their clinical practice. There are two possible inferences to

be drawn form this, one positive the other negative. The first is that both my relationship with them and their commitment to the research was a result of the position of trust we had built up. The second negative inference, is that women are unlikely to refuse, even when they wish to do so. While both are likely to be part of the cause, during the course of the study the second explanation did give me cause to re-think the presentation of the manner in which researchers ask people to be involved in research, particularly where the research is on women. I was aware that as women, the professionals and the users of the service as well as the researcher myself, has been subjected to a process of socialisation where by women are negatively sanctioned against saying *No*. This issue was first noticed during the initial introduction to the women, in that none of them refused to take part in the research. With regard to this issue, I was not too concerned about the professionals as I had lengthy interviews with them before conducting any real fieldwork and had negotiated with them in detail, concerning the nature of the research it's usefulness of otherwise to the practices and their access to the findings. Therefore in certain cases such as in the questionnaire for the well woman clinic some questions were included that the practice nurse specifically wanted answers to. However I was concerned for the women over this issue. A particular concern was over providing an opportunity for the women to refuse at the initial interview if they so wished, given the situation where the women were introduced to myself and the research in the ante-natal clinic during their first visit *(consulting room)* and that they might not want to appear to upset the midwife or even say no to a *friendly student*. Thus it was felt that because the women were being asked to give substantial amounts of their time for interviews, as well as allowing me to observe and record very personal details and relationships and private interactions in the clinic I needed to develop mechanisms which allowed the women to opt out of the research, or certain aspects of the research, in order to respond to a need the women might have for privacy with the midwife or health professional. Thus on first meeting the women and also at the first interview I stated that they could ask me to leave at any point when they were seeing the midwife if they wished I tried to do this in an informal manner which aimed to express that not only did I not mind but that they had a right to determine their own degree of privacy and involvement in the research. For an intrinsic aspect of adopting a feminist methodology which departs in its approach to respondents from their objectified status in a more traditional research protocol must be a commitment to providing a means where by women respondents are in control of their degree of involvement in the study.

Although no woman refused to be involved in the study or dropped out for the subsequent interviews, two women made use of opportunities provided to opt out by temporarily refusing access to part of their interactions with the midwife, this happened on two quite specific occasions. Both were instances where the women asked if they

could see the midwife alone for that one clinic sessions, both occurred in the middle stages of their pregnancy but before the second interview and were concerned with wishing to discuss personal details with the midwife. Interestingly at the post-natal interviews where I knew both of the women infinitely better by then both women detailed what had happened at these meetings with the midwife without me mentioning the incidents again; which is again an indication of the position of trust we had established which went beyond simple rapport in that the women wanted to discuss personally distressing incidents of their own volition.

Thus as far as possible the women were given every opportunity to withdraw access as they wished. With the best manner to achieve the women's confidence being to adopt an approach which was informal as possible. Certainly being introduced by the midwives helped provide me with an air of acceptability but I also needed to distance my self from the midwives, in order to allow for the expression by the women of any dissatisfaction with the midwives.

Finally perhaps as researchers it is wise not too make too much of our skills in persuading people to be committed to social research, but rather to be aware that people respond to us as individuals regardless of any other roles we possess.

> *Jane: Would you like to come to my delivery as you haven't seen any, I would like that actually.*
>
> *Researcher: Well yes if you are sure that you don't mind...*
>
> *Jane: Oh no, I don't mind you because I know that you are a proper researcher and won't be interfering with me, I wouldn't let a midwife or a doctor sit in who was doing research as you never know what they would do.*

Whereas Kirkham (1987) a midwife researcher in a similar situation was faced, by the opposite:

> "Indeed one patient I asked in ante-natal clinic if I could observe the labour answered, You can because you are a midwife I wouldn't have a Sociologist."

The Women

The main body of the fieldwork concentrated on following the progress of a sample of predominantly working class women, who were pregnant for the first time (*primagravida*) through the community maternity care system. There are several main reasons for adopting such a sample for the basis of the fieldwork. Pregnancy brings women into contact with the major components of the PHC team and in particular a wide range of female workers. The provision of maternity care also represents an aspect of health care delivery which is primarily concerned dealing with dealing with normality

rather than ill health. Thus an evaluation of maternity care provides an opportunity to assess the health care systems response to health care rather than disease care. Pregnancy and childbirth also represents an experience which is unique to women. Thus an evaluation of the health care systems approach to care provision in this area is likely to be a valuable indicator of the general approach in the NHS to women's health needs and also to what degree health care provision to women in the PHC sector is necessarily determined by the patriarchical nature of society. Following from this, I was interested in the processes where by women may become empowered through control of their health care, their experience of care during a normal process where female health practitioners predominate seemed an ideal starting point for such an analyses.

The decision to concentrate the major part of the field work on first time mothers, stemmed from the fact that it was decided to evaluate the choice and options available to women with no previous experience of the maternity health system and who therefore would be more likely by virtue of their inexperience of the system and biological process of pregnancy to require a greater amount of information, thus providing an opportunity to investigate what information and support they would receive from health providers and their perceptions of that information. Also women during their first pregnancy are most likely to have questions, which they would be required to go to sources outside of their own experience for an answer. The source they choose to go to would be a likely indicator of their relationship with the health care staff.

Finally there is a widespread incidence of primagravida women being classified as high risk cases and being refused home births or natural childbirth. I was therefore interested in evaluating if the midwives and GPs would label the women in this way.

Sampling

The women were sampled through the practices who were asked to keep a record of all new primagravida women who came to the clinic after a certain date. The original aim had been to then draw from that list a sample of working class women, which would also include a number of women from ethnic minorities and women across the age range. However the fates seemed to have other ideas and during the first three months of the project only 3 new women in total presented at both practices. This was despite the fact that the midwives normally found March to be a busy time.

The only response seemed to be to wait, but it seemed sensible to alter the criteria for sampling and to include any new primagravida woman. During this time (apart from stating observations and interviews with the three women) the fieldwork concentrated on interviewing the health workers and the midwives from the other practices, in addition to conducting preliminary observations at the clinic so that the workers could get used to me (and the tape recorder) and I could familiarise myself with the clinics. This extended period of familiarisation proved ultimately to be very useful as the concentrated period of

consideration of the workers view provided the basis for the depiction and analysis of their frame of reference.

At the end of October a full sample of 30 women was drawn up.

Structure of the interviews

The sample composed of thirty women who were first interviewed when they made their initial visit to the ante-natal clinic (approximately 12-14 weeks pregnant). Originally 33 women were contacted; two were lost due to early miscarriage and one moved out of the area. Each woman was interviewed at least three times composing in total 89 interviews with primagravida women *(one woman missed second interview due to early delivery at 29 weeks)*. All the interviews were semi- structured in nature, with key themes being explored which each woman.

The first two interviews were conducted in rooms in the health centres, one was the practice nurse's office and the other was the centre counselling room, both were comfortable informal rooms which were conducive to a relaxed atmosphere.

The initial interview explored the issues surrounding the women's choice over place of birth and expectations for the pregnancy and birth, as well as initial feelings surrounding the delivery of ante-natal care and their relationship with the health professionals. (*exact examples of questions asked are in Interview schedules appendix 1*) Two further interviews were then conducted with each woman: One during the later stages of their pregnancy (30-32 weeks) which developed and enlarged on issues already discussed concerning their experiences and expectations of pregnancy while also identifying any changes or developments in their feelings concerning their health care since their pregnancy began. Furthermore because regular observations were conducted on the women and workers' interactions during the period of their ante-natal care, it was possible to maintain a high level of contact with the women during their pregnancy. This regular contact resulted in being able pick up on any changes or significant events, although frequently if anything important had happened to the women they would stop me in the ante-natal clinic and inform me. Due to this increased contact with the women and their readiness to inform me of any changes or important events the necessity for more interviews than the planned three with each woman was removed. The final interview was conducted in the women's own homes approximately one and half months postpartum. This interview concentrated on their experience of care during labour, as well as gaining a retrospective view on their pregnancy and relationship with health professionals. The timing of the interview was chosen to allow for the health visitors to have been in contact with the women. (Seven of the women were contacted at around 3 months postpartum due to an overlap of holidays.)

Women and second pregnancies

In order to draw comparisons and to suggest how far extend the analysis to other women, 10 second time mothers were also interviewed at length (appendix 2). The aim of these interviews was, to gain a comparison with their experiences between the first and subsequent child. Within this I deliberately chose, from the midwives lists, women who had experienced GP unit deliveries or home births with the second or third. This was to explore if they felt their needs from the care provided at the practice differed from those of first time mothers. However ultimately, no substantive difference was found between the two groups, although comments in the text from these women are identified as 'second-time mothers'.

Well woman clinic evaluation

As already noted (see chapter 1), a series of structured interviews were also conducted with users of North well woman clinic (see appendix 3 for the questions asked). In addition, a single group of Asian women (12) were interviewed at a local Asian community centre, where a health day was being held and a well woman clinic was provided by the nurses from the North practice. These interviews were not a part of the original design of the research but were conducted as a result of discussions with the practice nurse at the practice. The aim of these small scale pieces of work was to, raise issues surrounding the wider applicability of some of the elements of the model of user-centred maternity care to respond to women's wider reproductive health needs, in addition to providing some commentary (albeit very limited) on the needs of asian women. The findings from these two surveys are addressed in chapter 7 where they provide additional data on the women's views, particularly in relation to the appropriateness and relevance of the different professions and gender of the providers of care. These surveys are also mentioned again in the consideration of areas for future research in chapter 8).

Sample Characteristics

The following series of tables details the characteristics of the main sample of women pregnant women. Two of the women (both from Park practice) were black from Afro-Carribean backgrounds, the remainder were white. All the women, with the exception of two women from the North practice, had lived within the city for the majority of their lives.

Table 2.1 Martial Status

	Characteristic	*No.*
Martial Status - 1st pregnancy		
At interview 1.	Married	14
	Cohabiting	9
	Single	7
At interview 3.	Married	18
	Cohabiting	5
	Single	7
Martial Status - 2nd pregnancy		
At interview 1.	Married	8
	Cohabiting	1
	Single	1

N=40

Table 2.2 Ages

Characteristic		*No.*	
AGE (at first interview)	All	W/C	M/C
16-17	5	5	0
18-21	8	7	1
22-25	8	7	1
26-30	2	1	1
31-35	6	1	5
41	1	0	1

NB - no women aged 27-30.

The next table details the choices the women made in terms of where they planned to deliver their baby.

Table 2.3 Bookings for delivery: (appendix 2 provides details of the individual women and their choice.

	North	Park
Consultant unit	1	4
GP Unit	7	9
Home Delivery	7	2

Overall these numbers were found to be typical of the practices normal booking patterns. Each practice booked on average 18-20 women a year for the GP unit. North booked about the same for home-births although Park booked considerably less around 6 in a year.

Table 2.4 Social class

	Characteristic	*No.*
Social class - 1st pregnancy		
	Working class	22
	Middle class	8
Social class - 2nd pregnancy		
	Working class	6
	Middle class	4

The original intention of the study was to adopt a predominantly working class sample of women, in order to redress the heavy concentration of middle class studies, (Reid 1983a, Nelson 1983) while also evaluating the validity of the claim that it is only middle class women who are dissatisfied with medicalised maternity care, (the reasons for not confining the sample solely to working class women has already been discussed).

Defining the class composition of the sample proved to be fairly problematic in that the Registrar Generals categories are far from being a *carefully calibrated instrument* (Stacey 1976). This criticism is particularly relevant when trying to determine women's social class position as the Registrar Generals categories are based only on economic roles adopted in the male public domain. However, despite such reservations, most studies have then proceeded to use it on the basis that there is little else available as a tool for determining the social class composition of a sample (Oakley 1979). However in conducting the research I found that it was particularly irrelevant to categorise the class experiences of women I interviewed, who have either never worked or who do not have a partner with which their class position can be determined and cross correlated as Oakley was able to do with her predominantly married middle class sample. Furthermore I was constrained from using the women's own occupations as the major criterion as a substantial percentage of the women sampled had never been employed since leaving school. It would have therefore, been inappropriate to analyse women's experience, solely in terms of an economic role, when other factors which are mediated by a class experience may have a greater impact.

Instead other life factors had to be taken into account, such as housing both location and tenure, educational qualifications qualifications, age at first pregnancy,

career or employment expectations, as well as an assessment from the interviews of the women's general life expectations, such as expected age at marriage or first pregnancy.

> *Well like I talk to all my old school friends who have all got kids now, well most of them have.* (17 year old working class woman)

> *It's funny just at the moment almost all my friends seem to be either pregnant or pushing a pram, just like a few years ago every month it seemed like we were going to a wedding.* (31 year old middle class woman)

Interviews - The Professionals

By evaluating maternity care the research also addressed an area in which there has been extensive debate and controversy between differing health professionals and users over who should determine, direct and control the nature of the care provided (Brooks, Long and Rathwell 1986, Newson 1982) with female worker in particular losing authority to the more male dominated professions (Newson 1982.) The evaluation of the relationship between professionals at the practices provided an opportunity to determine if there is a situation in which these tensions and conflicts can be resolved. In terms of interviews with the professionals these consisted of interviews with the members of the PHC team, from each practice which composed of:

Six general practitioners (2 male, 4 female) althoguh two left their practice early in the project (See appendix 1b). The 2 main health visitors and practice nurses from each practice and the two midwives from both practices. Each worker was interviewed at least once with the GPs and Midwives being interviewed twice during the research with supplementary questions being asked throughout the fieldwork period (usually after the clinics). This was very much a continuous period of interviewing occurred with the midwives, which enabled issues raised by the observations or interviews with the women to be followed up as well discussion of aspects arising from preliminary analysis . In addition interviews with *radical* community midwives were also conducted - six midwives in all were interviewed.

The content of the interviews and issues explored with all the professionals (Appendix 3) followed similar themes, which can be divided into three main areas of concern. The first consisted of exploring the professionals relationship and attitudes to other members of the PHC team and their perceptions of their own position within that team; as well as the broader issues concerned with their own professions role in the provision of primary health care to women. The second area was a detailed questioning of their policy towards and actual provision of health care to women, such as their criteria for home deliveries and their beliefs surrounding the values of women's participation in the decision-making process. I was also particularly interested in their views on

women's rights over their own health care and bodies. Following from this, the third area of questions aimed to elicit responses surrounding,how the professionals viewed their interactions and relationship with the women and to what degree they felt the care they provided was of value to the women.

Observations

The observations consisted of observing each visit the women made to the ante-natal clinic and their main post-natal visit. Combined with this, observational material was collected on other women attending the clinic before the research started which allowed the midwives to become accustomed to my presence and to familiarise myself with the mode of interaction of the clinics, as well as enabling observations to be conducted on women who already had children.

Observations of home visits were also made ante-natally with the midwives and two post-natal visits made by the health visitors from Norfolk Park practice. In total, 150 separate observations were completed, with each woman's appointments being observed at least 4 times throughout her pregnancy.

I also attended Ante-natal classes, as means of evaluating the full range of information provided by the health care system to women. The classes were provided by the two main hospitals and were conducted by three different midwives, all of which had been interviewed. 10 1 hour sessions were attended in all.

Data Recording

All interview and observation data with (the exception of the well woman questionnaire) were tape recorded. For the interviews the choice to tape record was a relatively simple decision in that note taking is by its nature selective and would have imposed on the women's accounts a form of instant filtering which could not have been founded on any rigourous analysis and would therefore have missed the emergence of categories that came up from analysing exact transcripts of the interviews. For the observations again, recording proved to be a far superior method to note-taking in that by placing it under a chair it was possible to forget about it, if I could avoid the temptation of banging it to check that it was still working. Tape recording proved to be an effective, unobtrusive means of data collection and thus particularly in the observational settings of the clinic, did not interfere with the informality of the interaction to the degree to which obvious note-taking would have done. The same issue also applies to the interviews in that I wanted the interaction to flow as naturally as possible in order to put the women at their ease, so they would feel able to express their real feelings on an issue.

However these are considerations which do not always fit with the reality of conducting research interviews, particularly in the private domain of women looking after children.

For example it would frequently be the case that I would end up walking around trying to quieten a crying baby while the woman talked into the tape so that she could be heard above the din. It is the relationship between the researcher and researched which can transcend this situation, because if that is genuine then the people being interviewed will be unlikely to be put off by the tape recorder, to the degree that they might in a formal interview.

In my previous experiences of interviewing of senior officers in the public domain of the NHS, they as well as I adopted the professional role of the interview as a coherent segment of interaction, which ended when the tape was turned off. Thus I was frequently presented with the statement, *"now that you have turned that off I will tell what you really think."* However the informality of the interaction with other women, making cups of tea etc changed the interview situation, thus no woman could be identified as having changed the information she had given me as being 'on or off the record' in the way that senior professionals in the NHS had done. Only one woman expressed any feeling similar to that and that was because she wanted to turn the interaction into a more social occasion.

> *Right is that it? Great turn that tape off and we can open this bottle of wine, now.* (Nicola)

The Process of interviewing

From the beginning, the conduct of the interviews were based within the critique of the hygienic model provided by Oakley(1981). It was during the conduct of the interviews that, like Oakley, an awareness of the limitations of the masculine paradigm of hygienic research were developed, for the experience of the interviews highlighted as Oakley had found the methodological invalidity of such a research protocol.

Within the interview situation, the aim was to try and adopt as non-hierarchical relationship as far as possible with the women. In line with Oakley's experience of interviewing women, it is important not to mystify the process involved in this, as in actual fact I found this easy to achieve for such an approach conformed with the informal nature of the interaction the women seemed to expect. While an informal approach is likely to constitute an element of good fieldwork,

> "The terms research and interview have strong connotations...Interviews may be associated with television practice where interviewees are regularly and systematically exposed and humiliated or the term may imply a cold and impersonal procedure which discourages volunteers." (Buchanan. Boddy and McCalman 1983)

However, Oakley (1981) found that an important development in her methodology was the concept of joint participation, in the research between her and the women she

interviewed. The implications of this was that her relationship with the women underwent a transition from participating in the research to a more personal relationship.

> "One index of their and my reactions to our joint participation in the repeated interviewing situation is that some four years after the final interview I am still in touch with more than a third of the women I interviewed. Four have become close friends, ... " (Oakley 1981)

In common with Oakley, I too have become friends with a couple of the women and I am frequently stopped in town by the women. However within this, differences and limitations to the *transition to friendship* with the women which correspond with Reid's (1983) critiques of Oakley were also found. Reid (1983a) argued that the concept of friendship with women who the research is conducted with is far less likely to occur within a broadly based sample, Reid's critique of Oakley is as follows;

> "She offers further instances of woman ringing up during the research with extra information of showing considerable commitment to the project in a number of small ways. All of this implies a level of appreciation of the research process which is often denied working-class women and common bonds of life style and interests between researcher and respondent beyond the simple one of gender which can sustain a friendship after that study is over." (Reid 1983a:92)

Certainly, as Reid suggests, friendship have been maintained more with the women who have a similar lifestyles and interest to my own. However Reid's criticism of Oakley is limited in its vision of the ability and interests of working class women. Although certainly working class women without easy access to telephones could not readily contact the researcher, however many of the women made themselves available for the feedback meetings and expressed a considerable and lively interest in the findings of the research. (See the discussion on communicating the data under the analysis sub-section).

Questions

In common with Oakley (1981), question asking from respondents raised interesting methodological issues which were central to the conduct of the research. Oakley was asked 878 questions in all, three quarters of which where requests for information concerning aspects of pregnancy, labour or child care. However some differences were found between Oakley's experience of being asked questions and the experience of interviewing from encountered during the conduct of this research.

Unlike Oakley's experience, I was asked very few clinical type of questions, which related to the women's care but then I never presented myself as having any expert knowledge in that respect, although it is difficult to determine exactly why this was so, given that I felt to have established with the majority of the women as close relationship

and rapport as Oakley described and given the women's views on being involved in the research.

However the majority of questions the women asked related to issues concerned with my views on maternity care that is, *where do you stand*? Thus some of the women were concerned to find out not only what I thought of an issue but also whose side I was on.(this tended to occur more in the first and last interviews, as well as during chats in the ante-natal clinic) This type of question tended to come from women who challenged the medical model of maternity care to some degree. Thus a frequent question from women who had made the decision to have their baby at home was, *where would you have a baby?* This was frequently asked by women who had experienced hostility from their friends and relatives, the people who would normally have been the key figures of support for the women. Secondly for many of the women opting for a home birth was a conscious rejection of the medicalised model of maternity care. As a result they did not wish for their experience to be used in a manner which would be detrimental to the form of care they had opted for and felt a commitment to. Thus for some of the women, my ideological standpoint on the issue of women's rights in maternity care determined their willingness to be involved in the project. To have refused to have answered their questions honestly or avoided stating my principles would have resulted in a high refusal rate.

> **Question** from Researcher:. *Where have you decided to have your baby?*
>
> Jill: *Well umm what's all this for again, like what are you going to do with this?*
>
> (I tell her as fully as possible again, and say that the practice will have access to the findings, but also that it is also for my thesis).
>
> Jill: *Yes, but what are you going to say, like what do you think about home births.*
>
> Researcher: *I think that home births are safe, very safe in fact, from what I have come across so far. If I did have a child I would certainly think about having it at home or at the GP unit.*
>
> Jill: *Oh that's alright then. I will certainly help. It's just that I am sick and tired of people reacting like your having it at home! You're not allowed! Your're mad! and then telling me horror stories all the time just because I am having my baby in my home.*

The example above illustrates one of the most important differences between the style of interviewing adopted for the study and that of the more traditional approaches where it would have been part of the research protocol to avoid answering the women's question in order to have maintained a bias free neutrality.

Other questions from women raised important methodological issues concerning the presentation of self in the research. These questions from the women related in the

main to ambiguities that my status or self presented to the women. This stemmed from the large degree of difference between the women and myself in terms of socio-economic position and life expectations. Thus I was frequently asked in a puzzled manner why I wasn't married and why I didn't have a child. A question that was also frequently asked, often with real concern, was if having undertaken the research and found out what pregnancy and childbirth were like I would decide not to have children myself;

> Angela: *Has it put you off? Finding out.*
>
> Researcher: *No not at all, it's made me realise how much work is involved and things like that but I don't feel ...*
>
> Angela: *Oh really it must have.*

Only one woman asked the opposite question and that was because being a health visitor had made her decide to have a child.

A further feature of the interviews was that women tended to devalue themselves and their contribution, a feature of doing research which was not encountered when doing research with high ranking officers and professionals in the NHS (This study is reported in Long and Mercer 1987). Thus women frequently made comments which attempted to apologise for the perceived poor quality of either their speech or content of their answers to questions.

> *Poor you having to listen to me droning on.*
>
> *Oh dear fancy having to listen to all that rubbish again.*
>
> *Oh my voice how will you be able to listen to it, I sound so awful.*

Finally interviewing strangers was considered a brave thing for a woman to do and one that did not entirely fit in with a role model for women.

> Nicola: *Were you nervous about coming here today because you didn't know me?*
>
> Researcher: *No it's the bit of the research I really like doing, I really enjoy hearing what everyone thinks, I think the first one I ever did I was nervous for though'.*
>
> Nicola: *Oh I would have been, like blokes must find it easy 'cos they are out all the time and are like confident.*
> *I suppose you find it easy because you are chatty.*

Hospitality: The researchers' and the interviewees'

> "Hospitality offered at the end of an interview should usually be declined, the interview may have covered sensitive and intimate topics and it may therefore be best to maintain a professional neutral manner right to the end

> of the interchange rather than to enter into a more conventional social relationship with the respondent." (Morton-Williams 1985:40)

In other words take the data and run. Such an approach would have been completely inappropriate to the interview situations experienced during the research, where particuarly during the post-natal interview the woman's domestic situation made such an approach not only unethical but inappropriate. During these interviews the tape recorder would go on and off and then on again while we made cups of tea, changed nappies and walked around with screaming babies.

Thus as Oakley (1981) identified to adopt such an approach to other women objectives them and reinforces a women's sense of passivity. Refusing hospitality is certainly part of the research paradigm where the male researcher distances himself from the respondents and adopts a public domain business attitude to interaction that means the research interview is a clearly defined piece of action, which operates smoothly and professionally. In addition there was there to some degree an expectation from the women that food and drink would be accepted and to have refused in many instances would have been insulting to them.

Finally these interviews also provided an opportunity for reciprocity on the part of the researcher. Having a car was for many of the women rare thing to possess and giving women lifts into town were very common after an interview. In some senses there appeared to be an expectation from the women, that assistance would be provided in this way, as it considered the 'done thing' that women helped each other out in this fashion.

Role in the observations

Observation seemed the most appropriate method in which to obtain a further layer of meaning and understanding to the interaction, beyond that which, was provided by the interviews. Furthermore observation was attractive as a means of gaining that meaning without imposing too much artificial sieving on the interaction for, as Kirkham (1987) noted the participant observer does not seek to control what she studies.

During the observations I placed my chair closest to the women, rather than the midwife, although as the midwives frequently had students with them and the women brought partners, friends their mothers and other children into the clinic. From the outset I chose not remove my self from the interaction completely and to sit in a far corner, as in the role of the passive observer, as to have done so would have changed the informal nature of the interaction in the clinic. However the midwives and women were used to having additional people 'sit in' during the clinics, students were common, as were friends, partners and relatives of the women. Thus I tended to be given a role which was similar to and somewhere between that of a friend of the women's and an observing medical or midwifery student. Both these roles demanded some form of participation, but to a degree which was not perceived as being central to the interaction. Thus in the all

female clinic I could easily participate by entering into humorous atmosphere or the general discussions the women held. However on most occasions I chose not to intervene or to involve myself in situations where information was being given or where the midwife/doctor were discussing with or trying to persuade the woman to adopt one course of action over another unless the midwife or woman asked for my opinion in which case I would tend to provide it. This approach was felt to establish the necessary dividing between participant observation and actively seeking to manage the interaction. Thus my participation in the interaction was fluid and in the observations the level of participation fluctuated from bystander to participant to observer, at different times and in different situations.

ANALYSIS OF DATA

A frequent comment from the women and the workers at the end of an interview or observed clinic session was a variation of "*what are you going to do with all that stuff?*" After just a few weeks in the field and faced with an ever growing mound of transcripts, it seemed like a very good question. This seemingly daunting task of analysing qualitative data stems in part from the complex nature of the data itself.

> "Qualitative data are exceedingly complex and not readily convertible into standard measurable units of objects seen and heard." (Schatzman and Strauss 1973)

It is precisely because of this lack of a direct translation into mathematical formulation which had led to the criticism that qualitative research is deficient in exactness and precision. Qualitative research has been charged with being "sloppy, vague, unsystematic and lacking in an empirical nature" (Borman, LeCompte & Goetz, 1986). Also qualitative researchers are accused of imposing their own world view on the data and thus generating further bias. Borman et al (1986) however go on to argue that it is possible to ensure that qualitative research is rigourous because of the way that qualitative researchers devise checks on their methodology and conduct the analysis of their data. Simply because qualitative data analysis do not employ statistical techniques does not infer an absence of rigour or of systems for validating the analysis (Strauss 1987), thus as Macintyre in detailing the strategies for qualitative analysis argues,

> "In essence the procedures for validating qualitative analysis may not differ as much as is sometimes supposed from those involving statistical tests in quantitative analysis." (Macintyre 1979:769)

The first issue relating to the analysis of qualitative data is that analysis is not a separate stage of the research, but is integral to the whole process. Interpretation and evaluation of qualitative data is a constant process of refinement of formulating and clarification of the

research problems, which takes place even when writing up (Hammersley and Atkinson 1983).

Thus by the time the reading through of those first few transcripts had been reached, the process of analysis had already began well, even before the point where the transcripts were being transcribed. In reading them, answers to questions previously posed were being formed, additional questions posed and concepts drawn from the observations notes were either being tentatively supported or rejected. Wiseman (1974) describes this as an important phase of the research which not only allows an expansion or revision of topics to investigate, but enables '*skeleton codes*' to emerge which are then used to organise the data as a basis for more comprehensive analysis. In this way, questions concerning the process training of student midwives by the community midwives and the women's view of technology were raised and subsequently followed up. In addition, some instant analysis also took place during the observations, as note taking would be used to highlight areas to be followed up, these '*speculative flags*' consisted of new issues usually raised by events, or reinforced earlier connections. These areas which had been flagged up could then followed up through the rest of the transcripts or further questions could be asked: For example a midwifes obvious annoyance with a GPs involvement in an incident at the clinic, raised the issue of who the midwife felt was ultimately responsible for the clinic. Thus as Schatzman and Strauss (1973) and Strauss (1987) argue, analysing data should be a *work strategy,* which provides the opportunity to adjust the methodological strategies employed in the research and more importantly to provide a means of developing and checking emerging concepts and theories.

This approach fits with Glaser and Strauss's work on grounded theory (1967) where the notion of *theoretical sampling* involves a process of the researcher generating theory by simultaneously collecting, coding and analysing the data. Throughout this process, the researcher is involved in a process of a search for any falsifying cases which could invalidate the emerging theories. This is achieved by:

> "examining cases which differ in known ways and the modification of theory until no further disconforming evidence can be found." (Long 1984)

Throughout the analysis the important factor is to build theory from a grounding in the data and to maintain that grounding, (Glaser and Strauss 1967).

In terms of the mechanics of the analysis undertaken in this research: All the tapes were listened to once and then transcribed by the researcher, a similar strategy was adopted by Fisher, Marsh, Phillips and Sainsbury (1986) to provide a means of enhancing accuracy and valid inference: by verifying that the emerging theories and concepts corresponded to the actual meaning in the data. For example, humour or

sarcasm do not easily come across from transcripts, but can easily affect the meaning of a statement. Then as already noted the transcripts would then be read with an eye to producing skeleton codes. At this stage a thumbnail sketch of the content of the interviews or observed interaction was also drawn up which functioned as an additional means of accessing the data quickly. Potentially useful illustrations of themes or what were termed 'juicy quotes' were noted to be possibly used as examples in writing up later, in addition one or two key themes which were immediately striking from the data were noted to be followed up through out the transcript, looking to see if they formed a storyline threading through the data (Long 1984).

In terms of developing categories and themes, certain issues were immediately striking and obvious from the data. Subdivisions and themes were then drawn up around the topic headings discussed in the interviews. Each transcript was coded according to the themes, not line by line but in chunks of statements or incidents, because a line by line analysis was found to fragment the interaction and obscure the flow and inter-relationships between once statement or small piece of interaction and the next. Using the method adopted by Wiseman (1974), these were cut up and sorted according to emerging codes where a piece of data could be ascribed to more than one concept it was copied. However initial themes were also drawn from the analysis of the literature. This illustrates a significant weakness in grounded theory. Glaser and Strauss (1967) urge researchers to enter the field without prior reference to established theory. However even those themes which were immediately striking from the data were in the main so striking because they illustrated either a theme or problem which the research had been concerned to address or they highlighted an important area within the literature or where previous analysis had not occurred. Thus as Baldamus argues

> "There are no 'facts' as such, independent of a pre-existing theoretical framework." (Baldamus 1972:282)

Thus the derivation of themes and concepts to construct theory from the data emerged in part as a result of issues being entirely grounded in the data, the overwhelming process of theorising about or even looking for certain themes stemmed from the original concerns of the study and were only in part as a result of new concepts being thrown up from the data.

A further feature of the process of analysis was, that different aspects and levels of analysis emerged from different stages of the research which were not part of a process of 'theoretical funnelling', (Glaser and Strauss 1967) but which came from changes in the role of the researcher as an ethnographer. Thus earlier analysis while the fieldwork was still being conducted had allowed different concepts to be fully explored; such as, the issue of the quality of the relationship between midwife and the women, where the freshness of the memory of the observed interactions enabled the illustrations to be

tracked down easily. However some themes were only found to be identified from the transcripts once the fieldwork had ceased and contact with the practices reduced perhaps enabling a more distanced view to emerge. The most important illustration of this is the women's feelings that at points the health workers at the practices did not meet their most radical demands.

Validation of the themes was attempted by constant checking for negative instances, here the summary of the content (thumbnail sketches) of each transcript proved useful in enabling concepts and themes to be either quickly supported or rejected. Those suggesting some degree of flow through the data could then be checked in more detail. The search for negative cases and inconsistencies in the theories and concepts was found to be assisted by the process of writing up.

> "The very effort of fleshing out the grand and the subsidiary topics alerts one to areas where specific types of data are inadequate, contradictory, confusing or absent." (Wiseman 1974:117)

Putting a structure on the data, through writing also helped to establish the degree of significance of issues and their relative importance to the understanding of the social settings and interactions being researched, such as the central importance of the relationship between the women and the midwives.

A final tool available to the qualitative researcher is that of '*communicating the data*'. Schatzman and Strauss (1973) argue that communicating the data can be a valuable means of enhancing the quality of the analysis.

> "Unfortunately data do not leap of the pages to provide the analyst with the insight or genius they need to carry it off. This suggests the need for an active discussion in the context of a triad among the analyst an audience and the data." (Schatzman and Strauss 1973)

Schatzman and Strauss argued that such a technique is particularly valuable when the data is not easily categorising into themes and classes. This concept of communicating the data was employed by Fisher, Marsh, Phillips and Sainsbury (1986) in their study of the experiences of children, parents and social workers of children going into care at the stage where themes and theories were emerging as a means of further developing them and adding depth. Thus they drew together working papers which they presented to researchers and social workers, which they found provided valuable critical discussions of the data. As Morgan (1972) and Roberts (1984a) point out, the researched may have strong views on the findings and what is written about them which may not always concur with the researchers interpretation.

Developing from this Fisher et al (1986) also found the concept of *co-research* to be valuable. This involved incorporating some of the respondents as research workers, through holding discussions meetings as a means of testing the validity of the findings or

emerging concepts. Thus methods of analysis of research findings which form an interactive process are likely to add depth to analysis, validate findings, or where researcher and respondents disagree, it can provide new interpretations of data or new areas for analysis.

The process of communicating the data and co-research proved invaluable in this study. This process was undertaken in two main ways: Firstly the women and the workers all received copies of summaries of preliminary findings, then towards the end of the fieldwork a series of small group discussion meetings with workers and women were held, where the findings were presented and discussed. In terms of contributing to the process of analysis these meetings proved useful to validate the theories and interpretation of the data, particularly in terms of checking out the priorities the women ascribed to different aspects of care and their perceptions of the quality of care. Although none of the major findings were disputed during these discussions, the emphasis placed on some of the findings was re-considered.

Finally, such principles also fit with the epistimological stance of the conduct of feminist enquiry through its commitment to reducing the researcher/respondent dichotomy As Roberts (1984a) argues, the responsibility of the researcher is not only to disseminate findings solely to those people who took part in the study but to other women and members of the public who the research findings are likely to be of direct relevance.

> "The responsibility of the researcher does not end when the last question is asked. If anything is to happen to the research and its findings then it must be made known by one means or another to a wider audience than simply the researcher and one or two of her colleagues. (Roberts 1984a:209)

In this research presenting the findings to a wide audience of interested professionals proved relatively easy, as established forums, from the local home birth group to the Association of Radical Midwives and the medical post-graduate seminars existed for such feed-back. Such presentations also proved useful in further clarifying and testing out some of the concepts. However dissemination to an audience of women beyond the original respondents is more problematic as women users of the maternity system do not have the same forums and presentation of findings remains with the press and popular magazines with attendant problems of misrepresentation and trivialisation (Roberts 1984a, Morgan 1972).

Finally perhaps the most important issue to note when analysing qualitative data in a rigourous manner is not bias or developing concepts but that analysing such data is extremely demanding and that the major problem a qualitative analysis faces is that such analysis can be inordinately time consuming,

> "An important and profound conclusion we arrived at concerning research methodology was that qualitative research workers need to be blessed with

longevity in order to stand a chance of mastering their data." (Fisher, Marsh, Phillips and Sainsbury 1986:29)

CHAPTER FOUR - THE WORKERS' FRAME OF REFERENCE

Introduction

This chapter is concerned with the philosophy of care held by the providers of maternity care within the primary health care setting. Broadly following from the model of the medical frame of reference developed by Oakley (1980) & Graham and Oakley (1981), the women workers frame of reference concerning care provision for women is identified. Thus the chapter is structured around the ideological components of the model of care held by the workers at the two practices. The chapter identifies the holistic nature of the model held by the women workers and the manner in which each component element is related to and dependant upon the whole.

In an analysis of the processing of women as *medical maternity cases*, Oakley (1980) identified five central components of the medical frame of reference which determined the nature of the relationship between user and provider.

> "1. The definition of reproduction as a specialist subject in which only doctors are the experts in the entire symptomatology of childbearing
> 2. the associated definition of reproduction as a medical subject as exactly analogous to other pathological processes as topics of medical knowledge and intervention.
> 3. The selection of limited criteria for reproductive success, ie perinatal and ante-natal mortality rates
> 4. The divorce of reproduction from its social context, pregnant patienthood being seen as a woman's only relevant status.
> 5. The restriction of women to maternity - their derived typification as by nature maternal and domesticated family orientated people." (Oakley 1980:10)

This analysis of the medical frame of reference provides an important analytic tool in evaluating alternative means of maternity and reproductive health care provision to women. If an alternative relationship between provider and user, particularly between female workers and female users was to exist it seems likely that such workers would possess a frame of reference concerning both women and the nature of reproduction which would prove to be fundamentally different from that of the medical model. Therefore it was largely through comparison with this framework that the workers model of care provision and philosophy of practice was evaluated.

In terms of the different professional groups, although certain differences between each group are highlighted, it is the components of the model of care held by the workers which forms the framework of the chapter rather than being structured around a discussion of the role of each profession in turn. A major concern of the chapter is to present an overview of the philosophy of care held by women workers and

identify any common elements which may be consistent across women workers irrespective of their profession.

Having said that, certain ideological and professional differences between the workers were identified, which raised difficulties for the implementation of a common model for the provision of maternity care. Where the chapter focuses primarily on the role of the midwives this is a result of the significance of their role in the provision of a user-centred model of maternity care to women.

The primary data discussed in this chapter comes from analysis of interviews with all the health workers at the two research practices, although the focus of the chapter will be concerned with the views of the midwives and female GPs. In addition, the data for the interviews conducted with other midwives working in similar innovative or *ideal types* of practices will be included.

The workers view of women

The workers at the practices: midwives, GPs and practice nurses worked in a predominantly female dominated environment, not only were their colleagues female but the majority of their patients were too. While this was obviously true for midwives, the GPs and practice nurses also found that the major part of their work (even excluding maternity care) involved working with women. At one of the practices the high number of women choosing to see the practice nurse caused a well woman clinic to be specifically set up to meet the demand.

In chapters 1 & 2 it was noted that, if an alternative relationship between provider and women users was to develop, a prerequisite of that relationship would be the possession by the workers of a positive view of women and of working with women. The evidence from the interviews and observational data indicated that a negative view of women had not been internalised by the women health workers, general practitioners, nursing and midwifery staff. Instead, working with women was considered by the workers to constitute an extremely rewarding aspect of their work. An overt expression of empathy or identification with the women users as other women was a common feature of all the workers' accounts.

> ***Question:*** *How do you feel about the majority of your work being solely with women?*
>
> *I do feel a lot of empathy with other women and I get on with other women on the whole very well. Yes that is a part of my work I enjoy.* (GP - Louise)
>
> *I think to do this job you have to have a feel for other women, you also need a feel for their babies too. The woman isn't going to have confidence in you if can't remember her name, her babiy's name and treat it like a little parcel.* (Midwife - Jean)

If the workers felt that working with women was a feature of their work to be valued, a shared experience was felt to enable the development of a form of communication between worker and user that went beyond the normal power relationships.

> "It is widely believed that women inherently feel greater empathy for the woman in labour than men. The dictionary speaks of empathy as the ability to share somebody else's feelings and emotions. I would suggest that much more is involved namely the ability to share someone else's bodily processes ..." (Jordon 1978:212)

This ability of empathise with another woman would, Jordan argues, hold true even if the woman had not experienced childbirth herself.

> "... even women who have not given birth themselves bring to the enterprise a deeper and more fundamental interest than men, principled interest which is grounded in the fact that their own bodies are built for the very same performance." (Jordan 1978:212)

The midwives in particular referred to this phenomenon detailing how they felt they empathised with the women in labour.

> *I don't think that you need to have children to be sympathetic for what another woman is going through ... You can really feel what the woman is feeling, think what she is thinking, often you want to try and push the baby out for her you get so involved.* (Community Midwife - Anne)

Throughout the interviews the workers presented a positive view of working both with women and of working in a uniquely female area of health care. In particular spending time talking to other women as a means of establishing a positive relationship with the women were viewed as some of the most satisfying aspects of their work.

> *I like working with women, because you get such a good relationship with them. They really open up to you. the clinics here are really good fun, as we usually all get on so well.* (Midwife - Alison)

> *I love it working on the community, the women are all great, it is such a laugh. The clinics here are great everyone just seems to enjoy them so much* . (Student Midwife - Claire, interviewed while on placement)

In direct opposition to the medical frame of reference, a positive view towards women underpinned the workers' approach and feelings concerning the nature of their clinical practice in providing maternity care to women.

Discussions with the researcher after the clinics confirmed the high value placed by the midwives and GPs on interaction with the women. In particular the midwives' were observed to value their contact with the women. Discussions after a clinic would frequently centre around the midwives' anticipation in looking forward to being with the women during the deliveries or concern that they might be unable to attend a particular

woman's delivery due to their own holidays. This positive view of working with women was not confined to the workers' personal liking for a few individual women, but rather a positive approach towards women's health care dominated the atmosphere of maternity care and the well woman clinics. Thus in opposition to the biomedical view and the prevailing patriarchal culture female, health workers expressed the view that the predominantly woman-focused nature of their working environment formed one of its most positive aspects. The midwives in particular felt that the woman centred aspects of their job was one of the prime motivations for continuing to work as a midwife.

> *I would just love to do the deliveries for them all, that is what I came onto the community for because at the hospital I just wasn't getting to know them at all. It is so rewarding getting to know the women all through their pregnancies and then helping them through labour. Now I am getting women coming for their second baby with me and that is really nice as well when that happens.* (Midwife - Alison)

Furthermore the practice nurse of the 'North' surgery stated that the woman-focused nature of her work not only provided the key to her personal job satisfaction, but had caused her to re-evaluate her methods of approaching health care. The nurse's experience of working with women in the clinic caused her to conclude that much of traditional nursing practice was inappropriate to meet women's needs and had therefore attempted to generate a new type of response to the provision of health care to women.

> *From a personal view I find it very positive, I find it very rewarding putting that sort of time into women. It has caused me to create a whole new way of working that I am trying to build up. You see, I think that women have a whole range of needs which no-one takes on board. Doing that for women just isn't seen as important enough. So that is what I am trying to develop, it is what I call 'responsive nursing' and working at that, finding out what women need, is really exciting.* (Practice Nurse - Mary)

Following from the workers' positive view of working in a female focused area the status they ascribed to actually caring for women is also likely to be another indicator of their approach to the provision of women's health care. As the above quotation by the nurse illustrated, identifying women's health needs and responding to women's health has frequently been given a low priority, (Zimmerman 1987).

However, a second factor which may affect the degree to which women's needs are met is that of the priority and value ascribed to undertaking the type of work which would meet women's needs from maternity care. The systematic devaluation of female dominated work has been shown to be a consistent feature of the value ascribed to tasks undertaken mainly by women such as caring (eg. Finch 1984a). Within the medical frame of reference there exists a hierarchy of tasks, with differing status attached to certain tasks, depending on who they are normally performed by (Navarro 1977) Medical procedures performed by the doctor occupy the highest status with other

workers actively banned from performing them such as suturing and writing prescriptions, leaving other workers, who are members of predominantly female professions to be delegated to deal with the *lesser valued tasks*. These tasks are generally perceived as either enabling and supporting the medical profession in performing their role, or too inferior and menial for the skilled medical professional to perform. Included in these lesser valued tasks, where they are noted at all, is dealing with emotional problems and providing emotional support. This has implications for the actual provision to the user of these aspects of care, as they are given low value. Care such as back-rubbing or emotional support in labour may therefore not be provided when a more highly valued technological response exists (Kirkham 1987:119).

The same hierarchy of tasks has also been found to apply to the provision of care within the community. Bowling (1981) in a study of general practice found that 54% of doctors interviewed felt that the presentation of *trivia* was a hindrance to their effectiveness.

> "They make life so disheartening you could be doing something so meaningful but instead you spend your life seeing a lot of rubbish." (GP quoted in Bowling 1981:113)

In particular, Bowling noted that dealing with emotional problems was seen as trivia by 81% of doctors, and caring roles were predominantly perceived by the GPs as the province of the nursing profession. This fits with Oakley's and Graham's separate findings that the medical frame of reference prioritises a narrow range of medical tasks to the exclusion of responding to women's other needs such as, counselling or emotional support. This is illustrated by the following example from Oakley (1980).

> "Doctor: why have you left it so long before coming here?
> Patient: Well I was so depressed I didn't want the baby. I wanted an abortion.
> Doctor: Have you ever had diabetes, tuberculosis, rheumatic fever, kidney disease, high blood pressure?
> Patient: No.
> Doctor: Any-one in your family ever had these?
> Patient: No."

However it is precisely the exclusive prioritising of strictly medical tasks at the expense of other aspects of care which have been identified by women as being responsible for their dissatisfaction with maternity care provision (Oakley 1984:243-244; MacIntyre 1982).

The allocation of low value to the caring aspects of provision has a further implication for those providing such care, as within the medical model the provider by virtue of being concerned with the provision of such care, holds a low status within the organisation. This in turn reinforces the low value ascribed to such tasks, as they are being performed by a low status worker.

Within the medical model the value ascribed to *hard* technical tasks performed by male dominated professions contrasts with the *soft* caring roles of women and are therefore allocated to lower status female professional groups. The issue is not one of skilled versus unskilled workers, but of attributing different values to fundamentally different skills. In addition to the hierarchy of tasks, patients themselves are subject to a similar typification (Jeffery 1979). For the treatment of *trivia* is not only perceived as demeaning to the workers' professional expertise but also has repercussions for the individual patient presenting with the *trivial* complaint, (which for them may be extremely worrying) as they are then treated as if they are of low value.

By contrast, within a user-centred approach the status of different aspects of care would not be expected to be medically or institutionally defined. Instead, the priority given to different tasks would be orientated to meeting the needs of the user in a holistic manner (Kirkham 1986, Orr 1986) and significantly the user would be expected to be a partner in defining those needs.

The women's involvement in defining their needs formed a central feature of the model of care held by the midwives, providing good quality care care was seen as applying their skills in response to the women's requests. The following example from a community midwife run ante-natal class illustrates the support the midwife gave to user definitions of need.

> *Very much we are there to do what you want, it's your labour. It is to give you help and what every woman needs is different. Recently I went to do this home birth and all I did for hours on end was was rub her back because that was all she wanted and that was fine. I felt I did what I was there for.* (Midwife - Moria)

Within a user-centred model the traditional hierarchy of tasks are reversed, it is the offering of support, dealing with emotional problems and advice giving which are valued. Importantly this value and high status is attributed by the workers precisely because such aspects of care are seen as appropriate to meet the women's needs.

> ***Question**: What would you say are the most important aspects of the care you provide?*
>
> *I think it is support. When you are pregnant people tell you all sorts of things and you get conflicting advice from all sorts of sources and they (the women) need to find out what is best for them. So you have to take time and help them find out what they think would be best for them and give them support to get that. I think that is the more important than anything else.* (Midwife - Doreen)

The workers at the practices perceived the aspects of their work which involved discussing issues with the women to be important and to carry a high status. Listening to what women stated their needs to be and providing support was felt particularly by the

midwives and nurses to be a central function of their role[1]. It was in the area of responding to a hidden agenda of women's needs, that, the workers felt their approach towards providing care was responsive to women's actual health needs. Simply treating presenting symptoms through the traditional five minute consultation typical within general practices or the fragmented manner in which hospital care was organised was therefore seen by the workers at the practices as unable to meet any but the most superficial of the women's health care needs, and completely inappropriate to respond to their most important ones. The workers argued that the current model of health care was particularly inappropriate to respond to the needs of working class women, who it was felt by the workers were unlikely to be treated in a sympathetic manner by the medical system.

> *Among health workers there is a great deal of ambivalence concerning women's health, we find that many hospital doctors have an awfully patronising attitude towards women especially working class women who don't play the right games. Like we get girls being refused treatment because they acted sullen or got angry with the questions the doctors were asking.* (GP - Maria)

The critique proposed by the female workers was that the masculine mode of service delivery within the biomedical tradition failed to even begin to address women's real needs for health care.

> *It worries me this lack of importance the women here are able to place on their own lives, the lack of control they have over what happens to them. I think this is where a lot of male GPs don't dig deeper and just treat the constant sore throat or whatever without finding out how the women cope with the rest of their lives. You see the women really don't have any control over any of the most fundamental aspects of their lives. Like, they get forced into abortions when they don't want them and forced into pregnancies by the men. It is these sort of issues that the male GPs don't touch on.* (GP - Maria)

However, the workers did not entirely reject medical priorities, such as the need to achieve safe care through performing routine ante-natal checks, but instead such monitoring did not constitute the sole focus or aim of the interaction between provider and user.

> *Well I was thinking about what we do the other day and how it differs from the hospital and I thought well we do everything they do - all the checks and everything. We are really concerned to make sure that everything is as safe as possible, but we do that as just part of what we do it is just incidental to everything else that we do.* (Midwife - Jean)
>
> *At the booking visit we go through all the details very carefully with the women, and at that visit there is quite a bit of question and answering and*

1. The implications this reversing of the hierarchy of tasks has for the women in terms of increased control and choice is expanded upon in a later subsection.

> *getting tasks done, but we say that is what we need to do and then once that is done it doesn't need to be repeated it's there and we can get on with finding out what she wants and needs from us. So we do all the checks but we say it is part of the whole of what we do.* (GP - Caroline)

Thus the workers rejected a dichotomy between providing safe medical care and between providing holistic user centred care. Instead, communication between women and workers was felt by the workers to need to be a two-way process in order to achieve good quality maternity care. The next subsection deals with the significance of the relationship between user and provider and the degree to which the provision of quality care was felt by the workers to be dependant on the establishment of a partnership between provider and user.

Women Workers And Their Relationship With Women Users

The quality of relationship between worker and user was highly valued by all the workers interviewed. The ability of a worker to establish a positive relationship with women users was felt by the workers to be a measure of the quality of their practice.

> *I worry sometimes that due to the pressure of work we aren't getting it right. But the value of it is that I certainly find it satisfying, getting to know them and I am sure they find the continuity satisfying as well.* (Midwife - Doreen)

Where the health workers felt they had established a positive and valuable relationship, was in cases where they felt that traditional role of the expert distant professional and passive receptive client had been breached to form a partnership. It was this concept of an equal partnership which formed the basis of the workers' view of their interactions with the women.

> *Its the two way thing that is vital, we should never say to women "you must" and try not to say "should". We are there to advise them, but we also need their trust and support to do that.* (Midwife - Angela)

In establishing an equal partnership with women user, the midwives and practice nurses felt that they possessed a distinct advantage over the GPs and to some extent the Health Visitors in the PHC team, because of differences in their traditional positions of power and authority over the users. The midwives and practice nurses felt that women perceived their professional groups as more approachable and responsive to users than 'the doctor' it was felt that women could be intimidated by the traditional status and authority of the doctor. The midwives in particular felt that working from the premise of an equal partnership with women constituted a natural element of midwifery practice. Their brief was to support the women in obtaining their goals and in doing so to actively identify with them. In adopting this position, the midwives felt they were conforming to their perception of the traditional character of the midwife, their true *with-woman* role.

Unlike the health visitors, the midwives did not perceive child surveillance and the underlying authority over women that this implies to be appropriate to their role. Within their model of midwifery practice, a central element of their role was to respond to the woman's needs and not simply those of her child.

Example: Conversation between two midwives and the researcher:

I think that the relationship we have with the women is very special and different because they know that we are there just to care about them and so they feel that they can confide in us and ask questions and say what they want. They know that we are there just to help them. Like, there was this girl up at the flats the other day, and I thought I must tell you this, and she said that she would let us midwives in, because we were proper, but she didn't like health visitors because they just snoop. (Midwife - Angela)

Oh that is really common attitude. They will let us in because they know what we are doing and they see a point to it but the Health Visitors really have problems. (Midwife - Alison).

The midwives valued a relationship with the women based on friendship, rather than professionalism and interpreted their relationship with the women in this context. The expression 'friend with knowledge' was used by all the midwives without exception to describe their criteria for an ideal relationship with women. The midwives and practice nurses felt they identified themselves directly with the user.

***Question**: What do see as the most important aspect of your role as a midwife?*

I see myself just as a friend with knowledge. Someone who can give them advice, who has that information that they wouldn't have really or can't get hold of. (Midwife - Cath)

I think really, the way the women see you. Especially post-natally as a friend who is going in there to help them. A lot of them do get post-natal depression and I think it really helps having someone they know and can trust going in. (Midwife - Alison)

This perception of a friend with knowledge formed the basis of their model of good midwifery care, and a yardstick with which they evaluated their own effectiveness.

It is really odd - I do have this problem remembering that I am a midwife. Like, when the husband says "oh you wanted to ask the midwife" and I wonder who they are talking about.
It is very odd. It feels really strange when they sometimes call me the midwife, because I am on first name terms with them and I can see that a lot of the women do begin to see me as a friend. I have been God-Parents for a few of them and they all send me cards and I have photos of all the babies I have delivered on the community. (Midwife - Cath)

The components of a 'friend with knowledge' role was viewed by the midwives as consisting of an equal relationship in which their function was to deploy their skills as an

advocate, which served to empower the women. The achievement of an equal partnership with the women based on the women's active participation was one of their criteria for successful communication and ante-natal care. Identification and solidarity with the women was felt by the midwives to form a natural constituent of midwifery practice and was therefore an element to be fostered within their own practice. The midwifes tended to express the view that a commitment to providing women with user-centred care was very much an intrinsic feature of midwifery practice. In contrast the midwives tended to feel that for the GPs and doctors' user-centred care was more problematic to provide, because a commitment to women was not an intrinsic feature of medical practice.

> ***Question.*** *Do you feel that, there is a difference between midwives and doctors in the way you practice?*
>
> *I think the difference between us and doctors is that we are more interested in the women, we give something of ourselves to them. Its like the other day this locum doctor came and did the clinic and we each took 5 women each, after 20 minutes he had finished all five and I was still on the first one and he was just amazed and afterwards he said to me 'what on earth do you find to talk about with them?* (Midwife - Alison)

The effective provision of care was seen to be dependent on a two way process, of an exchange of information and negotiation between user and provider. Thus there was a recognition among the midwives that the woman was a health worker in her own right (Stacey 1988) and that without her active participation in the interaction the quality of maternity care would be reduced. Furthermore here as for the majority of the central elements of their model of care; providing continuity of care was identified as being a necessary prerequisite to achieving that participation.

> *I have actually heard consultants say that continuity of care reduces safety because one person may miss something that another will pick up. Which shows how they completely misunderstand that 'picking up things' in maternity care depends on you knowing that woman and what she has been like throughout her pregnancy and on the woman herself. That two-way process of information is vital. She isn't going to be able to do that with a different person every visit.* (Midwife - Alison)

Finally, in advocating active participation by women and in identifying themselves with the users of maternity service the midwives felt that they were supporting a reassertion of the traditional role of the midwife (Flint 1985), a role which was a natural element of true midwifery practice. Where such a positive interactive relationship had not been established, this was felt by the midwives and practice nurses interviewed to constitute a failure on their part in terms of their clinical practice and was perceived as a serious breakdown in communication. The following quotation illustrates the concern such a breakdown in communication caused the midwives. The example is from a discussion

held with the researcher, after one woman (Sally) had just finished her ante-natal appointment. She had not participated in the interaction, only answering direct questions in mono-syllables.

> *I am really worried by her. Normally the women are being friendly and open towards me by now and she seems very close and abrupt. I feel that I just can't get across to her at all, you see most of the women by now they are quite willing to talk about what worries them and comments like hers can be picked up fairly easily. But I feel that I must be doing something wrong. I feel I haven't built up any relationship with her - she is very off-hand with me. I think I must try and give her a bit extra time and really find out what is bothering her. Yes, I think I should have tried harder there.* (Midwife - Alison)

However if a relationship did not work, the midwives were clear in asserting that the women were to have ultimate sanction over who their midwife was to be.

> *Sometimes you don't get on and when that happens you just say well, "would you prefer another sister?" Because obviously people are different and occasionally if I think that I can't get a relationship going then I will ask for another midwife to visit the woman. And if I find that they are clicking then I will ask them if they would like to have that person do their care and the delivery. Because if you haven't got a good relationship, then they might just as well have gone to the hospital and seen a different midwife every week. So I think that you need to be sensitive to what sort of relationship you have with each woman.* (Midwife - Doreen)

Emphasis was placed on achieving a good quality relationship as it was to the nature of the relationship between provider and user, to which the workers attributed any impact of the care they provided. The practice nurses and midwives in particular, felt that the quality of their care was directly related to the form of relationship they had established with the women.

> ***Question**. Can you tell me about what you feel is the most important aspect of the care you provide to women?*
>
> *Well there are several things the first is giving women a choice of what they want. Also having continuity of care. Being sort of a friend and not being above them but letting them talk to us and be able to ask things. So that they can say what they want, which is more important than anything.* (Midwife - Margaret)

However, the adoption of a 'friend with knowledge' approach to service provision created a problem for both the status and role of the general practitioners. The reasons for this are partly rooted in historical differences in the role, function and training of the different groups of health workers. The medical and midwifery professions evolved from radically different traditions, with the development and expansion of the medical profession emerging as a result of the erosion of the role of the more traditional healers

and the consequent development of professional authority over clients, (Ehrenreich and English 1978; Donnison 1977) a position which has been reinforced and reproduced by the organisation of modern health care systems and the training of health workers within the system (Salvage 1985).

For the GPs, adopting the role of an ally to the women was dependent on surrendering their medical authority, the foundation and justification of their expertise and involvement in maternity care. Unlike the workers based within the nursing tradition adopting a user orientated means of communication required the doctor to relinquish the prestige attached to their expertise; to lose the public professional face upon which their status was based. This was despite the fact that the doctors expressed a genuine commitment to challenging the balance of power and found a centred form of communication the most satisfying form of interaction.

> *I think the further up the hierarchy you are the more distanced you become, and the more difficult it is for you to be accepted by patients and also for you to break down those barriers.* (GP - Louise)

The appropriateness of the skills and expertise of the GP was also felt by the workers to brought into question because in the provision of maternity care the role the GP was orientated and skilled to provide, was very task centred. A large part of the traditional role of a GP is concerned with technical skills such as basic health checks. As noted earlier, these skills are perceived as occupying, within the user frame of reference, a lower status than the caring roles performed by the nursing related workers. This situation created a tension for those GPs at the practices who aimed to challenge accepted working practices, as they felt they were forced to recognize that by virtue of the type of training they had undergone they may have a lack of skills or expertise to fully meet women's needs.

> *The midwife knows a lot more about the care of tiny babies and it is that sort of information that is actually helpful to them, that is what they want and need. Because I recognize that is what is more useful and that is what women are interested in then I must see my role as doctor and that I should be looking through their blood tests. I actually have to keep reminding myself that my role is to support people who are more able to give all the supportive advice to women than I am. Which is a pity as that is what I enjoy doing and that is what brings you closer to the patients.* (GP - Louise)

This tension was further increased as the GPs also felt that the traditional role of 'the doctor' made them less acceptable carers to women, because established power relationships remained, even if only as a residue. The GPs felt that, by virtue of both their formal training and traditional relationship of power over users, there existed an

effective barrier to the development of *a friend with knowledge role* for a medical professional, but one which they were committed to challenging.

Thus the commitment to developing a user-centred model had profound implications for the role of each professional and for the relationships between workers within the PHC team. This theme will be picked up again later in the discussion on the roles and responsibilities within the PHC.

Overall, the workers at the practices defined their role as supporting and facilitating a collaborative approach to maternity care between women and providers which would be based on partnership of equals. The workers' view towards reproduction and their view of what the priorities of care should be within such a collaborative or partnership approach will be a central part of the focus of the next subsections.

Women and Their Context - Pregnant patients or women who are having a child?

Part of the feminist critique of health care has centred around the manner in which women's health needs are responded to only in the abstract, as services are provided without consideration to the reality of women's daily lives within which they have to make health care decisions; the result being that the service is frequently either inappropriate to meet their needs or inaccessible. Graham (1984) clearly identified the degree to which health choices are determined by women's economic and material conditions which limit the reality of the choices available to them.

> "Health choices are shaped by material as well as mental structures. The barriers to change are represented by the limits of time, energy and income available to parents. In such circumstances health choices are more accurately seen as health compromises." (Graham 1984:187)

However, where such services have a low usage the service organisation and provision has been rarely questioned by providers (Macintyre 1984). Instead, simply because a service has been provided an assumption is made that the service is appropriate to meet the users needs. Low uptake is seen to be caused by the individuals' lack of commitment to use the service, or a personal lack of interest in their own health. This has been particularly applied to working-class women who have received little ante-natal care or who have never used other screening facilities such as smear clinics, Thus a brief perusal of the medical literature reveals women, being seen as *'failing to come forward'* (Jackson 1979, BMA 1980) while high risk working class women are accused of being *'less interested in preventive medicine'* (Chamberlain 1983). This feature of medicalised maternity provision has been little addressed in the professional vision of improving

care, where the focus has tended to be on limited structural changes as the main area for improvement.

> "While it is widely accepted that detailed consideration must be given to the clinical aspects of the pregnancy and to the past and present medical status of the woman it is less often acknowledged that the quality of care offered will depend crucially on adequate appreciation of her family and home and social circumstances. A woman will derive little benefit from care which for logistic economic or cultural reasons, she finds unacceptable or inaccessible. Ante-natal care which addresses only the concerns perceived by professionals is therefore of limited value." (Zander 1978)

Associated with an unquestioning approach to the current structure or organisation of care is the treatment of the user of the service as an object of work (Kirkham 1987) with the only defining factor being her role within the organisation as a patient. As Oakley noted, within the medicalised model of maternity care, pregnancy and labour are removed from any sense of being embedded in the woman's social context "pregnant patient hood being seen as a woman's only relevant status", (Oakley 1980). Again, in opposition to the medical frame of reference, the workers at the practices stated a commitment to constructing the definition of each woman's need based on a 'whole person assessment' of that woman. The workers at the practice: the midwives, nurses and doctors, all stressed the importance of knowing the woman as a person, and the need to have an understanding of her social and working life outside of their clinic. This was felt by the workers to constitute a necessary prerequisite in order to respond to a women's needs in an individualised and appropriate manner.

> ***Question.*** *From what you have been saying you seem to value developing a personal relationship with the women, why do you feel that is important?*
>
> *Yes I do, because the more you know a woman the more you are able to give and expand your care to fit that woman. If you just see a woman when she appears on the labour ward you don't know what her home life is like or what she did for her job or what her husband is like. Because even on community even if you don't deliver the women, you can chat to them a lot about everything, without being over inquisitive and I think that does help when you go to see them afterwards even if they have had their baby in hospital* (Midwife - Cath)

The exact manner in which the workers set about achieving a deeper understanding of the women's lives and responding to the women as part of a whole person assessment will be detailed in the chapter 5. However it is worth noting here that the midwives felt that a whole person response to the women's needs, based on a detailed knowledge of the woman, was of sufficient value that they were prepared to invest a considerable amount time in gaining such information. The workers felt that a commitment of both time and energy to developing a broader understanding of the social and familiar context

the women came from was of central importance in enabling them to make more appropriate and sensitive decisions over both the content of care and over their approach to providing that care. The content of the care provided was felt to be enhanced in several key ways. Firstly, they felt the quality of the medical or clinical care they provided was improved, as the basis for medical decision making was strengthened. Workers felt they were able to respond more effectively to medical needs the woman has, such as being able to identify that a woman's back pains were a result of her working environment or that her blood pressure was slightly raised because her 2 year old daughter was not sleeping. Secondly, the midwives felt that the sensitivity of their approach to the women was improved as they were able to make adjustments to correspond with the woman's own personality and therefore were able to provide a more individualised response.

> *Getting to know them does help me quite a lot, because I can then try and act in a way that they would like, that fits in with their personality a bit.*
>
> ***Question**. Can you think of an example of the way this helps?*
>
> *Well take Bonita,* (woman just seen at the clinic and who is due to deliver while Jean is on holiday, which means that she must find someone to cover for her). *Well now, I think she feels quite vulnerable and needs to feel that she isn't being judged, and that she has the control. So I have been thinking a midwife like Doreen, who I often ask to cover, isn't right for Bonita as she needs someone who won't be too overwhelming for her. So I thought I would ask Alison to come and visit Bonita, because she is young, enthusiastic and won't seem intimidating to Bonita.*
> (Midwife - Jean)

However, although professionals exercise power over women, without detailed knowledge of the women as individuals, the possession of such knowledge could function to increase rather than reduce the unequal nature of the relationship between provider and user. A situation of increased power could occur by firstly enabling professionals to extend their sphere of control further into new aspects of the women's lives, such as the women's personal relationships, where previously their influence may have been more limited. Secondly, such information may result in the professionals increasing the extent to which their interactions are based on value judgements concerning the women's lifestyle and background. This situation would be likely to disproportionately disadvantage working-class women. Consequently, for such information-giving to function in the women users interests and have a positive impact on power based relationships it would need to be supplied in an atmosphere of trust between user and provider. Therefore the role of the worker would need to be clearly defined, with the worker's function being open to negotiation, with issues such as the surveillance role and who the worker identified with made explicit.

The workers, across all of the professional groups interviewed, consciously viewed the personal information provided by the women and the degree of interaction accessing such information required as a means to break down the traditional barrier between user and provider.

> ***Question.*** *I have noticed that you spend a lot of time talking to the women about their home lives, and that type of information. Do you think that ...*
>
> *Well that is something the health visitors face. You see we aren't there to judge them, and the women know that, we never have any trouble being let in at the flats where the health visitors get refused all the time. The women know that we are there for them, and not to have a snoop round their bathroom, like we are interested in them.* (Midwife - Angela)

> *Like I really hope they don't tidy up when we go into their house. Because they have got enough to do with out cleaning up because I am coming round. It can be nice as well when they don't because it can mean that they aren't worried about you going in.* (Midwife - Jean, to Student Midwife)

Overall, the workers viewed women as active participants in their health care. Adopting such a view also influenced their perception of their role as health care providers reducing the element of control and surveillance and fostering a commitment to a more equal partnership. Part of this was felt by the midwives to originate from within their traditional role as midwives, the "with woman" role of the midwife.

The Workers View of Reproduction

This subsection discusses the affect of the workers' view of reproduction and pregnancy as processes on their approach to care provision. This is examined through an evaluation of their approach on two issues:

1. Who is the user of the services and whose needs should those respond to? The workers approach to addressing the needs of the women within the context of being a pregnant woman and their view of the foetus the woman is carrying.
2. Is pregnancy perceived as pathological or normal? This is a consideration of the workers view of reproduction as a process.

1. Maternity care or Foetus care?

Within modern maternity care provision, the woman has ceased to be the central character in receipt of care, her needs having been separated from those of the foetus. The foetus has become a separate person, a parasite whose interests are seen as conflicting directly with those of the host mother (Hubbard 1984).

> "The medical model dicotomises not only mind and body but also mother and infant. Mother/foetus are seen in the medical model as a conflicting dyad rather than an integral unit." (Rothman 1982a:48)

Within the medical model the woman's needs for care and the care needs of the foetus she is carrying are perceived as conflicting directly with each other, meeting the needs of one excludes meeting the needs of the other; for example a woman's desire for a supportive environment during labour and to give birth at home have been seen to endanger the foetus whose needs are perceived as best met with high technology solutions in hospital (Rothman 1982a:48). This is not to imply a conscious attempt to actively prevent women from accessing care which would met their needs but rather that once the needs of mother and foetus are seen as separate, and the life of the foetus is seen to be in danger, then it is perhaps inevitable that the needs of the foetus would take precedence over the needs of the mother for a positive experience during labour. Thus it is ultimately the needs of the foetus which tend to predominate in the focus of current maternity care.

Furthermore the foetus, having been discovered by the medical profession (Arney 1982:94), has become the ideal patient. The impact of this is that the mother tends to be reduced to a *vessel* for the production and containment of the foetus - the *ideal incubator* (advert for drug in the BMJ). The most extreme scenario of this model is that the pregnant woman ceases to exist. A recent case example of this is illustrated by the following comment from the surgeon Professor Tynan, just having completed an inutero operation.

> "We are not proposing this for patients where existing post-natal treatment seems adequate. We are talking about a group of patients who are ill in the womb." (The Guardian 1/2/ p4 1990)[2]

The fact that this operation was conducted on a pregnant woman who in normal circumstances would be considered as the user of a service, is not even considered by the surgeon. His patient is the 38 week old foetus. A foetus is the ultimate conformist to the sick role, unlike women who at the very least possess the potential to complain and resist medical authority. A foetus is the perfect passive recipient of medical care, 'tiny helpless dependent' (Rothman 1982b:28). While there may be specific historical reasons for this situation, not the least of them being the dramatic decline in maternal mortality shifting the emphasis from concern for the mother to infant mortality rates, coupled with the development of the potential to investigate the foetus with ante-natal technology (eg. Arney 1982) the end result is that the needs of mother and child are polarised.

Such a separation plays an important role in directing policy concerning maternity care towards a more medicalised hospital care for all pregnant women. This is because the mother/foetus dichotomy supports and reinforces both the tendency towards intervention in all pregnancies and the high status ascribed to such 'heroic interventionist medicine'. An example of this can be seen in the statement by another member of the same team responsible for the inutero operation, who called for the routine ultra sound scanning of *all* pregnant women to detect potential problems which could be treated by their pioneering surgery (Interview, BBC Radio 4 News, 1.2.1990). This call was given some credence in the media despite the very small number of women who would benefit from such screening - even if the surgery was successful.

A further feature of this trend towards treating the foetus as the primary recipient of maternity care is that the woman's needs are seen as being in direct conflict with those of the foetus. As already noted, a common feature of the medical disapproval of women who have natural childbirth is the view that such a birth is likely to prove hazardous to the foetus.

This view was strongly opposed by all midwives interviewed and by the GPs at the practices who argued that the woman was *the* person who possessed ultimate responsibility for herself, her pregnancy and for the foetus. The comment *"it's her baby"* was made by the midwives and GPs in many instances as a means to support and give validity to a woman's actions or decisions.

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2. Although the operation was hailed a success by professionals and the media alike the baby died a few days after being born, prematurely, suggesting that medical outcomes may even take precedence over foetus rights.

> *One practice in ...* (names a local practice) *gives the women a terrible time, tells them that they are not thinking about the baby and all sorts. You see if they feel like that they should just send the women to another practice rather than hound them, they haven't got any right to do that anyway, it is her baby. They can be a bit stupid like that at the consultant unit as well.* (Midwife - Ann)

The workers rejected the medical model's dichotomy separating woman and foetus. They identified the needs of the woman and the needs of the foetus as being inextricably linked. Meeting the needs of one was also seen as responding to the needs of the other. Within such a philosophy providing emotional support and a positive experience to the woman was seen as likely to improve the outcome of labour for both mother and child, producing an easier birth for both participants.

Finally because the pregnant woman is perceived as a parent rather than a patient, ultimate responsibility over decisions surrounding her unborn child was identified by the workers as resting with the woman and not with the professionals.

2. Pregnancy pathological or normal?

A further dichotomy identified by Rothman (1982a) within the medical model concerns the separation of emotional and physical needs with the priority being given to the latter. Meeting a woman's needs for comfort, control and emotional support in labour are seen as conflicting with the need to achieve safety through rational and efficient management of labour (Rothman 1982a:48). Following from this the routine use of technology to enhance safety is not only perceived as failing to meet the full range of women's needs but also constituted in certain circumstances an inappropriate means to provide safe care. Part of the community midwives' view of reproduction consisted of their definition of what constituted safe practice. This was defined in a more broad and encompassing definition than the medical view. Within the medical model safe maternity care is provided through some form of intervention, because differing degrees of intervention are the only range of responses available to a medical practitioner. In contrast, the midwives in the community felt they had at their disposal a wider range of responses, with the safest response in certain cases being non-intervention. This was because they felt that firstly, the implications of intervention in terms of potential costs to either the mother or foetus could outweigh the benefits. Secondly, within the context of the majority of normal birth, childbirth as a process did not require such intervention. Thus as a result the episiotomy rates of all the midwives were all equally low. Such intervention was seen as applicable only in extreme need, such as in an emergency or abnormal situation, rather than as a standard procedure necessary for all births - as it would within the medical model.

> ***Question.*** *Apart from requests from the women themselves, what aspects of intervention, including pain relief, do you offer yourself or do?*
>
> *I have been out on the community for 4 years and I haven't done an episiotomy until this Sunday - when I had a baby in distress.* (Midwife - Cath)

The midwives also expressed a view concerning a different role for technology in labour. They saw the use of technological interventions from pain relief to monitoring as tools which were at their disposal to assist the woman to have the type of labour and outcome that she wanted. Importantly one of their criteria for use of pain relief was that of assisting the woman to maintain or regain control of the situation.

> *I have given women pethidine, just twice. Both times the woman was completely exhausted and in so much pain that she had just lost control and they just needed something to just bring them back to just ease it a bit so that they could take over again and get back in control.* (Midwife - Alison)

In contrast to the medical frame of reference, the workers emphasised the normality of birth and reproduction. Pregnant women were defined only against standards of normality derived from other pregnant women. Pregnancy was seen as a normal physiological process similar to other physiological processes, such as eating and sleeping. According to the midwives' definition, abnormal pregnancies and labours were defined as those which deviated from the standard of a normal pregnancy. This standard was broadly defined by the midwives, there was an acceptance of the existence of a wide variation between individuals but which would still conform to a normal pregnancy.

> *The difference between us and the consultants is that they only see a pregnancy as normal after the event. We say that all pregnancies and labours are going to be normal unless there are indications to say otherwise.* (Midwife - Jean)

Part of the midwives' criticisms of the local consultant units was concerned with the way defining pregnancy as a pathological processes resulted in an organisation of care which processed the women as patients. Adoption of a sick role was seen as inappropriate in the midwives' view to meet the needs of women who were healthy and going through a normal process.

> *Little things make it worse for the women. Like on the labour wards there is pressure on the women to use bedpans and that makes them more of a patient.* (Midwife - Jean)

Although the concept of risk was not absent[3] from the workers' model, one of the primary factors emphasised by the workers was that of the normal processes of reproduction. This was reflected in the way they viewed the management of care. One illustration of this is the issue of eating and drinking in labour. At the local consultant unit, women were not allowed to drink during labour, as patients - a precaution to prepare the women for the perceived likely event of the women having to undergo surgery, Furthermore as the obstetric unit falls within a surgical speciality, women in labour in being denied food and water were being treated no differently from any other patient. The midwives and GPs at the practices adopted a different position, within the definition of birth and labour as normal events, eating and drinking were seen as assisting the woman to work during her labour and to prevent dehydration caused by strenuous exercise, as they would with any person undertaking heavy physical work. There were certain perceptions that women in labour normally preferred light meals and still drinks, but this was felt to be part of the natural process of pregnancy rather than preparation for intervention.

> **Question**. What would you say were the main priorities for your care?
>
> *Women who are having babies aren't sick and we shouldn't treat them as if they are. Its all about the way you approach pregnancy. Like in labour, it is much better to give a woman a drink than set up a drip - really obvious. It's about thinking about what you are doing.* (GP - Caroline)

The workers interpreted pregnancy and birth as normal physiological processes, which were normal to women. The workers not only recognised the naturalness of pregnancy, but as a result valued the women's view of their situation as valid criteria on which to make decisions concerning the management of care.

> *I always say to them you have got to listen to your body and be prepared to listen to the alarms that your body sends off and be prepared to rest if your body tells you to. I always like to listen to the women in labour as well, I mean really listen to what they are saying their body needs and what they are saying they want.* (Midwife - Doreen)

Overall the philosophy of care and approach to reproductive health care at the practices and among the other midwives interviewed, emphasised the concept of normality. In addition, this was in direct opposition to the medical dichotomy separating emotional and physical needs and to the tendency towards polarising the needs of mother and foetus. As will be demonstrated in the next section the midwives, in common with Rothman's (1982a) construction of a midwifery based model, felt that, for a woman's need for a successful outcome to be achieved they had to be seen as a totality.

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3. See the section on constraints for a discussion of the influence of the hospital over this aspect of the workers philosophy.

Criteria For Reproductive Success

Graham and Oakley (1981) identified that within the medical paradigm positive reproductive outcomes have a very limited range of criteria namely perinatal and maternal mortality rates.

Although the delivery of a healthy child and mother was a priority of the midwives, they were not concerned with mortality rates per se. Instead the midwives worked with a much broader criteria of successful outcomes; based on an assessment of the woman's physical and emotional needs in addition to her social and economic situation. These were seen in terms of the emotional and psychological experience for the woman. Did the woman see it as a good experience, did she feel that it was worthwhile? - were all questions which fell within the midwives definition of a good reproductive outcome. Furthermore, the answers to these were not simply seen in terms of the outcome of a healthy baby or the development of a good relationship between mother and child, (the idealised bonding). In contrast to the medical model's narrow definition of patienthood being the women's only relevant status, within the midwifery model it was the woman's individual experience which was seen as important. Rather than the outcome being solely interpreted in terms of her new status of motherhood the midwives believed that pregnancy and birth were positive experiences, which could possess a value in themselves for women.

> *Like, the women are always thrilled with the baby, it isn't just that I look for. It is like I wait for them to say "oh it is good isn't it Jean", that it was worth it for themselves. Just that they thought it was all worthwhile, because that is how I felt after my first. I thought "oh this is great", and sometimes that doesn't come from the women, I don't get that feeling and then I feel that perhaps I have failed in a sense.* (Midwife - Jean)

The criteria for maternity or reproductive success were also seen by the midwives in terms of the lowest degree of intervention required on their part. The midwives were in part predisposed towards a non-interventionist approach to care provision because they had re-interpreted the value ascribed to the different features of their practice, effectively reversing the ranking within the medical model, with emotional support receiving the highest value and technologically-orientated tasks the lowest. For the midwives, a central element of sound midwifery practice was providing a means of supporting a woman and meeting her needs in labour, without relying upon technological or medical intervention. The more passive and non-directive was their role the greater their satisfaction with the support they provided.

> *I try not to interfere too much at all, normal births are better not managed in that way, as you are just intervening unnecessarily. My criteria for a good birth is one where I come away and think well that was good I didn't do much there did I?* (Midwife - Jean)

This approach is directly linked to their view of pregnancy and birth as consisting of a natural process, rather than a pathological condition. The view that pregnancy and birth were natural processes within the boundaries of normal physiology and that as a result a non-interventionist approach to maternity care constituted the most appropriate response to the provision of care, was felt by the midwives to constitute a philosophy which formed a fundamental part of midwifery. By committing themselves to normality the midwives felt they were reasserting the traditional craft of midwifery.

While the GPs were committed to the same philosophy and approach towards intervention as the midwives and adopted the same broad definition of reproductive success, the practical implementation of this philosophy was for them more problematic. Unlike the midwives, their training and philosophy was orientated towards the pathological rather than the normal. Rather than re-assert a traditional role in their practice they were actively having to reject much of their training. As the GPs felt that the conditioning of their training was an important factor in perpetuating the medical model which they felt they had to overcome. It is perhaps not surprising that the GPs in discussing their approach to care stated that they found the relinquishing of control over the birth process and over other staff a 'scary' process, as the following comment from the GP concerning her feelings towards home births (at the North practice) illustrates.

> *Like sometimes if I am not needed or the woman wants me around then I will be there and just sit on the stairs and read a book. If I am not needed. It can be a little scary to tell the truth, because you have been trained to be so aware of all the things that can go wrong.* (GP - Caroline)

For the four female GPs interviewed, challenging the medical model was felt to be particularly important in terms of both their interactions with other staff within the PHC team and with the women users. The women GPs specifically, saw a need to move away from the traditional authority of the doctor and develop a process of deprogramming themselves so that they could reject the model of professional dominance and authority which their medical training instilled. The doctors argued that the most appropriate manner in which to interact with women was to distance themselves from their medical training and to reject openly the traditional role of the doctor as both the head of a hierarchy within the PHC team and the key provider of care to women.

> *I think the most important thing is being able to step out of your professional role. And the higher up the hierarchy you get the harder that gets and the harder for your patients to accept and the harder for me to do and for other workers I work with to do as well.* (GP - Louise)

For the GPs the traditional role of the doctor was also perceived as being a fundamentally male one, in so far as they felt their training had forced them to adopt a

masculine role model which hindered the development of a positive empathising relationship with the women users.

> *I am also very aware that women doctors are not always as sympathetic as we feel they should be, and are often as unsympathetic as men, because the training often makes women doctors forget that they are women themselves. So that women doctors who are trying to do something positive often feel that we have to consciously forget we are doctors and relearn or become more aware of the woman side of our characters.* (GP - Kate)

Thus the women GPs felt that an important element in creating an alternative model of health care provision to the medical model was a recognition of the need to identify with other women as women themselves; being a woman was therefore felt to be a central factor in defining the quality and direction of their practice.

> *I know someone like ...(names another doctor). I can imagine her just chucking away the thing that she is a doctor and just doing what she needs to do - woman to woman. I think that is what is important - is to throw away all this stuff about being a doctor and professionalism.* (GP - Louise)

Unlike the medical profession the justification for the midwives presence came from the users sanctioning their presence rather than that sanction coming from professional authority and the health system itself.

Choice, Control and Support - Three Priorities For Care

Within the medical frame of reference the priorities of care are centred around the needs of two systems. Firstly, fulfilling the demands of the institution: such as note taking, booking, and other bureaucratic functions. Secondly, performing key medical tasks which comply with the demands of the medical model. The functioning of these are achieved in harmony with each other, with medical and institutional needs forming a symbiotic relationship - ensuring that the needs of both are met.

Within this organisation at worse the woman becomes a vessel, an object for medical processing (Arney 1982; Oakley 1984). At best the needs of the women users occupy a lower level priority, but to an extent will be accommodated if her needs do not conflict with medical or institutional priorities, such as *allowing* male partners to be present (for further examples see Kirkham 1982, 1987). Thus at best women can expect a more humanitarian paternalism, which as Stacey (1988:24-23) points out, this new reproductive patriarchy may be more benevolent but is not any less repressive for that.

The model adopted by the workers at the practice and the policy of their clinical practice aimed to reverse this position by placing the needs of the individual women central in the provision of care. Perhaps even more fundamentally, the workers stated

that the woman's rather than the professionals definition of need formed the basis for the type of care provided. Within this the workers aimed for an approach to care provision which responded solely to the expressed needs of the women users.

> *Well you see when it comes down to it, it is all about them telling us what they want and what they want us to do, and us doing it.* (Midwife - Ann)

Within current maternity care provision the definition of choice for women users can more easily defined as composing a humanised compliance with medical authority (Wagner 1986). Research in the area reveals that although women may be encouraged to express their preferences for certain forms of management, such as *asking* for the natural childbirth room, ultimate control of the decision making process rests with the professionals, and specifically the medical profession. As Graham (1982) noted in a survey of ante-natal literature,

> "... a narcissistic and self directed approach to pregnancy is conditional upon and secondary to the woman's acceptance of a higher medical prerogative."

A key factor in the maintenance of this medical control over childbirth has been seen as regulation of the flow of information (Wagner 1986). A localised case example of such an ideology underlying policy developments in care provision is recent development of policy in Sheffield. The report of a working party concerning long term strategy for maternity and reproductive care, despite local user opposition, strongly recommended in the *interests of safety* and in line with the consultants' report, to centralise provision thereby closing the local GP unit and building a new consultant unit. However the report also advocated a supposedly new commitment to user participation.

> "The mother must be recognised as a full and equal partner in her care, able to influence and participate in the service and support she receives." (SHA report of the working party on the future provision of obstetric services in Sheffield 1988)

However, a closer reading of the Sheffield proposals reveals a complete absence of a commitment or any actual policies to devolve greater control of the decision making process to women users. The choice offered by the committee to women is fundamentally one of passive acceptance of professional management of their reproductive and gynaecological health. Home confinement, continuity of care and low technological intervention are all accepted as being attractive to women but the focus of the report is on the potential risk of all pregnancies and at every point any commitment to user choice is carefully qualified always leaving the ultimate decision and thereby the power to the professionals.

> "General practitioners facilities within the maternity unit are attractive to some mothers and their wishes should be acknowledged **where appropriate.**" (SHA report of the working party on the future provision of obstetric services in Sheffield 1988 - my emphasis)

In response to this position of ultimate control by medical authority Wagner (1986) identified two aspects of medical professional power loss which are essential pre-requisites for women to possess choice and thereby control over their pregnancy and reproductive health care: loss of control over precisely what happens to each woman and an implicit recognition that the "woman also has valid information and should control her own body and life".

Thus it is the definition and availability of choice which forms the beginning of the departure between a woman centred model of reproductive and maternity care and the medical model. The workers and midwives in particular advocated not only the right for women to be given choices, but also women's ability to make sound and reasoned decisions concerning the management of their reproductive and maternal health care. This notes a significant departure from the bio-medical view. For the workers at the practice a lack of medical or professional training was not seen as a reason for exclusion from the decision making process as it is within the medical model.

Here a necessary implication of the feminist critique of the medical model is given some support (Graham and Oakley 1981). If workers view pregnancy as a normal event and view women's reproductive capacity positively rather than being seen as inherently pathological, an effect is produced whereby women are increasingly included in the decision making process because the foundation for their exclusion has ceased to be part of social reality. Where pregnancy and childbirth are seen as pathological and subjects of specialties within medicine, the only criterion from which to make judgments and decisions is through medically derived knowledge. Consequently, as most women do not possess this knowledge, there is no imperative or necessity to include them in the decision making process; the most that can be expected is for the professional to consult the woman concerning their actions.

By contrast, if pregnancy is seen as both a normal part of ordinary life and as a process which can be effected by the woman's life experiences, then the woman's own input becomes more important. Furthermore if a woman's knowledge concerning her pregnancy is an important element in the provision of appropriate care then the woman's participation in the decision making process becomes essential for the professional to make full use of their skills.

However, this situation could lead to an outcome which still fails to provide the women with control over the situation. Medical control could still be maintained through surveillance of natural childbirth, with women at best being able to participate in

some of the decisions over the management of their care (Arney 1982) but having to conform to medical criteria and policies for the management of a natural childbirth.

The workers at the practices argued that their approach to women's involvement in care went beyond simple participation in the decision making process. Ultimately the workers saw decisions over care provision as being the women's choice, that the user should direct the provision of services according to her expressed needs was fundamental to their policy for the provision of care. Definitions of ideal care were based upon the women's choice and perceptions of need rather than professional or medical criteria.

> *... you see the woman is the one having the baby. She is the one that is doing it and who is going through the labour. Like they say all this about midwives being wonderful and the new midwife and all that, but the woman is the one who is going through the labour and so I think that she must be the one who chooses.* (Midwife - Ann)

As already noted, the devolving of decision making to users as a means of enabling women to exercise control over their own pregnancy and labour was a central feature of the workers' model. This commitment to user control over the decision making process was felt by the workers to take precedence over their own judgment. For the midwives this remained constant even where the women expressed a preference which the midwife would not personally have advocated.

> ***Question**. Where do you draw the line, or do you, over conflicts between what patients want and what you feel is safe?*
>
> *Well obviously we do have a criteria which we have to work on and there have been women who we felt it would be better for them to have a hospital delivery, but then if they say no it is their choice. In those situations we just sort of cover ourselves and say that we are not that happy and ask for the hospital to cover us with back up. But it is the women's choice your job is just to be prepared to cope: Whether you agree with her or not.* (Midwife - Angela)
>
> *I think you have to, in those sort of cases, be prepared to be proved wrong. You have to think "well it is her pregnancy - her baby", your role if you like is to give support, you musn't go around saying "you musn't do this" or even "you should do this". Women are individuals and you must see them like that.* (Midwife - Jean)

In the GPs although expressing an overt commitment to user control tended to adopt a less strong position than the midwives to the maintainence of that control in a situation of conflict.

> ***Question**. Where do you draw the line, or do you, over conflicts between what patients want and what you feel is safe?*
>
> *Well you do need to get the balance right in those situations. I think its the need to balance safety. Its your job really to make sure the woman knows all the facts, but its up to her.* (GP - Caroline)

The impact of this on the provision of care is explored in the subsequent chapters.
This view reveals an underlying trust in women's ability to make sound decisions and a commitment to women's right to control their own reproductive health. At the same time the midwife rejects the primacy of medically based knowledge and accepts that decisions based on criteria other than a limited range of medical information possess validity, and in certain circumstances greater weight, than professionally derived knowledge. How then did the women workers and particularly the midwives and nurses see their role in the decision making process and in the management of care?

The key to understanding the women workers approach to their role relates back to their interpretation of their relationship with women and their view that a function of their work was to empower women. The midwives and nurses perceived their role as a that of a friend with knowledge as a result their role was to impart that knowledge to women by enabling women to make informed choices.

"Informed choice" within the medical model can be seen as serving to educate women to accept the dominance of medically based criteria for decisions. The medical frame of reference can only provide women with a one dimensional choice, as both reproduction and women themselves are seen within a limited set of medically based criteria of need. The workers viewed women's needs holistically and were therefore likely to be better placed to provide a full choice to women. Furthermore as they perceived that a key element or function of their role was to empower women (see later section on empowerment) they expressed an aim to provide women as fully as possible with all the facts from which to make an informed choice which was genuinely derived from full access to information.

> *I think the most important thing we offer to women is to enable women to make choices an informed choice. Its about giving them as much as possible all the facts and information, from which they can make their choice. Telling them all the details that they don't get in the hospital and the implications of test findings, choice over cutting the cord that sort of stuff. Information they might not have if you didn't tell them.* (Midwife - Alison)

Following from the commitment to enabling women to make choices over their care, the workers saw their role in terms of providing support to the women and their families. However, the term "providing support" is somewhat of an euphemism in the health service and among welfare professionals in general. The definition of what exactly constitutes support tends to be worker defined. Kirkham (1987) and Manikiem (1979) found that although midwives based in the consultant unit perceived their role as providing support to women, the support provided functioned to ensure the users passive compliance and thereby the smooth running of the ward.

> "Patterns of communication between nurses and patients reflect this authority/subordinate role ... It has been relatively easy for nurses having been conditioned as women, to relate to the passive model and to discourage independence and autonomy in clients." Manikiem (1979).

The decision to instigate the use of pain relief is a useful example in this context. Kirkham (1987) found that midwives felt their role to be one whereby they would suggest or administer pain relief if they felt that the patient might become too distressed and pose a potential threat to the quiet ordering of the ward. The control over the decision making process was clearly not in the hands the users.

By contrast the community midwives involved in this study stated that they would always discuss pain relief with women in order to provide women with an awareness of their options, but that under normal conditions in labour the decision to even mention pain relief in a conversation was the woman's. The midwives argued that to even suggest the possibility of pain relief to a woman would undermine her confidence and ability to cope.

> *I think doing like they do in hospital - always asking the woman if she needs something for the pain - destroys any control she has. Like, if a woman seems to be coping and doing well then I just kind of step back. You have to see, rather than constantly bothering her. If she needs help and encouragement then obviously you give it to her.* (Midwife - Jean)

The support that was provided by the midwives was understood by them as almost entirely user driven and defined. The manner in which they acted and the form of support was seen as responding to the expressed needs of the women.

> *Well you do what ever makes them feel confident, I mean I haven't tap danced on the table yet but I have to might one day. (laughing)* (Midwife - Cath)

> ***Question.*** *Can you think of specific examples that the woman want?*
>
> *Well like this last woman, she was perfectly happy with me just massaging her back for hours and leaning on me like this (demonstrate position). So we just did that for hours and that is all she needed a midwife for. So that was my contribution to her delivery really.* (Midwife - Moria)

In order to evaluate the degree of the midwives commitment to a user directed mode of service delivery, the midwives were all asked at what points they would, or felt they might, exercise control over the situation.

> ***Question.*** *Have you ever or would you ever instigate the decision to have pain relief? Have you ever suggested pain relief before a woman has?*
>
> *Well I have very occasionally, but very rarely probably about three times.* (Midwife - Jean)

One very rare occasions once... (Midwife - Cath)

On the community just the one time I think.. (Midwife - Ann)

I would I think if the woman really did need it, but I can't remember ever suggesting it first. (Midwife - Doreen)

The decision to suggest pain relief was viewed by the midwives as a last resort, to use only in a case of absolute need, when all other means of help or assistance had been exhausted. Furthermore the criteria adopted by all the midwives for instigating the use of pain releif conformed to a similar pattern. Such intervention was advocated where it was felt that using pain relief or intervening by rupturing a women's membranes would enable the woman to regain control of the situation and to enable a normal delivery to take place.

Well there was this one woman. She had been in labour all day from about 8 in the morning and I went to look after her at about 9 at night and I was with her all night and it got to about 7 in the morning and she still wasn't fully dilated and she was so exhausted and she was so tired she had got really tense and given up. She needed just a little bit of pethidine to relax her and get her body going otherwise it would have been one of those labours that went on for days . So I gave her some as she really did need it and then everything was fine, she delivered normally. (Midwife - Alison)

Who Are The Experts?

The medical frame of reference asserts the dominance of medical knowledge and skills over all other forms of expertise. This necessitates that women's expertise, knowledge and abilities are systematically undermined and devalued. Within such a model women are viewed as possessing less intelligence than the professional experts and therefore require constant and vigilant supervision by health workers. At the level of individual practitioners the medical model often coincides with social and economic prejudices to further disadvantage women users. Stimson (1976) found that doctors actively disliked those patients who were the most different from themselves, with working class women being least favoured by doctors as patients. This replicates and mirrors the patriarchal devaluation of women in society and affects the treatment of women within the health care system on a regular basis through influencing the nature of the relationship between user and professional (Roberts 1985).

Graham and Oakley (1981) identified the manner in which the medical frame of reference systematically devalued all aspects of non medically based knowledge and expertise. Within such a model women need not be given any choice or information quite simply because as non-medics they do not possess the knowledge from which to make a judgement. Thus women by virtue of being patients are within the medical frame

of reference excluded from the decision making process, even those who merely ask to be involved are perceived as taking deviant action. Previously such a phenomenon has only been understood as directing the interaction between medical practitioner and user, however all the nursing and midwifery staff interviewed perceived the medical frame of reference and associated devaluing of women to form a common feature of nursing and midwifery practice. The midwives felt from their own experience that within the hospital environment the pressure to conform to medical imperatives defined and maintained a barrier between her and the 'patient'.

> *In the unit where I worked, they tended to be very critical of women coming in and asking for a different sort of care, even over simple things such as not wanting their membrane ruptured, or a foetal scalp electrode put on the babies head. The immediate attitude to that was, she doesn't know what she is talking about, what is she doing telling us our job?* (Midwife - Ann)

> *I have heard them, this is other nurses, other women say about another woman just because she was quiet with them, and didn't say much. "Oh she is a bit thick" and put that on the women's notes. You know just like that, and then everyone will read that and treat her like that.* (Practice Nurse - Kim)

But if user control is accepted by the worker then as a result the professional can no longer dictate the course of action women should adopt.

> *I see my role as making women aware of the choices they have, the fact that they have choices. Although we try very hard not to influence them one way or the other. I think the golden rule has to be, you can't say "never do that" and try not to say "should", to women it has to be their choice.* (Midwife - Jean)

Within such a model information giving was felt by the midwives to be a two way process, with health worker and user both contributing to the growth of knowledge concerning the experience of reproduction. Part of their learning as midwives came from this listening to women. Thus women are understood as possessing an important amount of expertise.

> *I think that the women themselves have taught me most. Just by listening carefully to them. You have to listen to women - I can always tell a poor midwifery student if she doesn't spend time listening to women.* (Midwife - Cath)

Responsive Flexibility - a rejection of task orientated care

One of the central components of the workers' critique of the medical model and the hospital system was the rigid and routine method of clinical practice and providing care to women. Both GPs and midwives felt that this was a fundamental cause in the hospitals inability to respond effectively to women's health needs.

> *When I was training I worked in high technology units you had to work according to laid down procedures and formula laid down by the hospital. That formula had to be followed regardless of whether it was appropriate or not for that particular woman.* (Midwife - Alison)

The community midwives and GPs were therefore highly critical of the *task orientated* nature of care within the hospital, saying that the real needs of women would not be addressed through such a system of care. The midwives were also highly critical of the role the hospital midwives played in perpetuating an inflexible and therefore inadequate system of care, the community midwives felt that passive and unquestioning acceptance of the current system by the staff within the hospital system maintained and replicated poor quality of care.

> *Some of the midwives I was coming into contact with at the hospital were very blinkered as to their practice and they didn't seem aware of any procedures or development in midwifery or even any practice of midwifery at all that was outside of their hospital. They didn't want to be aware or do anything to rock the boat.* (Midwife - Jean)

Part of the consumer critique of the medical model has been that women have been forced to ask and demand the information on which to base their choices. The workers at the practices advocated a flexible approach to care provision, which they argued consisted of a responsibility on their part not only to respond sympathetically to direct requests from women, but to be active in updating and expanding their knowldege base in order to communicate accurate information to the women.

> *I think that as well as having a sound core of knowledge and experience which you are adding to all the time, you have got to keep your mind open to all sorts of of new developments not just in midwifery, but in health generally. Because you get them asking about all sorts of things like homoepathy and acupuncture and what have you, and if you are very sceptical about things it is very easy to say well "that's no good" and "it's no use for childbirth" ... What I am thinking about is more an openness to different ideas which might be of value they might not you have got to be prepared to look into them. Then you can help them to find out about it, or answer them if they ask you. Otherwise if you don't do that you can't give them the help they need.* (Midwife - Alison)

Among the midwives quality, of midwifery practice was judged according to the midwives' commitment and ability to respond to women needs in a flexible and open manner.

> *Some of the midwives can be a bit intolerant about things. Like one midwife who has worked abroad is very intolerant of the amount of support women need over breast feeding. She thinks they should just all do it naturally. I think that she needs to be a bit more patient of their needs a bit more, it goes back to open mindedness.* (Midwife - Margaret)

This was seen to constitute an appropriate response for each individual woman's needs.

Part of the foundation of the midwifery model as opposed to the medical model was an absence of moral prescription which judged women and of narrowly defined women's role or lifestyle within a range of behaviour which closely corresponded with the practitioners own. A noted feature of the medical model and generally of the approach to providing health care to women is the manner in which it replicates and reinforces patriarchal values and conditions for women. Thus an anticipated feature of a woman centred model would be a rejection of imposing normative values and instead a move towards supporting women in defining their own life course. Among the midwives the prevailing view was they could not function effectively as midwives or assist the women if they became involved in imposing values and judgements on the women.

> ***Question**. Can you describe you ideal midwife?*
>
> *You have to have a feeling for the whole family, which is impossible to do in the hospital but you can in the community and you have to have a regard for their values of family life. I think the rest of your own attitudes do come across to the mothers so if you feel that at the back of your minds that family life is fraught with problems and that women say shouldn't have more than two children or something then it won't work. You can't have any preconceived prejudices or ideas on how people should conduct their lives. You have to accept other peoples ways of doing things, which isn't easy sometimes.* (Midwife - Jean)

Empowerment

Previous subsections of this chapter have documented the workers' view that their role was to facilitate increased user choice, and control over their health care. A theme underpining the workers' philosophy towards their role, documented throughout the chapter, has been that of empowering women users. However this was also a feature of their work which was explicitly acknowledged by the workers; Teaching women how to obtain the service they as users wanted was seen by the workers as an important and legitimate part of their practice. All the workers expressed a commitment to adopting a policy which would enable women themselves to prioritise aspects of the management of their own health care and to direct the interaction between themselves and the providers of care to achieve their goals. Thus a key element of their practice was to empower women to manipulate the hospital system to their own ends and achieve the women's goals.

> ***Question**. What do you feel are the main priorities of your care?*
>
> *...teaching people the assertiveness techniques that they could use to, get a better service from the hospital. Like positions in labour, all the hospitals are more than willing to let people walk round in labour but people have **got** to ask actually ask for it.*(her emphasis)
> *The doctors and midwives will explain what a monitor is for and why they are going to break the waters and stuff like that, and they will ask*

> *the women's permission. But, unless the woman is actually genned up in advance, then the woman won't actually get that service and that is what we have got to offer.* (GP - Louise)

As will be shown in the next chapter, support from the workers at the practices was used by the women as support for assertive action and demanding a service orientated to their needs within the hospital system.

Empowering women was seen to be of key importance for working class women whose own needs were perceived by the workers as being sacrificed in order to fulfil their commitments to caring for their families and partners. The workers recognised the extent to which women's lives and control over their health and reproduction are constrained by both the material structure of their lives (Graham 1984) and the patriarchal mechanisms operating in society to define nature of the social environment.

> "The right to choose means very little when women are powerless...women make their own reproductive choices, but they do not make them under conditions which they themselves create, but under social conditions and constraints which they as mere individuals are powerless to change." (Petchesky 1980)

The very real health consequences of deferring their needs to the needs of others was acknowledged by the workers not as an individual problem for each woman to manage herself but as part of the weak economic and structural position women are placed in.

> *Like, women are just never listened to, no-body ever listens to their problems they have to spend all their lives caring about other people and that is where the sort of responsive nursing I an trying to develop comes in. By giving women time and listening to them they can decide what they want.*
> *Like, the other day a woman came in for a smear test and I talked to her first and she just sat there and cried for an hour because things had got so much on top of her and she ended up coming back for the smear, but she really needed to have that time to talk through her problems.* (Practice Nurse - Mary)

> *That is another thing most of the women here have no idea what it is like for anyone to care about them, or give them any support.* (GP - Maria)

The workers recognised the powerless position of women and constructed their approach to their practice to respond to that. Firstly, the workers felt their commitment of time and energy to women formed the key to any ability they might have to empower women, in particular continuity of care was seen as an essential element. Secondly, enabling women to discuss their problems and providing someone listen to them, was seen by the workers as providing women with a facility which was not accessible to women through their normal contact with the health service or even in daily their lives. It was in this respect that workers felt they were particularly responding to the needs of working class women.

Extensive sociological and feminist research has identified the ineffectiveness of the medical model as a means of addressing women's health needs for some time, (Stacey 1988). The critique of the medical model held by the workers is certainly not original in nature but it is significant that the critique is coming from within the system. In these practices, it is women health care providers who are consciously attempting to provide a working alternative for women, which aimed to empower them to exercise greater control over their health care.

Limits of their care

A final feature of the model held by the workers at the practices was an acceptance of the limitations of their care in terms of their ability to have an impact on the women's health. In recognising the degree to which women are powerless to control and maintain their own health, the women workers also faced their own powerlessness to effect any far reaching change in the quality of women's health, particularly the health of working-class women. In addition, there was a recognition among the GPs and practice nurses that the women frequently sacrificed their needs to meet those of their partners and children. Unlike Rothman's ethicist (Rothman 1986:30) the willingness of women to meet the needs of their families at the expense of their own, was not a source of surprise but rather one of concern.

> ***Question.*** *How much impact do you feel that you have as a health worker on women's health?*
>
> *Oh I have no illusions - that we can change anything. I will happily write letters to the council and say that a patients' housing conditions are affecting her health. Sometimes it works some times it doesn't, so I don't have any illusions about a health workers' impact.* (GP - Maria)
>
> *What can you do? I mean I write letters, ring up the social security, but when all is said and done little really changes for these women. Its like another country here ...* (GP - Louise)
>
> *Not really effective at all. Most of the women I cover are low social class and a lot of it is financial. I can't change things like their diet, because they haven't got the income to change it.* (Midwife - Alison)

This recognition of their own lack of power on a macro or political level to improve women's health care was closely allied to the rejection by the workers of individual pathology as the prime causation of ill health. This had the greatest effect on their approach to the provision of health education and preventive health care.

> *Like, many of the women just get by on cigarettes and being brave. So I don't tell them you must stop. I always say can you try and cut down. I mean they do try -they know it is not good for the baby.* (Midwife - Breda)

All of the workers in giving health education advice stated that they incorporated a recognition of the constraints the women faced. One midwife organised ante-natal classes to address the need for a local accessible class within the NHS.

> ***Question.*** *I have noticed that you never really mention NCT classes - is there any reason for that?*
>
> *I used to mention it all the time and the women would be keen and then I would say it is £2.00 and the nearest class is the other side of the city and their faces would fall. So I run classes here, like the NCT ones with all the natural childbirth stuff. The ones who have come have been really keen and said it helped. But in an area like here it takes a long time for anything to really take off. A lot won't come.* (Midwife - Alison)

Conclusion

The frame of reference concerning women and reproduction held by the workers at the practices was clearly a departure from the medical frame of reference, identified by Graham and Oakley (1981). The workers stated they held a philosophy of care which aimed to place the user at the centre of care provision. Medical priorities, such as testing a woman's urine and blood pressure, although not ignored were not seen as the sole or main purpose of the interaction between provider and user. The workers expressed a commitment to user control and choice which went beyond simply offering alternative courses of medical management, but instead the workers stated they aimed to enable women to exercise control over the direction of their maternity care. User control and direction over their care was shown to be supported by the workers in certain key ways:

The workers placed a high value on the women's active participation in the decision making process as equal partner in their care. Furthermore commitment to user participation was shown to be a feature of a model of care which viewed reproduction as a normal healthy process and which acknowledged and incorporated the expertise women as users of the service possess. Thus the role of women users as "health workers" in their own care was a central element in the midwives and GPs model of care. Active participation by the women was seen by the workers to be facilitated in Four main ways: Firstly, their adoption of a flexible and open approach over the most appropriate management of pregnancy and labour and secondly through their commitment to the provision of continuity of care. Thirdly, the workers perceived empowering women to exercise control over their health care was a key function of the information they gave them. Finally the development of a positive relationship where traditional barriers between user and provider are broken down was defined within the workers' model as serving to enhance the degree of control women have.

Thus within the model of care held by the workers at the practices responsibility and decision making, rather than being transferred to the providers of care, was felt by the workers as something which should remain with the women and which they as health care providers, should be active in facilitating. However the doctors recognised and felt the constraints imposed by professionalism much more than the midwives. They too felt that a relationship based on an alliance with the women was the ideal basis for the provision of health care to women. However they felt that this was much harder to achieve within their position as general practitioners.

The key element of this model was the central role played by non-medical practitioners, the midwives and the nurses. Although grounded in medically orientated training within the hospital system, the midwives perceived their knowledge-base to possess additional origins, through a re-emergence of traditional midwifery knowledge and a "with woman" role. Thus the workers frame of reference concerning women and reproduction, could be said to have produced a different model of the most appropriate form of care provision from the medical frame of reference. This model is very much in line with the ideological framework for a user-centred model identified by previous feminist and sociological research which was highlighted in Chapters one and two.

Finally the necessary implications of the feminist analysis of the medical model are to some degree supported in relation to workers' and professionals' approach to health care provision for women; as a change in the frame of reference that workers hold concerning reproduction away from a medical model and towards a woman-centred approach appears to result in a radically different model for approaching care provision.

The effectiveness and success of such a change will depend both on how far this corresponds to the model held by women users and the application of the model in practice. It it these two issues that form the focus of the remaining fieldwork chapters.

CHAPTER FIVE - THE WORKERS AND THE WOMEN - THE MATERNITY CARE PROVIDED

INTRODUCTION

In the preceding chapter it was demonstrated that the workers at the practices held a fundamentally different conceptual model of pregnancy and women's health needs during childbearing from the medical model. In addition the conceptual framework held by the workers was also found to correspond closely with the proposed framework as identified by previous research and radical pressure groups, for a form of maternity care which could actively function in the women user's interests. The remaining sections of the thesis are concerned with an analysis of the translation into practice of this model for a user-centred maternity care.

This chapter documents largely through the use of observation data, the manner in which the model for user-centred maternity care held by the workers is implemented in practice. This exploration of the actual care provided is approached in two ways; The chapter is firstly concerned with exploring the nature and patterns of interaction between providers and the women users. Secondly the chapter provides an account of the key components of that care.

Furthermore if maternity and reproductive health care for women is to provide an alternative to medicalised maternity care in terms of user centred care, a key determinant of that models effectiveness will be its ability to function to empower the women to exercise greater control over their experience of reproduction. Thus an additional area for analysis is the degree to which the workers and the type of care provided enabled the women to exercise greater control over their maternity care and experience of pregnancy.

The chapter concludes that the implementation of the model of care held by the workers at the practices provides women with a central role in the decision making process, and in certain key ways empowers the women to exercise a greater degree of control over their health care than within traditional maternity care. The findings further suggest that conflict need not invariably be a fundamental feature of the relationship between the providers and users of the maternity service. In particular, the relationship between women users and women from the nursing related professions and especially midwives are shown to be of central significance in the provision of care which could be defined as user-centred.

The chapter is divided into three main sections, each details major themes and elements of the care provided at the practices. The first section is an examination of the organisation and physical structuring of the care environment. The second section deals

with issues relating to the form of communication between provider and user. Finally, section three details the remaining key components of the maternity care provided. Throughout the chapter the term 'workers' can be taken to refer to both the midwives and the GPs, where this includes the practice nurse this will be explicitly referred to. Although much of what follows in this chapter is concerned with the relationship and care provided by the midwives, this is because of their central role in the provision of care. The GP is referred to where they had an input into the care or where a difference was found in their response from that of the midwife.

SECTION ONE - STRUCTURING ALTERNATIVE CARE

The Territory

This section presents the manner in which the workers at the clinics attempted to structure care in a way which was accessible to the women. The section demonstrates that the aim of the workers in organising the clinic was to provide the women from their initial encounter with the clinics a clear message of moving away from processing them as medical maternity cases. This section is also concerned with the impact such reorganisation of care has on the women from the possession of their notes to a pleasant environment. Finally the actions of each worker within the territory of clinics and their degree of control over the territorial space of the clinics is discussed in relation to differences between the professional groups.

The processing of women as medical maternity cases begins with the organisation of the ante-natal clinic or labour ward through a depersonalising structure of different cubicles for changing, examinations and form filling. The combined effect of this process is to create and reinforce user passivity.

> "A cubicle system for examining patients, and the requirement that patients lie on couches ready for the doctor, militate against doctor patient interaction as equals." (Graham and Oakley 1981:69)

Armitage (1975)[1] details a floor plan of an ante-natal clinic divided up into clinics, changing cubicles and sisters room, a pattern which corresponds closely with the organisation of the ante-natal clinics at the hospitals local to the research practices. At these clinics the women are seen by the midwife in one room, weighed in another and finally see the doctor in another cubicle the overall effect being to create and reinforce a fragmented approach to care. Graham and McKee (1980) noted this fragmented approach had a depersonalising and isolating impact on the users of the service as it resulted in the women rarely speaking or interacting with anyone let alone making friends at the clinic.

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1. Quoted in Graham 1980.

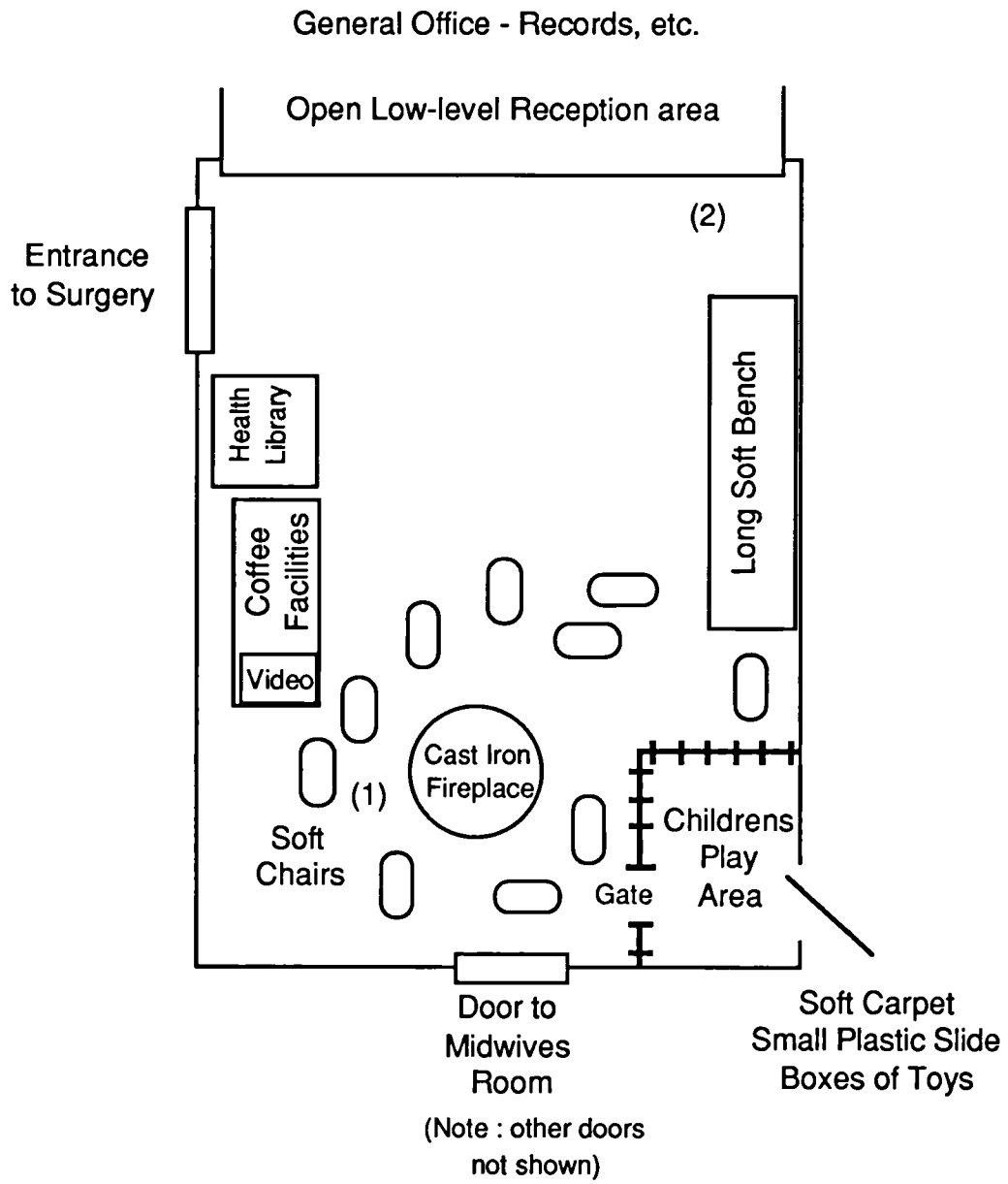
In contrast to the women's situation the ante-natal clinics, GPs practices and labour wards constitute a familiar environment for health care providers, frequently forming not only a normal working environment, but a social base as well (Savage 1986:177). In addition, the spatial organisation reinforces a sense of ownership of the territory belonging solely to the professionals with clearly marked exclusion zones separating public space accessible to users and professional 'staff only space' (Comaroff 1977:119). Thus to the female service users this is an environment which is completely removed from their every-day experience, where the '*sentimental order*'(Glaser and Strauss 1968:14) provides the guide to the appropriate norms of behaviour, in this case comprising of passivity and compliance with medical paradigms.

However, the workers at the research practices were overtly critical of the form of spatial organisation associated with medicalised maternity care. At both practices workers felt that their role should be to create a situation where the environment of the clinics constituted jointly-owned territory. Attempts had therefore been made at both practices to challenge such organisation as a means of increasing and enhancing user access and control. At the North practice this expressed commitment by the workers was implemented through the design and building of a purpose built surgery which was completed during the first two months of the research. Key design and organisational features of this surgery were specifically incorporated to enhance user-accessibility and to facilitate an alteration in many of the traditional patterns of behaviour of users and medical staff within a health care setting.

Figure 1 details the floor plan of the surgery and the waiting area and notes some of the key patterns of interaction within the waiting area. These features, in terms of the design of the surgery, constituted a major structural departure from traditional clinics: with the provision of attractive, comfortable seats surrounding a fire-place; a large equipped children's play area; and a low open plan reception area, as opposed to the receptionist being screened off. In addition, relatively simple features were included to provide an accessible atmosphere: such as removing names from all the doors; providing tea and coffee making facilities; and providing health videos for people to watch, (eg. a popular one among women at the ante-natal clinic was a baby massage video). The women themselves viewed the organisation of the clinic very positively, with the clinic being perceived as a welcoming and pleasant environment. The 'friendly atmosphere' of the clinic was frequently cited by the women as a positive feature which enhanced their experience of ante-natal care, as the following examples illustrate.

> *I have never seen a doctor's surgery - like it is amazing, really amazing. I didn't think they could be like that.* (Sharon 2)
>
> *Its lovely round that fire on days like today* (snowing) *I really don't want to go home it certainly makes it pleasant.* (Jill 1)

Figure 1 - Sketch Map of the NORTH Main Clinic



Notes

1. The arrangement of the room was not fixed. The women were observed to move the chairs around frequently to talk to friends.
2. Women also tended to collect here and talk to each other and the receptionists.

In addition, two features of the surgery were particularly appreciated by the women. The first was the provision of a safe enclosed children's play area. Whilst this was commented on by the women with children, the first time mothers also supported this initiative with several commenting that the children assisted the creation of an informal

atmosphere within the clinic. Thus the provision of this area acted to support the development of the clinic as a territory shared between the women and the workers. The second feature valued by the women was the opportunity to talk to other pregnant women who were going through the same experiences as themselves.

> *I really miss going actually, it used to be quite nice meeting up with everyone.* (Julie Lack - Post Natal)
>
> *It's good to see other women in the same boat as yourself* (Sandra 1)
>
> *Well it is a nice place to go isn't it.* (Ellen 2)

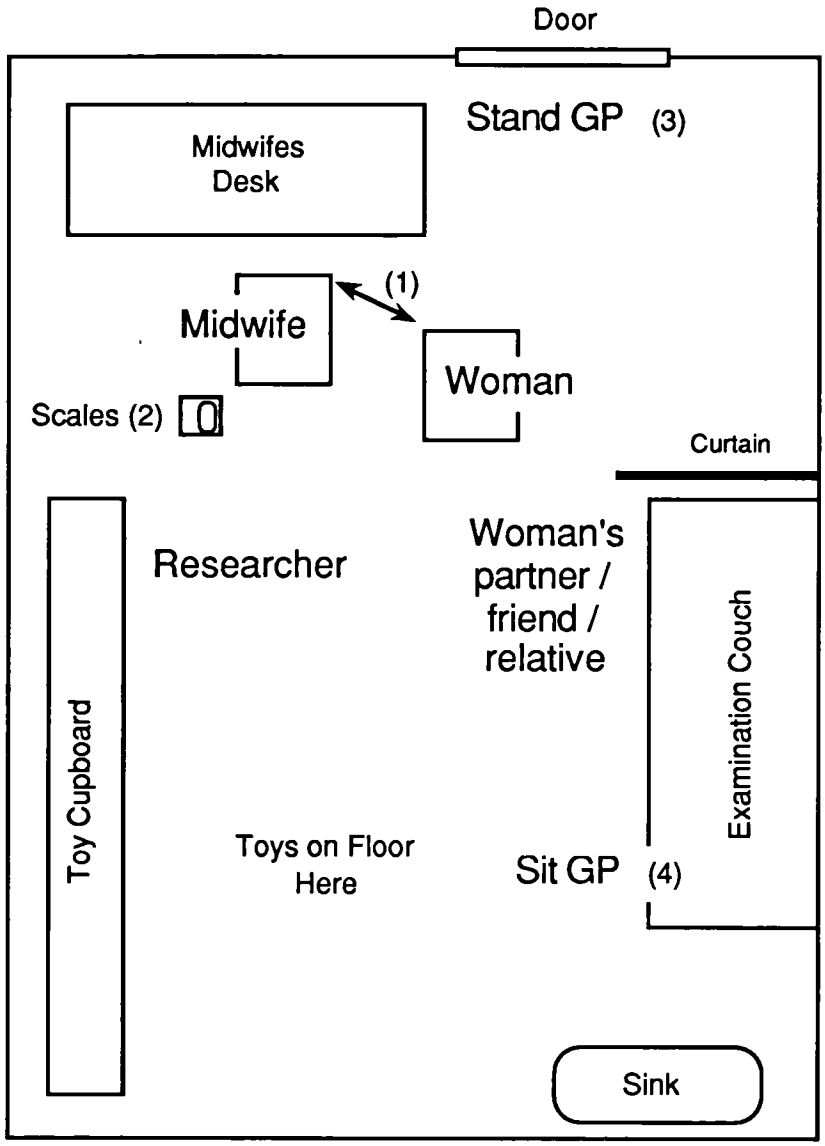
Among women pregnant for the first time the clinic was particularly felt to be a valuable source of 'contacts' with other women in the area.

Observations at this ante-natal clinic revealed a considerable departure in the women's behaviour from the passive waiting behaviour typical within more traditional ante-natal clinics. (West Birmingham CHC 'Women Waiting' 1984:21) Within the practice clinics' waiting area a high level of movement was noted among the women, who were observed to move around freely, making use of the tea and coffee facilities and talking to the other women at the clinic. Not infrequently women were observed to resume conversations in the waiting area with other women after they had completed their visit to the midwife or GP.

At the second practice, 'Park' the opportunity for structural and spatial re-organisation was severely restricted due to the site of the radical practice within a 1960's traditional-design health centre. The design of the waiting area consisted of rows of steel and canvas chairs facing changing cubicles and examining cubicles, (never used but still present) with a high screened off area separating the receptionists from the patients. Within this area the women were observed to adopt a passive role with little interaction or movement occurring. The talking that did occur tended to be subdued and between women who already knew each other.

Potential change within this area was restricted by the unavailability of funding but also by divisions within the PHC team. The 'radical' workers felt largely powerless to change the waiting area as the other GPs were perceived as unlikely to co-operate or support any changes, while the receptionists were openly hostile to any attempt to challenge 'traditional and accepted working practices'. However, the midwife, practice nurse and the three radical GPs attempted to alter this situation, in arranging their rooms in a manner which was felt to create a more positive atmosphere. They had altered the position of their desks and provided 3-4 chairs and plenty of toys as a means of encouraging the women to bring other family members and their children with them. A floor plan of the Park practices midwife's room is detailed in Figure 2 which also identifies some of the features of the behaviour of participants.

Figure 2 - Sketch Map of the PARK Midwives Clinic



Notes
1. The distance between woman and midwife was usually observed to be quite short.
2. These were ordinary bathroom scales which were pushed out of the way when not needed.

3 & 4 show the only places that the GP was observed to adopt - always outside the central core of the interaction.

In mentioning the practice many of the women felt that the waiting area was of a poor quality, although few were overtly critical, the following comment being typical.

Dunno. It's alright. A bit boring isn't it. (Sally)

In general the waiting area at this clinic confirmed the women's generally low expectations of the 'user friendliness' of buildings in which they waited for public

services, (a few women compared the building to the local social security office.) Women who already had children tended to comment that it was difficult to manage the children in the waiting area. Overall the women were highly conscious of the need to maintain quiet and order in this area, a difficult if not impossible goal to achieve with a small child. Such a view did not however form part of the comments made either about the North practice or about the midwifes room at the Park practice, where the women felt more relaxed and less concerned about compliance with norms of behaviour which were difficult to achieve.

> ***Question**: What about in the midwifes' room - what do you think about that room?*
>
> *Ah that's fine, it's fine in there as she (daughter) can run around no bother. Out there it is a real job just keeping her still.* (Carlie - Park practice)

Thus within certain limitations both practices had, through the spatial organisation of their clinics, made an attempt to normalise the situation as much as possible and to create a more accessible atmosphere for the women. The specific goal was to foster a culture which responded to the women's entire needs and reinforce a sense of participation and control over their care. However, innovative developments such as reorganising the surroundings women wait and labour in have, within the hospital system, tended to achieve little in terms of altering the power relationship between user and provider. The major reason being that such developments have tended to be implemented in isolation, without any effective attempt to challenge the power relationship between user and provider.

> "Redecorating hospital rooms with flowery wallpaper and curtains and installing beds that look like something out of homes and gardens is all too often a distraction from the real enterprise of changing professional attitudes towards childbearing." (Haire 1972)

It therefore seems likely that within any effective implementation of a policy aimed at developing a user-centred approach any organisational or architectural change will constitute only one element of a more comprehensive programme rather than a single isolated development. In particular the challenge to the power relationship between user and provider will be central to that development.

Controlling the territory

The development of rapport between the midwives and the women was to form a major theme underpinning the women's accounts of their experience of maternity care. Although the nature of this relationship and the manner in which it was established will be documented throughout the remaining chapters, certain key features of the midwives approach acted to create a sense among the women of accessibility to maternity care and

professional time which were not apparent in the manner of the GP. One illustration of this is the way workers at the practices approached the beginning of each woman's appointment. Within the clinics the midwives and GPs were observed to come out of their rooms to ask the next woman to come in. It was the policy of both practices that all staff should do this as it was felt to be an improvement, in terms of 'user friendliness', over having a buzzer or similar arrangement for informing the patient that their turn had come. However, at both the practices a clear difference was observed between the manner of the GPs and the midwives in how they approached interactions between themselves and the women in the waiting areas.

The GPs tended to come out of their room a few feet and call the women in to see them.

> Example: (GP Caroline - GP opens door - steps out of room)
>
> GP: (Looking down at notes and calling out over the room) *Julie Lack?*
>
> Julie: *Yes.* (Collects bags, gets up and goes over to the GP)
>
> GP: (Smiles) *Hello.*
>
> (Door closes behind them : total time 25 seconds)

Although the GP smiled and was pleasant to the woman, the overall impression created was one of being seen by a professional - albeit perhaps a sympathetic one. From the very initial encounter between the GP and the woman the parameters of professional authority were already being set.

In contrast, the midwives adopted an approach more typical of the type of interaction which could be expected to occur between friends or colleagues with a good working relationship. As the following interaction between the midwife and Julie illustrates.

> Jean - Midwife: (leaves room and goes over to where the women are seated and talking)
>
> Sue: *Hello Jean.*
>
> Jean: *Hello, how are you - alright? Good Holiday?*
>
> Sue: *Oh great, really great, thanks. Just the waiting now* (patting her bump).
>
> Jean: (Laughing) *Well we will see how that's going in a minute. (turning to another group) Hello all.*
>
> (General greetings from the women) *Now who is next? Its you isn't it Julie?*
>
> Julie: *Yes that's right.*(standing up)
>
> Jean: *Rightieho, everything alright?* (both walking back to midwife's room)
>
> Julie: *Oh fine. Tired.*
>
> Jean: *Oh well your blood tests have come back so we can check them. Sleeping alright?* (Both enter Midwife's room)

(Total time :1 minute 10 seconds)[2]

Clearly notable differences existed between the midwives manner and the doctor's manner in the waiting area, with the midwives tending to adopt a more informal and approachable manner. In doing so the midwives achieved a number of effects - they did not convey the need for promptness on the part of the women or that their schedule was too tight for them to chat informally. By moving over to the space occupied by the women and being prepared to engage in conversation the midwives created the impression of having time available for the women. This informality formed one way in which the midwives were observed to demonstrate, via their interactions with the women, their movement away from the stance of a distanced professional.

Given that both the midwife and doctor possessed similar amounts of available time (as they shared the clinics equally) to adopt an informal open approach in the waiting area, the observed difference in approach between them is an interesting one; which illustrates the fundamentally different nature of the two traditions of medicine and midwifery.

The observed differences in their behaviour in the waiting areas indicates that a key part of the difference between how the midwifery and medical professions interact with users is located at the level of their presentation of self, in socialised types of professional behaviour. These observed differences between two groups of female workers who were both committed to breaking down the power relationship between provider and user, indicates how difficult it can be to challenge traditional patterns of communication and interaction. The suggestion is that much of the power relationship between provider and user is conveyed to the user and also reinforced by the minutiae of interaction.

Many of the women acknowledged this difference between the two groups in their perception that during the clinics the midwife possessed both more time for them than the GP and was easier to approach.

> *The GPs here are very nice but they are still well doctors you know.* (Ellen)
>
> *Like, Caroline* (GP) *is very nice, but you still do feel that you don't want to bother her too much because she is busy.* (Sandra)

In particular, the actions of the midwife in the waiting area were referred to by some of the women as evidence of the midwives identification with them and adoption of a *with-woman role.*

> ***Question**: Why did you say that you preferred the midwife?*

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2. Both these interactions were from fieldnotes rather than being taped.

> *Well, it was when I was sitting in the ante-natal clinic and the midwife she would come out and talk to everyone and I used to think it is just like she is every woman's auntie.* (Mary)

In terms of creating an accessible and open approach, the example of interactions in the waiting area indicated a clear difference between that of the midwife and GP which reflected the differences in their traditional roles and values. This remained (if reduced) despite conscious attempts by the GPs to challenge such behaviour and structure the provision of care in a more user-centred manner.

Organisation of the clinics - Time and Access

The common image readily conjured up ante-natal clinics is that of women waiting in rows for the professionals to see them; access to professional time is regulated and restricted by the organisation and structuring of the clinics. While this image is readily applicable to patients in general, the meaning of women waiting can not simply be understood solely within the context of a lack of resources and staff shortages (Graham 1980), but constitutes a clear display of the differential values ascribed to women and professionals. The phenomenon women waiting in ante-natal clinics is more comprehensively understood as:

> "... an expression of the low premium placed on patient/woman time and the high premium placed on medical/male time." (Graham 1980:168)

The approach towards the women's time is a useful indicator to the value that the organisation of care and the professionals accord to the users of the service.

At the clinics in this study, although women were given appointments - in reality they were seen in turn by the midwife, and the waiting-time was dependent on both the speed of the midwife and how busy the clinic was; a situation not dissimilar to hospital ante-natal clinics.

Waiting times at both the clinics were not long in comparison with studies showing the length of waiting times at consultant ante-natal clinics (Oakley, 1984a:245), but neither could they be seen as short except in relation to the hospital, with a wait of 20 minutes being the norm to see the midwife. (The longest observed wait was 45 minutes). The key difference identified at the practices was not the length of time the women waited but related to the underlying cause of the delay and both the women's and the professionals attitude towards women waiting.

As already noted, the interactions between workers and women were longer than is typical within the health service, this tended to result in the clinics being long and was one of the main causes of the women waiting any considerable amount of time.

The midwives interviewed stated they felt a tension between providing women with a full allocation of time and between the needs of the other women waiting at the clinic.

> *Like some times you really want to find out what is bothering them, like Sally just then. But you know that it would take an extra half an hour to talk through with her and all the time you are aware of the others waiting out there.* (Alison - Midwife)

> *I am really concerned that perhaps sometimes we don't always achieve really top quality continuity of care. Because of the time factor you just physically don't have the time. Not if you want to be fair and give all of them a share of your time.* (Doreen - Midwife)

The waiting times experienced by the women were not a function of any attempt to conserve professional time as with the block booking system in the hospitals. Instead, waiting related more to the demands placed on the midwives through their provision of large amounts of time to the women and through the shortage of resources in terms of additional midwife time. This constraint was recognized and acknowledged by the women in their view of the time they spent waiting at the practices. The women assessed their experience of waiting firmly within the context of an evaluation of the quality of care, whereby the act of waiting was not perceived to equate with a devaluing of their needs. Long waiting times, while being interpreted by the women as frustrating were, they felt, justifiable in terms of the practice clinics, because of the quality of care and the commitment from the workers to them in terms of time.

> *Oh I never really minded waiting, because once you were in there you could be the only pregnant woman in the world. It didn't matter a bit.* (Elaine)

Several of the women illustrated this through making a clear distinction between waiting at the clinic which was felt to be a worthwhile investment in terms of outcomes and that of waiting at the consultant clinic where their time was perceived to have been wasted. In particular the women felt that the short time allocated to them when they did see a worker at the consultant unit resulted in an inadequate quality of care. The women felt that a necessary element of care which was of value was the provision of time by the health providers to respond to their needs:

> ***Question:*** *You said that the two clinics (hospital and practices)were very different in what sort of ways was there a difference?*
>
> *... Alison* (Midwife at the practice) *was busy, I would have to wait quite a while before seeing her, but I never minded that, because when I did go in to see her you would get what you wanted out of seeing her. You knew that you would get your share, because she would give you time . Whereas in the hospital you could wait and wait and then they would see you for about one second.* (Francis - Post Natal)

One way in which the midwives attempted to address the problem of long waiting times was to compensate the women for time spent waiting at the clinics through adopting a policy of visiting the women at home. Here the high degree of autonomy possessed by the midwives enabled them to respond to the women's needs and to provide the additional time the women required. All women who were booked either for a home birth or a GP unit were visited three times at home by the midwife prior to the delivery. These home visits lasted on average between 45 minutes and 1 hour, significantly such a visit was observed to enable any concerns the women had to be dealt with in more depth than was possible at the clinics.

The women's response to these visits was highly positive as they felt they received a more personalized and individualised service as a result; none of the women perceived the objective of these visits as being to assess either their home or their lifestyles, which fitted with the midwives expressed aim of moving away from a surveillance role. In addition a few of the women said they needed to interact with the midwife on their own territory before they felt that they could build up a positive relationship.

> *I really did feel that once she started coming here you forgot that she was seeing all these other women and I just thought of her as my midwife. It all felt much more personal. I am not a very good mixer and I didn't like having to go to clinics.* (Amanda - Post Natal)

The resulting impact of the visits was that they were felt by the women to contribute greatly to the development of a positive relationship between themselves and the midwife. The perception of the women was that such visits provided them with clear evidence of the midwives personal commitment to them - a commitment which was felt by the women to constitute a fundamental departure from the type of worker-user relationship they had previously encountered;

> ***Question:*** *What would you say you was the reason for liking the midwife so much?*
>
> *Oh visiting me. It was like when my blood pressure went up, and I had to have it checked every day. Now with me only living over the road most of them would have said, "Oh well you can pop in here then" but Jean* (Midwife) *didn't, she said "Now you need the rest. I will come and see you every day".* (Annie - Post Natal)

This personalised commitment of time from the midwives was for many of the women an element of their care which was one of key positive features of the midwifes care. The midwives were observed to attempt to provide personalised care to all the women through open access to the clinic and themselves. For example the midwives would say that the women could come to the clinic whenever they felt they wanted to - outside of their set appointments and all the women were given the midwives home telephone number.

In addition, although the GPs did not provide their home number, they did provide a telephone service out of clinic hours where the women could get advice. Within medicalised maternity care, access is usually restricted to the clinics opening times and more specifically to the women's individual appointments. The open access provided at the clinics gave the women the confidence and reassurance that if faced with an unexpected or sudden problem they would be able to access appropriate advice and help. The importance of such open access for women is reflected in the high usage the women made of these 'out of hours' services. Only 3 women out of the 30 stated they had not contacted the clinics or staff outside of their appointments. Of the women who had made use of flexible access: 15 telephoned the midwife[3]; 12 made additional clinic visits (usually after a call to the midwife or GP); and 15 telephoned the surgery. Calls to the midwife were in the main related to concerns over premature labour, bleeding and informing the midwife what had happened after a visit to the hospital. However, the women valued such access even when they did not make use of the provision themselves.

> *She cared about you. She gave me her own telephone number which was wonderful really reassuring, just knowing you could get help when you wanted it, if anything went wrong and you didn't know what to do. I mean she said, not to worry ring any time, I wouldn't ring her at 3 in the morning, but it was good having it.* (Jane - Post Natal)

The organisation and structuring of the clinics illustrates the beginning of the development of a partnership between women and workers. One feature of this partnership which emerged through the issue of waiting, was that of an expectation of flexibility from both sides. The midwives expected to commit their time to the women but at the same time the women felt there was a requirement on them to understand the constraints the workers were under and to accept some degree of wasted time.

Thus overall at the practices the workers and the midwives in particular were able to provide flexible and responsive care through enabling the women to access professional knowledge and support when the women themselves defined the need to. This flexibility and personal commitment from the midwives was a major contribution to the creation of the supportive relationship the women felt they had with the midwife. The next section of the chapter is concerned with the form that communication took.

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3. This excludes calls made to the midwife when the women went into actual labour at term.

SECTION TWO - COMMUNICATING INFORMATION

This section evaluates the form of communication which occurred between the women and health providers at the practices, in particular the emphasis on the type and detail of the information exchange between the women and workers.

In chapter two it was noted that the ability of women to exercise control over their own health care is largely dependent on the possession of appropriate and relevant information, while similarly the maintenance of professional medical control over childbirth is achieved through the exclusiveness of knowledge to the professions. It has been shown that access to information in relation to the process of pregnancy and the organisation of health care, women are unable to exercise any effective involvement in the decision making processes to challenge inappropriate models for the management of their care, (Webb, 1986:10).

Within medicalised maternity provision, workers have been shown to be highly ineffective in meeting women's needs for information. A case in point is the comparative study of 2 clinics conducted by Reid, Gutteridge and McIlwaine (1983) they found that among staff at the clinics they studied there was a clear expectation that women would be active in their search for information, with the result that only if women asked specific questions would they be provided with information. This assumption formed a sharp contrast with the reality of the situation, where many women did not actively request an explanation even when they felt they required one (Reid, Gutteridge and McIlwaine 1983:53). This presupposition by workers is problematic for three reasons:

Firstly, it assumes that women possess the knowledge base from which to generate an appropriate question which will provide them with the information they need. Secondly, it fails to take into account the socialised passivity of women which the routine processing of maternity care achieves, a passivity which is further reinforced by the unequal power relationship between provider and user (Kirkham 1987).

Finally, the provision of information from professionals to women has been found in certain key ways to be inappropriate to meet their needs, as the knowledge the women needed to access was not provided in the explanation (Oakley 1980).

Given this situation women are likely to require considerable support if they are to articulate their needs and to exercise greater control over their experience of reproduction and maternal health care.

Chapter four noted a clear expectation among the workers that their role in the provision of information was to enable women to exercise a greater degree of control and choice over their health care. Information in the workers model was perceived as functioning to expand the woman's knowledge base.

Access to Information

In terms of the practices' implementation of this, a culture of access to information by the women was established from the women's first encounter with the midwife or GP where the notes are clearly seen to be the woman's property.

Example: Initial booking visit for a GP unit- The midwife asks the woman's permission to keep the notes and provides the explanation for doing so. Normal procedure was to hand the woman her files and the end of the first visit once they had been filled in.

> Midwife - Alison: *Right, I will send your files to the hospital and sort out your booking for the GP unit with them and then when they came back, and I have filled them up to date, you keep them. Is that alright then, if I just hang on to them for a bit?*
>
> Tracey: *Oh yes, fine.*
>
> Midwife: *It is just better if I have all the information with me in case they query the booking at all. I should have them up to date and everything ok for you by your next appointment.*

From then on the midwives would ask the women's permission to see the notes at each interaction and clear reasons would be given to the woman for the midwife needing to keep them for any period of time. Furthermore, the midwives actively encouraged the women to ask questions arising out of their reading of the notes, thus the midwives were observed to ask the women if there was anything in their notes they would like explaining and to state what they were writing.

During the course of the fieldwork at the ante-natal clinics no woman ever forgot her notes or lost them. In addition women were observed to make active use of their notes in two ways; firstly, they used the information on the notes to access knowledge about their health status. Such information from their medical records was found to provide the women with considerable reassurance, in that they used the information to monitor and measure their progress or status of their pregnancies and to assure themselves of normality.

> ***Question**: Did you ever read your notes?*
>
> *Yes I did, I kept them here by the fireplace and sometimes it was nice just to read them and look at the chart and see how the baby had grown. We* (husband and self) *would look through them after the clinics as well just to see what was what.* (Jane - Post Natal)

Secondly, the maintenance of the exclusivity of medical knowledge to professionals is a feature of patients exclusion from the decision making process: Accessing and using information in the notes was a way of providing women with part of the means to exercise control over their care, of being a party in the decision making process. Roberts (1985:111) suggested that the use of their notes by patients could prove to be a powerful tool in terms of enhancing the women's sense of control over the interaction between

themselves and providers. Roberts argued that the simple act of a patient keeping a health worker waiting while they looked something up in their notes would be a significant transfer of power to the patient. Evidence from the clinics suggests that such active use of their notes was seen to be appropriate behaviour by both woman and provider, providing some support for the impact Roberts suggested;

> Example: Ante Natal clinic visit. (Midwife - Alison ; GP - Louise)
>
> Midwife: *Was there something you wanted to ask?*
>
> Susan: *Yes there was some thing in my notes* (opening notes) *they wrote at the hospital - we didn't know what it meant.*
>
> Midwife: *Oh great, right..*
>
> Susan: (Looking in notes)
>
> (Midwife and GP wait)
>
> Susan: *Oh yes here.* (points)
>
> Midwife: *Can I see* (both lean over notes) *Oh NAD. That is just them using an abbreviation. It means everything was fine - Nothing Abnormal Detected. They shouldn't use it really.*

The women's reaction to the different policy of the hospital towards access to written information provides a useful illustration of the importance to the women, of having their notes. In what was for many of the women a stark contrast to the practices in their encounters with the hospital system they found that access to their notes was unavailable. For several of the women who experienced this, such a denial fostered a culture of mistrust as it led the women to question the motives of the professionals in denying them knowledge and information about their bodies. Furthermore it was the contrast between the two systems of care they encountered which prompted a questioning of the hospital systems exclusivity of knowledge. In providing access to medical records the practices were providing women with a base from which to compare and evaluate a form of provision which differed to the traditional organisation they, and patients as a whole, are familiar with. Having experienced an alternative form of managing information women clearly expressed a preference for access to their medical records.

> *Well like in the hospital my notes were taken off me and that was really weird, as all through I had been able to see them and know everything. Suddenly, wham, you're not allowed to know - it's not your body any more. That is really worrying in a way, because you start thinking what is it - is there something they won't tell me? All sorts of things go through your mind. Especially having to go in, it was the little things like that which made it worse.* (Jill 2)[4]

4. Jill had a threatened miscarriage and was admitted to hospital for a few days - she delivered at home as planned.

Thus access to information contributed to the women's sense of reassurance concerning the normality of their experience while absence of information functioned to increase levels of anxiety. In addition to providing a comparative framework or base from which women could evaluate their differing experiences of maternity care the provision of access to written information about their pregnancies helped to foster a culture of inquiring about health and enabling women to increase their knowledge over their health status.

The next subsection details the manner in which this culture was further supported during the interactions between user and provider.

Question asking

This subsection provides further discussion of the manner in which the workers facilitated and supported question asking from the women and the women's view of the way their queries and questions were responded to.

The midwives were observed to adopt a form of interaction with women which aimed to facilitate questions from the women in several specific ways: Firstly overt references to question asking were typically made by the midwives to each woman during each interaction, with a visit at the clinic usually finishing with the following query from the midwife,

> Midwife (Alison): *Now, is there anything else you would like to ask me?*
>
> Midwife: (Jean) *Is there anything else you want to know from me?*
>
> Midwife (Jean): *Well next time after you have been to your classes, you will probably have lots to ask me as they usually give you an idea of things that you might want, or not, unless there is anything else now you would like to ask now?*

However given the traditionally unequal nature of interactions between professionals and user and the typical patterns of user passivity in such interactions, question asking needs to be supported by workers beyond a simple expectation that women will freely respond to a single direct query from workers. Kirkham (1987:96) noted that the likelihood of women asking questions is dependent on the workers meeting certain criteria of availability for questioning, such as: being in close proximity to the woman, ceasing speaking and maintaining eye contact. The manner adopted by the midwives was observed to conform to Kirkham's criteria for availability. The midwives were observed to cease speaking, while looking directly at the woman, and to wait for her reply, no cues were provided which would suggest that the interaction had finished, such as standing up, or asking the question while turning to write in the notes. Although the common action to signify the ending of an interaction was to pass the notes back to the woman thereby signifying an end to her appointment, this usually occurred between 4-5 completed paired turns after the midwife had asked if the woman had any questions.

The opening from the midwife, asking if the woman had any further questions was asked in some form in 73 interactions and initiated a question from the woman in 40 of the observed interactions.[5] However, many women were still observed to reply in the negative.

The observed response from the midwife to a negative reply was invariably to re-ask the question again, or to provide a further opportunity for the woman to raise issues the woman felt was important. The following example illustrates how the midwives attempted to facilitate questions from the women: firstly, the midwife checks with the woman that she has no further questions, and then provides time for her to raise any further issues:

> The end of an ante-natal clinic encounter, two days before Lynda's expected date for delivery, the interaction had lasted 25 minutes. The focus had been on Lynda's feelings about the delivery and how to manage the early stages. Lynda had already asked four direct questions during this visit. Lynda is a second-time mother))
>
> Midwife - Alison: *Is there anything that you would like to ask?*
>
> Lynda: *No, I feel fine about everything.*
>
> Midwife: *Just remember keep calm, remember the breathing and keep ambulant, and I will be over when ever you call me and feel you would like a bit of support, David will be there won't he?*
>
> Lynda: *Oh yeah, he is getting more worried you know, like nervous. Funny, I ain't bothered at all.* (laughing)
>
> Midwife: *Oh yes he is isn't he, he is more scared than you.*(laughter from all) *Right that's it then,* (still holding notes) *if you are sure that you haven't got anything to ask?* (pause looks directly at Lynda)
>
> Lynda: *No I feel fine really great.*
>
> Midwife: *Well all the best then and see you soon.* (Hands notes to Lynda - Lynda takes them and stands up to go) *Bye.*

The midwives were observed to place particular emphasis on fostering and establishing culture of question-asking during the early stages of each woman's pregnancy and again towards the end when the women were focusing on their needs in labour. Particularly in early ante-natal encounters the midwives were observed to establish a function of their role as being that of an information provider. Observations of these ante-natal visits indicated that the midwives checked carefully if the women had any queries providing a number of opportunities during each visit for the woman to raise a query. During their first two encounters with the women, the midwives were observed to place additional emphasis on promoting question asking from the women. Women were encouraged to write questions down and suggestions were made by the midwives as to the possible

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5. Total interactions observed equals 150 - each woman observed 5 times.

sources of questions, such as questions which hospital visits may have raised, but which were not addressed by the hospital staff.

> Brenda's first visit - after a pregnancy test a week before at the practice.
>
> Midwife - Jean: *Any questions, or anything that you would like to ask me?* (Pause - notes still open on desk)
>
> Brenda: *No, don't think so.*
>
> Midwife: *No?*
>
> Brenda: *No, can't think of anything.*
>
> Midwife: *I know it can be really difficult - you come in here and can't think of any of the things that you wanted to ask. If you think of anything, anything at all, just jot it down, sort of make a list. Or if anything worries you, you can always ring me up, or if it is a Tuesday you can come in even if you're not due to come in.*

During the third trimester and particularly in the last month of pregnancy, a considerable amount of time in the interactions between women and the midwives was spent on discussions over labour. Question-asking was further encouraged by the midwives through stating that the classes the women attended were a potential source of questions and by arranging with the women a specific visit in her own home, where her concerns and preferences for labour would be discussed in detail. Ante-natal classes were perceived by the midwives as an additional source of information for the women which would assist the women in deciding on the management of her labour.

> *Rightieho then, by next time you will have started your classes, and they might give you a few ideas and questions over what you would like, because sometimes they mention things and you think "oh I would like that", or even "ugh I don't want that". And then, the time after that if perhaps I come and visit you at home and we can talk about what you would like and really chat about the labour. Is that ok?* (Midwife - Jean)

Although again there appeared to be a perception by the midwives and GPs that the women's encounters with the hospital system (in this case the ante-natal classes) would generate questions, but which would not be answered within that system. As a consequence there was an expectation that it would be the responsibility of the workers at the practices to answer such questions.

The perception by the workers that the ante-natal classes may not be a forum where women raise issues themselves was supported by many of the women who attended the classes. A majority of the women found the classes impersonal and intimidating, women unused to speaking out in a formal environment stated they rarely, if ever spoke in these classes. Women without a partner to provide additional support stated they found the environment of the classes particularly intimidating and felt unable to speak, let alone ask questions. Observations of a series of these classes revealed them

to be organised in terms mini lectures by the midwives, and the topics focussed on the medical management of labour within the hospitals.

> ***Question:*** *Did you ask any questions at the ante-natal classes?*
>
> *I thought the classes would be more of a chat really with other women, but they were just like school. No I didn't ask any questions. You couldn't, they were just awful - everyone sitting there in rows.* (Jill 3)
>
> *They were just about when to go into hospital and that was all really. They kept just saying when you should come in, which is no good for us at the GP unit, I will have my midwife with me, because Alison comes to see you at home first. So no I never asked anything of them, there didn't seem any point.* (Sharon - Post Natal)

Answering women's questions

A final manner in which a culture of question asking can be promoted or negated by workers is through their response to questions from the women. Where questions are deflected or blocked the result is likely to be that the woman will perceive and accept that the rules of the interaction exclude asking direct questions to care providers, (Kirkham 1987:97). Similarly a detailed explanation in answer to a question will create a supportive atmosphere within which it is appropriate to ask further questions or access additional information.

Previous research on medicalised maternity care has identified the manner in which health care professionals and in particular doctors employ or adopt strategies to negate question asking and to divert patients responses to behaviour appropriate solely to the medical encounter.

Oakley (1980) noted two strategies through which professionals achieve this. One was to trivialise the woman's question by using abbreviated *common-sense* explanations.

> "Patient. I've got a pain in my shoulder.
> Doctor. Well that's your shopping bag hand isn't it?" (Oakley 1980:16)

The second mode used by the medical professionals was to technicalise their patterns of speech as a means of asserting the dominance of medical knowledge over the woman's lay knowledge. Both modes observed by Oakley were used to re-direct the interaction to within the medical definition of appropriate areas for consideration, ie those with a narrow range of medical relevance.

In response to direct questions from the women the midwives at the practices were observed without exception (no incidents to the contrary were observed) to provide detailed in depth answers, which frequently generated further discussion around the topic the woman had raised, as the following interaction illustrates:

Daphine: *Do you know which way it is lying?*

Midwife - Jean: *No it is a little bit too early for that yet.*

(NB. The midwife could have blocked further discussion by finishing here having answered the question but continued) *Give it another 4 weeks. At the moment it will be swising around all over the place as it won't as yet be lying for very long in one place. Yes, give it another 4 weeks I would say. Can you feel it doing somersaults?*

Daphine: *That wakes me up sometimes. It felt that it was somersaulting and I wondered.*

Midwife: *A massive sort of churning?*

Daphine: *Yes that's it. I have also felt like an 'up and down', and sort of wondered what that was?*

Midwife: *Oh yes, they get hiccups as well, that is the 'up and down' sort of feeling.*

Daphine: *Oh yes, I have had that quite a lot recently.*

Midwife: *Yes you can't do anything about it, it is just one of those things.*
(Phone rings - midwife interrupted)

In particular the midwives provided comprehensive explanations of the meaning of technical or medical terminology. The midwives were observed to use medical terms, but their use was not to technicalise the content of their explanation but instead functioned to impart medical knowledge, for example in the illustration below; the midwife states that Kef means Kephalic, but then proceeds to explain the meaning behind the medical terminology;

Karen. *We didn't know what this meant on the hospital forms. They write it straight down after feeling the baby and we were wondering what it meant.*

Midwife. (Alison) *Oh, lets have a look. That just says what the position of the baby was when they felt it. 'Kef' is kephalic which means that the head is down. Here is says 'ROA' which means that its back is on the right. So what this means is that it is facing the right way for the delivery*

Karen. *So it is where?* (pointing to her stomach)

Midwife. *Well the 'ROA' means that its back is there and its head is there. I mean that is what it was like the other day - it may have changed sides now.*

Karen. *I thought its head felt like it was up here.*

Midwife. *Yes, it may well be there by now, because they do turn around a lot. Do you feel it sometimes grating in your pelvis.?*

Karen. *Yes I do.*

(The interaction continues with a full discussion of movements and where the baby is at the moment when Alison palpitates the abdomen)

What do women ask about?

Direct question asking in observed interactions between workers and women was found to be a frequent and consistent element of communications between the women and midwives. In addition the women were observed to make statements of fact, which were responded to by the midwives as if they were direct requests for information,

The women were observed to ask questions on a wide variety of issues, significantly in contrast to Reid, Gutteridge and McIllwaine's (1983:55) findings where women turned predominately to friends and relatives, the women at the practices used the midwife as a source of information on medical matters such as different types of pain relief available and the meaning and implications of forms of intervention such as breaking the waters or cutting the cord. In the later months of pregnancy women were observed to ask more questions on how to manage labour and maintain control during labour.

Women required information on what would happen to them during labour, the process of negotiating the system and how to recognise the onset of labour.

> Julie: *How will I know I am really in labour with all these Braxton-Hicks?*
>
> Karen: *What do I do when I go into labour - call a taxi or what?*

As already noted women were frequently observed to ask questions which within the medical model would be categorised as trivial or outside of the arena of medical significance to which the midwifes responded to with comprehensive answers;

> Maggie: *When the baby has hiccups it seems to do it only on one side, is that alright?*
>
> Midwife: (Jean) *Oh yes, you are probably hearing it through its back as is it lying like this.* (Shows them using her own body and hands)
>
> Husband: *Oh, that is why is it?*
>
> Midwife: *Yes, the back is here and the limbs would be here, so it would just be the back that jerks.*

In certain instances the midwife by demonstrating a willingness to respond to questions which fell outside the criteria for medical relevance, enabled the woman to raise issues which were causing her some concern. During the interaction provided below; the midwife asked twice if Amanda had any questions, before the issue concerning Amanda was actually raised (ie that her use of a sun bed could have harmed her baby). In order to reach that issue, the midwife also had to demonstrate her willingness to respond to non-medical concerns, such as having her hair streaked. Finally the midwife returns the direction of the interaction to the woman by asking for level of concern.

Amanda is nineteen and appeared quite shy , she was unemployed her husband is a steel worker.

Midwife - Alison: *Right today well we will just get a sort of history from you. Right and if there is anything you want to ask at any time, or is there anything you want to ask now?*

Amanda: No.

Midwife: *OK, have you had a positive pregnancy test?...*

(approximately half way though interaction at 22 minutes)

Midwife: *I will go through details about labour and what is going to happen to you during your pregnancy later on, unless you have any questions?*

Amanda: *No, that's fine....*

(end of interaction 10 minutes before end)

Midwife: *Right now do you want to ask about anything at all? (looks directly at Amanda pauses)*

Amanda: *I want to have my hair streaked that won't affect the baby at all will it?*

Midwife: *Oh no that is fine. A lot of people find that a perm doesn't take in pregnancy for some reason but streaking your hair is fine.*

Amanda. *Oh why is that?*

Midwife: *I don't really know exactly but perms do seem to go wrong in pregnancy; so don't splash out on a perm.*

Amanda: *What about using a sun lamp?*

Midwife: *I wouldn't advise you to really, it certainly isn't recommended.*

Amanda: *I went on one in October and I read they can hurt the baby.*

Midwife: *Um. Let me see, oh you probably weren't even pregnant then, so you were alright. I mean they don't think that they would do you really serious harm, but they just advise against them. Once is alright. I would say just don't go on through your pregnancy. Were you worried?*

(Interaction then proceeds around the woman's concern that she felt she may have harmed her baby's health)

Significantly, answers to questions which could be termed as being medically trivial were felt by the women to provide considerable reassurance[6] because their concerns and priorities were being responded to.

In addition the responses to such questions further supported the development of a positive relationship with the midwife; as the midwife established that she could be confided in. The manner of the midwife assured the women of a non-judgemental treatment, such assurance was observed in several instances to enable the women to raise issues which they would not have done had the midwife not provided clear indications

6. The issue of reassurance is further expanded upon in the women's chapter.

that she would not be critical of them. This assurance was established and reinforced by the midwives throughout the period of the woman's pregnancy:

> Midwife - Alison: *Can I weigh you now?*
>
> Karen: *Oh no, I hate this, oh.*
>
> Midwife: *Gerra away with you. I won't shout at you.*
>
> Karen: *They do at the hospital.*
>
> Midwife: *Well lets have a look. Well you have put some on, well done - not bad. How are you eating?*
>
> Karen: *Not enough really*

Women booked for the GP unit or home delivery were given an additional opportunity to ask questions concerning the individual policy of their midwife over such issues as how she normally approached the provision of care to women in labour. At the practices active use of this opportunity by the women was endorsed through the midwives habit of planning a home visit to discuss the birth plan. In fact all of the midwives interviewed stated they visited the women at home who were booked either for the GP unit or home delivery specifically for this purpose. These visits lasted on average between 40 minutes to 1 hour fifteen minutes (longest observed) and were considered by the midwives to be a central element of their care to each woman.

During these visits the midwives were observed to discuss with the women a birth plan, which provided the women with opportunities to veto or opt for different forms of management of their labours, the birth plan covered issues such a pain relief preferred positions in labour to syntemetrine and vitamin K injections. This opportunity was seen to be particularly valuable by the women who experienced this form of care and this visit was mentioned by many of the women as an important source of information about the process and experience of labour, in that they felt able to establish clearly the type of care they would receive, having made their preferences explicit.

Question asking and the GPs

The GPs in common with the midwives expressed a commitment to encourage women to ask questions of them and expressed a willingness to provide the information the women required. However, observations of interactions between women and the GPs revealed a different pattern of question asking from the midwife and women interactions. The observed frequency of question asking was much higher in interactions between midwives and the women than between the GPs and the women. In interactions with the GP women rarely asked more than one question per interaction. In addition these questions were narrow in range, generally being confined to technical or strictly

medically relevant issues, such as 'has the head engaged?'. In addition questions were also frequently asked to enable the women to clarify their responses to the GP, such as :

> GP - Caroline: *Have you felt the baby move yet?*
> Anna: *Not sure - what does it feel like?*

The use of the GP for technical information by the women fits with the role of the GP as being a technician to provide specific medical advice, which is identified by both the workers and the women users (see relevant chapters). Thus the narrow range of questions asked by the women could be interpreted solely as appropriate given the role they had ascribed for the GP. However the interactions between the women and the GPs also indicated that despite their expressed commitment to providing information to the women the GPs did not spend as much time as the midwives on attempting to facilitate opportunities for the women to ask questions as the midwifes were observed to do. Thus for example; the GPs query asking the women if they had questions came much closer to the end of the interaction (on average 2 completed turns) than it did with the midwife, and a negative answer was never observed to be followed up by the GP:

> GP - Caroline: *Ok, that's your card for free prescriptions, and we should have the results of the tests next time you come. Is there anything you would like to ask me?*
> Belinda: *No.*
> GP: *Right ..*

Belinda's "No" is here taken at face value by the GP and not followed up, in addition her negative response is supported as appropriate by the GP who states that the midwife is the both the relevant and available person to discuss her needs and to raise questions with

> (GP continued from above) ... *You will see the midwife next time and you can discuss with her nearer the time what you want to do about classes and preparation for the delivery. Have you got stuff to read about being pregnant?*
> Belinda: *Phew have I!*
> GP: *Oh plenty then. Great right that's it then.*

It was common as in the interaction above, for the GPs (from both practices) to identify the midwife or books and ante-natal classes as appropriate sources of information, rather than prompt for questions to be asked of them. The observed effect was to establish their role as information collectors rather than providers. Accessibility for the women to the GP could therefore be considered to be reduced by the way they structured their encounters with the women.

Providing knowledge

As was noted earlier in this section and in the workers chapter part of the process of information giving to the women from both the midwives and GPs point of view was concerned with providing the women with access to knowledge which is normally exclusive to professionals, which the women would have difficulty accessing in any other manner.

The main aims of the workers were two fold: firstly, to provide women with the relevant information from which to exercise an informed choice. Secondly to establish the women's right to involvement in the decision making process.

Within the current mode of service provision, women's rights are often negated by the system with many women being unaware that they possess rights and choices, chapter six notes that many of the women felt that they had to comply with medical pronouncements concerning their pregnancy and particularly over the place of birth. In order for women to exercise control they have to be informed about their rights within the system. However due to the nature of women's reinforced passivity they are unlikely to bring their needs to the fore without opportunities and support coming from the workers.

Questions were frequently anticipated by the midwives and the information provided by the staff at the clinic. On every occasion, without exception when the midwives were observed to palpitate a woman's abdomen, information on their status was provided, usually the position or size of the baby. Women were also encouraged to feel the position of the baby themselves and were shown how to identify this,

> Midwife - Alison: *Can I have a feel?...Oh its easy to feel the baby.* (takes Dawn's hand) *Its head is down there and its back is there and that's its bottom.*
>
> Dawn: *Oh yes - wow.*
>
> Midwife: (listening to heart beat) *and it sounds lovely - just like a little train.*

In providing information medicalised language common to the hospital system was also not used, but neither were the euphemistic language noted by Oakley in doctor women interactions. Typical information consisted of clear statements on the status of the woman's pregnancy:

> Midwife - Jean: *Yes the head is going down, I would say that feels about 2/5ths into your pelvis, that's good spot on for your dates. Is that beginning to feel uncomfy?*

The open type of question referring to how the woman was feeling "Uncomfy?" was typical in that the midwives were constantly observed to re-direct the conversation back to the woman, to provide opportunities for the women to discuss how they felt.

Earlier in the subsection dealing with the midwives' responses to questions it was noted that the midwives readily and unquestioningly explained technical and medical language for the women. Their opposition to language which excluded the women is demonstrated by their response to students who used the medicalise language of the hospital system which resulted in preventing the pregnant woman from readily determining the results of a test or procedure. On several occasions when students were observed to use such language, the students were publicly sanctioned by the midwife and the terms automatically explained; in the following example both midwife and woman jointly query the students' medicalised behaviour.

> Midwife - Jean: (while palpitating abdomen) *Perhaps, Jenny if you could test Mary's sample for me* ... (turning to student) *alright?*
>
> Jenny (Student) : *N.A.D*
>
> Mary: (frowns, looks questioningly at Student Midwife) *Eh?*
>
> Midwife: (frowns at Student turning to woman) *that means everything is fine, nothing abnormal. Silly really we shouldn't use such silly terms, its a bit daft, 'OK' would be just as good, but I suppose it doesn't sound technical enough.*

Significantly, after this incident the student during her next six weeks at the practice altered her responses to "everything's Ok" and directed such responses to the women. Although she was rarely observed to provide much more information than that.

Macintyre (1982) found in her study, that women's confidence in their care resulted from being given full information while distress and lack of confidence was equated with insufficient information. However definitions of what constituted reassuring information differed between women and their attendants. The women in Macintyre's study needed to understand the context and underlying meaning of their situation and therefore required information which explained the significance and implications of that situation, simply being told there was nothing to worry about was insufficient,

> "It was not just that they wanted to be told that the size of the fetus was unimportant but that they wanted to know in what way it was unimportant". (MacIntyre 1982:394)

Explanations of the implications and the reasoning behind their statements and opinions were a consistent feature of the midwifes responses to requests for information from the women, as the following example illustrates.

> Sally: *Someone at the hospital said that they thought it was going to be small*
>
> Midwife Alison: *No. What it is, is that when you have a long-ish abdomen like yours at first glance the baby looks small for dates, but it isn't - its exactly on. Let's check with the old tape measure.* (Pause - checks) *Well your baby is just a nice average size, actually it's just*

> *growing as it should be - well within the average range.* (Shows Sally the chart).
>
> Sally: *Oh that's a relief when they said that* (at the hospital) *I thought "Oh my God!"*

As a result of her full response the midwife was able to provide Sally with considerable reassurance, not only did she assure normality, but she was able to correct inaccurate information from the hospital which had caused considerable anxiety, as the quotation from Sally her self confirms;

> ***Question**: How do you feel about the clinic today?*
>
> *... I had been really worried that it was going to be too small, you hear of baby's just stopping growing don't you. But that worry has all gone, 'cos she tells you and she is so matter of fact about it. She said why they had thought that* (at the hospital) *and you know then there is nothing to worry about.* (Sally)

Although opportunities for asking questions were felt to be very important by the women, the women also expressed a view that they did not wish to possess entire responsibility for accessing that information. The majority of women preferred not to have to be active in their search for knowledge but instead wanted to feel that they would be be provided with comprehensive information from the workers irrespective of the extent of their own questions.

> ***Question.** Did you ever feel that you were being given too much information, like being told things you didn't need or want, or things that weren't helpful?*
>
> *Oh no. I was so anxious that I wanted to be given every opportunity to ask things again and again. And to be told things, you really need to be told everything, because you are so worried that everything is going to be alright that you want everything explained to you.* (Francis - Post Natal)

In addition for many of the women the emotions, concerns and fears created by many of the events surrounding pregnancy resulted in them feeling unable to ask questions, and were therefore dependant on health care providers to volunteer the information.

> *You hear the words Spina Bifidia and your brain turns to cotton wool and although they ask you if you have any questions, you just can't ask them - you are just spinning. (Laura 2)*

In contrast to their experience at the practices the women found that in their encounters with the hospital such information was not provided, and this was a major source of concern. When confronted with an uncommunicative attendant in the hospital, some of the women tended to question the quality and safety of the care provided, in certain cases the women felt that not providing information was due to the fact that the provider simply did not know the answer:

> *... and when I asked a question I might as well have talked to some-one on the bus, because they didn't know anything, the person on the bus who had kids would probably have known more it was ridiculous.* (Francis - Post Natal)

> *I mean they were very nice, it was just that they didn't seem to know what they were doing. You would ask a question and they would sort of say, "oh nothing don't worry". I thought well perhaps you don't know, so I just asked Jean everything because she knew what was what.* (Sarah - Post Natal)

Previous studies (Macintyre, 1984; Kirkham 1987) have identified the lack of reassurance responses such as 'don't worry' actually provide, the women in such situations did not tend to query the abilities of the attendants to provide their care as a result. The questioning of the safety or competence of attendants could in part be a result of the practices providing the women with an alternative set of expectations surrounding good practice. Support for such a conclusion comes from the women's reaction to the lack of information from the hospital; the women having been given a choice between two different forms of management of their care opted for the one which gave them the greatest amount of information and which they felt as result provided the safest care.

It was noted earlier that health professionals tend to assume that women will be active in their search for information. However from the interviews with the women it became apparent that women valued the provision of information from health professionals without actively having to seek out such information.

The women from social classes V and VI[7] stated that in terms of accessing information verbal sources from friends and professionals at the practices were the primary sources of knowledge, with very few using childbirth books apart from the 'Health Education' booklet provided at the practices. Only one woman referred to the childbirth literature and substantially fewer women attended childbirth classes than did the middle class women. Working class women were therefore particularly likely to benefit or be hindered by the quality of the information provided by health professionals at the practices. In terms of the women's view of the quality of the information the women who were identified as being working class, in evaluating the information provided from their ante-natal appointments, rated the information provided from midwives as being highly useful. Although the majority of both middle and working class women felt that they would not have accessed such information in any other way this was particularly true of the working class women. Therefore the midwife was seen to have greatly increased their knowledge base from which to make choices and decisions. The detailed and comprehensive nature of the information was frequently commented on as being invaluable in providing them with increased choice and control over their experience of pregnancy.

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7. An explanation of how this is defined in this study and a discussion of the limitations of using such a classification is provided in chapter three.

> *I have been four times now and they have been right nice and told you everything that there was to be told, so like you feel that you know everything that there is to be told. They talk about it here.*
>
> ***Question:** What sort of things have they talked about with you?*
>
> *Well they have talked about any problems I might have had and if I have not understood anything. They like tell you things here and are right friendly as well. Well, I think the best thing was the way they asked you about everything, like the birth Alison went through everything checking what we would want* (Jane 2)

The women's positive response to such detailed information provides a further illustration of the inappropriate nature of many professionals restricted responses to requests for information from women.

At the practices the women felt they were enabled to exercise a greater degree of choice over aspects of their care, than they felt would have been possible within a more traditional form of organisation of care.

> ***Question:** Looking back over the care you had, what would you say was the best aspect?*
>
> *Just in talking to other people I feel very fortunate in the care I have got. Being told about the choices available. I get the impressions that many people aren't given any choice. Like the midwife told me about things that I wouldn't have known about, like not cutting the cord, until it was too late.* (Julie - Post Natal)

The information provided by the midwives could be interpreted as functioning to empower the women to gain a greater degree of control over the biological processes of their pregnancy; such as coping with the pain of labour. The form of information giving to the women was not confined to explanations of clinical procedures or physiological processes. Instead it consisted of imparting to the women information which provided them with the ability to exercise choices and thereby increased control over their situation and health care. This potential to make choices based on full information, had an important impact on the women's status within the user-provider relationship as it served to increase and strengthen their involvement in the decision making process, as full partners or health workers in their own care, with increased control over their pregnancies and labours:

> *The best thing was the way* (the midwife) *explained things before really well, telling me what would happen, because pushing the head out was really painful that feeling of being stretched. She said that would happen and what it would feel like and I was really glad of that as then I wasn't frightened as I knew what it was.* (Amanda post-natal)

The main impression from the women concerning the provision of information was feeling that the approach of practices and workers formed a significant departure in terms of health care provision from the norm. The women simply did not expect a health professional to provide in depth explanations. Furthermore the women in considering

the degrees of information provided were frequently surprised at the amount of *'time'* the workers made available for them.

> ***Question:*** *Do you feel that you have been able to ask all the questions that you wanted to?*
>
> *Oh yeah! Like they will let you sit there as long as you like, they just leave the time up to you. You can just sit there as long as you want.* (Anita)

> ***Question:*** *Is feeling able to ask questions different to what you have found elsewhere?*
>
> *Oh yeah! with doctors it is, um, um, here is the prescription, and out the door with you. Here well it's just nice.* (Sandra)
>
> *It was really wonderful. I still don't believe it. Like they really spent time over you sometimes I would be in there 40 minutes and they never tried to hurry me out.* (Claire, her emphasis)

While low expectations of the time allocated to users of the service by providers may actually be a perception common to all users of the health service, for women however, the value of being given time possesses an added significance. The allocation of time as the women perceived is a comment on their worth, and the significance of their health needs. The lack of time provided by professionals to women indicates within the health system a reflection of the low priority both within the public and private domains attached to women's needs. The significance of this issue is illustrated by the women's continued surprise throughout their pregnancies at the quality of the service they encountered at the practices and in particular the support given to their involvement in the decision making process; as is illustrated in the next subsection women did not anticipate the availability of any choice over the management of their pregnancy.

SECTION THREE - KEY FEATURES OF THE CARE PROVIDED

This next section of the chapter documents the key features of the care provided at the practices which comprised the central elements of their alternative to the medical model, such as the provision of reassurance and an holistic response to women's needs. The section does not aim to provide a definitive analysis of these features, each one could merit a study in its own right, but instead, aims to provide vignettes which illustrate each features role in the provision of care at the practices. In addition the section completes the exploration of issues such as, control, empowerment and the provision of choice, which have already been been partly commented on in previous sections of the chapter. Finally the section also highlights the limits of the workers ability to provide women with control over the place of birth.

Women and choice

Choices and the opportunity to decide between alternative options were provided to the women throughout their pregnancies. Possible intervention and the range of options available were observed to be discussed with the women in depth. One further example of the degree of choice available to the woman was the provision of choice over the place of birth. This was provided in two ways: firstly, the practices stated an explicit policy of allowing women to choose where they wanted to be delivered; secondly, as noted earlier in this chapter, the midwives and GPs were observed to spend time discussing the range of options available to the women and providing opportunities for women to make that choice.

The midwives and GPs provided choice through their discussion of the options available for the place of birth. The midwives and the GPs were both observed to discuss the range of options available for the place of birth in depth with every woman as the following case example illustrates:

> Example: Midwife - Alison GP - Louise
>
> Midwife: *Now have you thought at all where you would like to have your baby?*
>
> Sharon: *No. Where is there?*
>
> Midwife: *Well, you can go to the Hospital, that's the Jessops or the Northern General or Nether Edge, and come here for some of your ante-natal care and go there for some and then when you go into labour you will be looked after by the midwives at the hospital.*
>
> *Or you can book a home birth or at the GP unit. It is really up to what you would like.*
>
> GP: *Do you know what the GP unit is?*
>
> Sharon: *No, I didn't know you could even have it at home.*
>
> Midwife: *Oh yes is that what you would like?*
>
> Sharon: *Don't know really, what is this GP ...?* (pause)
>
> Midwife: *GP unit? It is at Nether Edge hospital. Well with that and with the home birth you come here for all your ante-natal care and see probably me or Louise. Then when you go into labour I will come and see you at home, then when you are ready we will both go into the hospital and I will do the delivery there. It is a pretty good system really, but it is entirely up to you?*
>
> Sharon: *I will have you, at the GP unit, if I can.*
>
> Midwife: *Great fine, right I will put down the GP unit then.*

However despite an expressed commitment (documented in chapter four) by the workers to provide women with the knowledge of the criticisms of the hospital system, such a critique was never put to those women who opted for the consultant unit. Workers did identify the strengths of a home birth or GP unit, but were never observed to overtly

present their critique of consultant units as a place of birth to the women. When interviewed about this issue, the workers expressed a desire not to impose their values on inappropriately on the women.

> *I never say to a woman to have a home birth, or not to go to go into the consultant unit, because she has to decide what is best for her.* (GP - Caroline)

In contrast as will be noted in chapter seven some of those women who opted for a consultant unit felt that such information would have been valuable.

Women and Control

The midwives' model of care was identified in chapter four as aiming to establish a relationship with women based on an equal partnership, in which the women's contribution to maternity care in particular their ability to learn from the women was a central prerequisite for the provision of quality care. Thus within the user centred model of care adopted at the practices the women were incorporated as health workers, (Stacey 1988:6) who have an important contribution to make both to the provision of their own care and also to development of the midwives clinical practice. Observations on the interactions between the women and the midwives revealed the women's expertise being valued by the midwives.

Firstly, the women were observed to be able to define what was of importance to be dealt with in the interaction. As the following illustrates, the midwife provides a detailed response to the woman's concern. This concern defines the course of the interaction through the midwife's detailed attempt to provide a solution.

> Claire: *I have got terrible backache.*
>
> Midwife - Alison: *Ah, that's really common, it's not serious, but I know that it is for you. It can come from the way the baby is lying. So getting down on all fours can help, or lying on something like a bean bag, because it takes the weight of the baby off your back. But then spending three months staring at the floor isn't much fun. Also, the back rocking exercise does help, but there isn't much beyond that I'm afraid. Is it stopping you sleeping at night or anything like that?*

This response provides a sharp contrast with Oakley's (1980) findings of the way interaction is directed and controlled within medicalised maternity care to solely medical concerns.

Secondly, the midwives were observed to incorporate into their practice the women's view of their health status and their view of the progress of their pregnancy, and in particular the women's subjective knowledge which resulted from "the women's capacity to sense and respond to the sensations of her body", (Graham and Oakley 1980:54).

Midwife - Jean: *How have you been?*

Maggie: *Well I used to be getting a lot of heart burn but that has stopped so I am eating better, but the pressure down here has got a lot worse. I think its the head gone.*

Midwife: *Do you feel you have lost a bit of weight up here or that there has been a shift in the way the baby feels with that pressure.*

Maggie: *Yes that's right.*

Midwife: *Well you would expect it to be engaging at about now so that change is a good sign, so your almost certainly right, If I can have a feel now I will be able to tell ...* (Palpitates abdomen)

(The midwife then confirms that the judgement was the woman's)

Midwife: *Oh yes, you were right, the head is well engaged.*

Significantly the midwives were observed to actively take account of the women's subjective view concerning areas which within the medical model have been shown to be considered as inappropriate for negotiation and discussion with non-professionals, (Oakley and Graham 1980). The midwives in their interactions with the women asked the women for their knowledge and definitions over key areas of their pregnancies, such as the expected date of delivery and the position of the baby. In almost all the observed cases the expected date of delivery was also identified with reference to the women's own judgment,

Well I make it due on 27th July, does that feel right with you? (Breda - Midwife)

The scan said that you were 32 weeks when do you think that the baby will come? (Alison - Midwife)

In addition to such direct use of the women's expertise and subjective experience, the GPs and midwives were observed to express their knowledge or expertise in terms which supported the validity of the women's experience or knowledge. The workers were observed to clearly reject a role which would allow them to express expertise over areas which were outside of their own personal experience, but instead gave an open acknowledgement to the status of the women as possessors of an exclusive form of expertise:

GP: *Have you felt the baby move yet?*

Julie: *I am not sure. What does it feel like?*

GP: *It feels like, well I don't actually know myself but women tell me it feels like faint butterflies moving.*

(Male GP - Simon)

The midwives who were interviewed who had children themselves stated they felt conscious of a need to create a balance between the use of their personal experience of

childbirth and at the same time maintaining an awareness of the uniqueness each individual woman's, as the following midwife stated:

> ***Question:*** *Do you think that having had children yourself affects the care you give?*
>
> *I think you have to be very careful because it is easy to start saying well it was easy for me so it will be for you and thinking women are making a fuss when it's different and hard for them...The way it helps is you know how sensitive the women can feel and it makes you more gentle doing examinations that sort of thing.* (Midwife - Doreen)

Although on occasions the midwives were observed to refer to their own experience and to their professional knowledge, this was coupled with a stress that the woman's own experience was individual to her. The primacy of the women's subjective experience was consistently reinforced in the interactions by the midwives through referring to the individually of the woman's situation and by stressing that her definition of her experience was valid. In the following example the the midwife details the appropriate management of the woman's positions in labour as being the woman's choice.

> Sharon: *Will I have to like lie down all the time 'cos Sis had to and she didn't like that?*
>
> Midwife - Alison: *Oh no, you can move about freely. You may find that once you are approaching the end of the first stage many women find that they get into one position they are quite comfortable with and that is the one they are going to stay in, because that is where they feel comfortable and in control in. If you don't feel very comfortable or that another position might help then I could suggest alternatives to you. As long as you are feeling alright and the baby is doing OK then you can do what ever you feel like doing. We can adapt the room and push the bed out of the way. It is really up to you and how you feel.*

The direction of the interaction was observed to be in the control of the women. The following interaction illustrates the manner in which the woman user directs the interaction to discuss her priorities. This is a role which the midwife accepts and responds to with detailed information.

> Anita: *They (Braxton-Hicks) are starting to feel real bad and I haven't been getting much sleep.*
>
> Midwife - Alison: *Is the baby kicking you a lot then?*
>
> Anita: *No, its just that they haven't fixed the central heating yet* (Anita's flats are currently being repaired by the council).
>
> Midwife: *Oh, they haven't fixed that yet?*
>
> Anita: *No, its got worse. Because I am high up and all the air gets into my building and my flat. Why couldn't it be in the hippy's in the next block - they would never have noticed.* (Laughing).
>
> Midwife: (Laughing) *Oh, you poor thing. Haven't they even started fixing it yet?*
>
> Anita: *Well, they have done something, but it only seems to have made it worse. Its the air travelling through the pipes.*
>
> Midwife: *Oh, no ...* (Interrupted by Anita).
>
> Anita: *Oh, I had me scan yesterday.*
>
> Midwife: *Oh did you? Was it nice?*
>
> Anita: *It was good to see it like, but she said I was 32 and I said I am not, I am 30 weeks - I know my dates.*
>
> Midwife: *Oh well, scans are only accurate to within two weeks, so.* (Looking through notes). *But the head circumference is above average - here see this line here. So I will see what I can tell when I have a feel. But if the baby does come a bit early - well it is no problem.* (Meaning that she will be there to do the delivery). *Your blood count is a little low.*
>
> Anita: *Oh yes. I meant to say I needed more Iron tablets.*

The women were therefore a part of the decision making team - a position which was recognised and valued by the women. An important element of the value of this involvement for the women was the increased sense of control over their experience that this provided. As already noted earlier, (in the section concerned with communication,) information provided by the midwives enabled the women to exercise control over the process of reproduction. An additional way in which the midwifery model furthered the women's ability to exercise control is documented in this sub-section. In the following example Judith felt that her sense of control had been supported and reinforced by the midwives response to her rejection of pain relief.

> *You never felt that what you said didn't count. Like when Janet said, did I want some gas and air when I was pushing as she said it can feel different with pushing and might hurt a bit more and I said that I didn't and she never said 'Oh you ought to or you must' it was just fine that I said no. It was brilliant I just felt I could have or do what ever I needed.* (Jane)

However some of the women's experiences of consultant unit deliveries contrasted with the women's experience of labour with a community midwife present. In the interviews with the women a quite fine but important difference was identified by them, between the workers positively providing options and being negative in asserting professional definitions of their needs. Where workers (all from the consultant unit) were identified by the women as having attempted to suppress the women's definitions in favour of enabling their professional definitions to dominate, this was invariably mentioned by the women as a source of dissatisfaction with their providers.

> *I was lying on my side, I don't know why, I was just comfortable that way, but this bloody midwife kept saying, "into the middle of the bed, into the middle of the bed" and dragging me over making me stop what ever I was doing, "like stop that contraction and move!" Stupid woman. They also kept trying to push drugs on me, "You don't have to be in all that pain dear there is no need to be silly is there?". I hated her so I her told her to stick her drugs.* (Belinda - unplanned hospital delivery)

However reported instances of open conflict in such situations were rare from the women, for the reason that the women found it difficult to actively challenge the consultant unit midwives definitions, when they perceived their own definition held little validity.

> *They ended up giving me an epidural which I wasn't happy about at all.*
>
> ***Question:** Did they make you?*
>
> *No they **suggested*** (her emphasis) *I did. They sort of looked at me and said, you'd feel much better if you have an epidural, once they said that I though 'Oh I can't be coping that well, maybe it is going to get really bad I must have ages' so I just gave in. You see you think 'oh well they must know what they are doing', but she wasn't that long, and I felt I could have coped.* (Ann Atkinson - second term mother)

On the surface there may appear to be little apparent difference between the hospital and community midwives actions in offering pain relief. In Belinda's example and the midwife in the example above, both professionals offered and suggested alternatives to the women's current course of action. However in the first example the woman felt there was a shared assumption that she held the power for the decision an assumption which was clearly absent from the later account of a woman labouring in a consultant unit.
One observed reason for the development of such a difference relates to continuity of care. The shared assumption that the woman was a member of the decision making team having been established, throughout the pregnancy in discussions with the midwife who would be attending the birth.

> **Example 1**
>
> Midwife - Jean: *Have you come across anything in the classes that have given you any ideas of what you would or wouldn't want?*

Example 2

(45 minutes home visit covering pain relief and preparations for labour)

Midwife - Jean: *Right well I just wanted to reassure this visit that we wouldn't do anything in labour to you that you don't want or wouldn't want without there being a very good reason for doing so and also to make sure that you know what the reasons would be and when I would do something.*

Judith: *No I haven't felt that you would do anything without my agreement.*

The feeling which Judith expressed above that, final control of the process rested with the women as users of the service, that their agreement would be sought was a feeling expressed by the majority of women and one which was grounded in their actual experience of care.

A key indicator of the women's satisfaction and degree of control over the decision making process is exemplified through the experience of those women whose labours or pregnancies did not proceed normally or who had to transfer to the consultant unit for delivery as a result of a potential abnormality being detected.

For example: In interviews Judith had been particularly concerned not to have an episiotomy, a concern she had expressed both to the midwife and during the interviews. Her concern came from her perception that an episiotomy would be performed both routinely and without her consent. During her labour an episiotomy, in the opinion of the midwife, became necessary. Her account reveals that although the decision was taken by the midwife, Judith's authority for the operation had been sought and given, and she was satisfied with her transfer of decision making power to the professional for that issue.

> *Well Jean* (Midwife) *said, "I know you didn't want one but I feel that if you don't - I think you are likely to have a bad tear", and I said fine. I knew that she had made the right decision because that was what I needed.* (Judith post-natal)

This illustrates a further feature of the form of control the women had. It was not the case that the midwives lacked power over the women or did not exercise it all, as has been shown they had to make quite powerful suggestions during a woman's labour recommending alternative courses of action. It is more that the power they have to influence or direct the management of a pregnancy or labour is bestowed on them by the women's trust as some-one who has the appropriate skills rather than from their authority as a professional.

This shared control given to the women by the midwife also resulted in a sense of responsibility over the decisions that were made. In certain instances where the outcome did not conform to the women's expectations they were still able to retain a sense of having been in control of the situation.

> *Well I was pushing for a long time and Jean* (Midwife) *suggested that if she broke my membranes it might speed things up a bit, well I did feel tired so we thought that might be a good idea. But I still ended up pushing for another hour and the pain got really bad after that, because all the cushioning had gone. So I think we made the wrong decision on that one.* (my emphasis). (Mary - Post Natal)

Providing Reassurance

It is important to distinguish between the function of reassurance within the medical frame of reference and the aim of reassurance as defined by the women. Macintyre (1982) noted in a prospective study of primigravidae that reassurance was consistently and inappropriately provided in response to requests for information from women. It is the limited sense in which reassurance is provided, when it is used as a substitute for information that women find dissatisfying.

> "Some women described feeling that any requests for information were treated as requests for reassurance and as reflecting anxiety rather than a desire to know the answer." (Macintyre 1982:393)

Reassurance provided by the midwives at the practices constituted a major component of their care. However, such reassurance was primarily concerned with instiling confidence in the women. In particular the midwives concentrated on two areas they provided reassurance, these consisted of assurances as to the normality of both, pregnancy and labour and aimed to give the women confidence in their ability to manage childbirth and the child during the post-natal period.

> *Well she was just really nice and encouraging nothing specific. She makes a lot of you, which she probably does for every woman that goes into that room but that doesn't matter she just makes you feel good, and I probably needed that more than most with being on my own.* (Rosie post-natal)

In answer to a concern expressed by the woman the midwife would assure 'normality' if appropriate to do so, and would provide detailed explanations or discuss the implications if normality could not be assured. Furthermore this was observed to be the response from the midwives irrespective of the medical relevance of the woman's concern, as the following interaction between Jean and Catherine illustrates,

> Midwife - Jean: *So how are you?*
>
> Catherine. *Well I have been having a lot of funny dreams is that normal?*
>
> Midwife: *Yes, that seems about par for the course.*
>
> Catherine. *Yes I dreamed I gave birth to a kitten and it was a very naughty kitten.*
>
> Midwife: *Yes that is perfectly normal, you do seem to get a lot of funny dreams in pregnancy. How else have you been feeling?*

Catherine. *Just a little tired but not too bad.*

Kirkham (1987) identified that midwives were constrained from providing genuine reassurance by the hierarchy in which they worked, and as a consequence 'reassurance' in the context of the consultant unit functioned to either block the women's questions or to reassure the staff.

In contrast to the situation depicted by Kirkham the midwives in the community were observed to provide reassurance through detailed explantions. Information was observed to be provided to explain medical procedures and medical or midwifery views to women frequently over issues which are infrequently explained to women such. In addition assurances of normality were again provided to the women through such explanations, reassurance 'for the women' was therefore a feature of the midwives explanations to the women.

Cheryl: *I don't seem to be gaining that much weight..*

Midwife - Alison: *Well it doesn't matter as long as the baby is growing well and it obviously is, so it doesn't matter that much if you don't put the average amount on.*

Cheryl: *Well I suppose I won't have that much to lose then.*

Midwife: *That is we don't worry as long as the baby is growing well. And it is.*

Holistic response

"Patient: I'm a hairdresser, I only do three days a week is it alright to go on working ?

Doctor: Up to twenty-eight weeks is alright on the whole, especially if you have a trouble free pregnancy as you obviously have. After that it's better to give up.

Patient: I only work three days a week I feel fine.

Doctor: Yes everything is fine but now you've got to this stage it's better to give up just in case."

(Oakley 'women confined' 1980:19)

In Oakley's illustration above, the professional view is embedded both in the concept of abnormality and potential risk and in the view that the woman's only effective means of meeting her babies needs is through compliance with medically defined criteria; such as giving up work to rest. This formed a sharp contrast with the manner in which the midwives typically dealt with similar issues in their interactions with the women. In responding to such issues the midwives were observed to offer an holistic response to the women, which reflected their departure from the medical frame of reference as a basis from which to construct a model for maternity care provision.

This holistic response from the midwives had three main components; In the example below the midwife firstly rejected the notion of pregnancy being an inherently abnormal condition where normal activities are required to be suspended, with the adoption of a sick role by the woman. Secondly emphasis in the interaction is placed on the woman's definition of the situation, that is her view of her health rather than just the professionals view. Finally the midwife accepts the relevance of the social, economic and emotional aspects of the woman's life to her pregnancy and reproductive health, such as her need for money or to work outside of the home, as opposed to directing the discussion to a narrowing range of medical factors.

Example: Sharon ante-natal visit at 6 months

Midwife - Alison: *When do you stop work?*

Sharon: *Well I wanted to ask about that because I stop work at the beginning of May and if I want to carry on any further then I will need a doctors certificate and I want to but I wondered was it right to do?*

Midwife: *Well it is really up to you and how well you are feeling. If you are feeling well then there is no reason to stop really. A lot of people do want to stop by then, but if you want the money or just want to carry on..*

Sharon: *I don't want to work, but I could do with the money, I really just want the money not to work.*

(laughter from all present)

Midwife: *It's a real pity they won't do that. Are you going back to work afterwards because if you finish late then you can go back to work late, which some women feel they like?*

Sharon: *Well they said I will get paid for 18 and then I think I can have 29 weeks off, but I am not sure.*

Midwife: *Trouble is they keep changing the regs and I haven't been able to bring myself up to date yet. We can have a look at the leaflets on the way out. But really the best thing to do is to see how you feel when the time comes to it. Like some people really want to finish and I have known others carry on until they are due. like I went to deliver some-one last week and she actually started off in labour at work and she had felt really fine and had wanted to carry on, so see how you feel is I think the best thing.*

Involvement of other family members

An expressed commitment by the workers to developing a response to each individual woman's needs was identified in chapter four. A recognition of the woman's pregnancy and the birth of an additional child as being an event which was of relevance to the rest of her family (including partners and friendship networks) formed part of the workers response to this issue.

"I try and make the clinic as casual as possible so the women can feel that they can come here. They can bring any-one they like in I don't mind, as long as they want them here that is all that matters. You see a lot get put off by the hospitals where they can't take any-one in and they have to

> *leave kids outside, well a lot and rightly so really won't do that."*
> (Midwife - Alison)

In labour the women reported that the involvement and participation of additional supporters such as partners, friends or relatives were actively supported and facilitated by the midwives. The women were encouraged to bring into the clinic any supporters they wished and neither was this limited solely to male partners. Women were observed to bring friends, mothers and female partners with them and to arrange with the midwife that these women would be their supporters during labour.
Midwifes were also observed to accommodate additional children the women had with them and to encourage their involvement in the pregnancy.

> Child playing on floor while Lynda is being examined - child calls out for her mother)
>
> Midwife: Alison: *Oh do you want your mummy, here do you want to see your mummy's tummy?* (midwife lifts the child up and puts her next to Lynda on the table)
>
> Lynda: *She calls the lump my button.*
>
> Midwife: *Do you want to feel mummy's button move? Here give me your hand, feel that?*
>
> Lynda: *Did you feel the baby move?*
>
> Jamey. *Ooh mummy! (laughter from everyone)*

This kind of involvement was perceived by the midwives as providing support to the woman enabling her to feel comfortable and assisting in other children adjusting to the future change that would occur with a sibling. Involvement of other family members was also shown to function to increase the general awareness among those members of the role and function of the midwife.

The presence of friends, partners and relatives at ante-natal clinics was supported and encouraged by the midwives through involvement in the interaction: For example asking if they would like to listen to the heart beat was a common means of achieving this.

> Midwife - Alison: (turning to male partner) *Did you want to listen?*
>
> Partner: *Oh yes*
>
> Midwife: *Here I will show you how to feel as well so that you know what is what. Right put your head here press hard and let go.*
>
> Partner: *Oh it is really fast.*
>
> Midwife: *Yes it is about twice as fast as an adult one. I am trying to persuade Louise (GP) to buy something which means that you* (Sally) *can hear as well.*

Empowerment

Throughout the chapter certain key elements of the care provided by the practices have been identified which have functioned to empower the women. This forms a contrast

with much of the previous research on interactions between user and workers in the hospital setting. Research has demonstrated the ways women's encounters with the hospital system function to maintain the sentimental order and unequal distribution of power between user and provider (Kirkham 1987). The medical management of reproduction controls women by reinforcing and perpetuating women's passivity and lack of self determination Thus medical authority reduces women's control over their bodies and women users of a service are reduced to a position of powerlessness. While the nature of the relationship between user and provider within the medical model has clearly been identified as one of conflict, discussion of women's resistance to such control seems underdeveloped in previous studies. The concentration on women's enforced compliance and passivity in the face of medical authority has tended therefore to overshadow any analysis of women's opposition and said little of any potential existence of solidarity and support for each other among women. Finally studies concerned with analysis of childbirth were largely conducted during the late 70's and early 80's, before the impact of the consumer movement in childbirth could have permeated through the system and been taken on board by providers and users alike.

Thus one issued raised in the research was the question of how far women users could effectively challenge medical authority and to what extent providers concerned with challenging the medical management of maternity care actually support women in any challenge to medical control over the reproductive process.

Already throughout this chapter certain key elements of the midwifes role have been shown to enhance the women's sense of control. However this section adds a further dimension to the impact of the model of care provided by the practices, that is the degree to which the women are enabled to cease to be passive recipients but function as 'active strategists' (Lewin 1985) through active opposition in their encounters with the medical management of care.

Data presented so far have indicated that the women's experience of maternity care within the hospital still confirms to the medical model of management. Thus for example the typical response to patient questioning was the absolute requirement of women to defer to medical authority and comply with their processing as maternity cases.

Example: Jill was referred to the hospital solely for an ultrasound scan, however the system she encountered was geared to process her as an ante-natal clinic patient.

Question: *What was it like at the hospital?*

A sausage factory. Like they said "where is your yellow card" and I said, I don't have one I am a home birth, "Oh which consultant are you booked under?" I am a home birth, so this went on for a bit and then it was "sample?" and I said "I didn't bring one", I didn't need to have my urine and blood pressure done as I had had them done yesterday and that I was only there for a scan, and this midwife said "Oh its patients who decide things like that now do they?" ... (Jill)

Such put downs have been documented as key elements through which medical social control is maintained (Ehrenreich and Ehrenreich 1978:59) Thus the midwives response to Jill was in fact a verbal warning stating that she had stepped outside her prescribed role. However Jill's subsequent response does not provide the anticipated degree of compliance, but instead her access to an alternative to the hospital system in terms of knowledge of her health status (provided to her in her notes) and a sense of support from her community midwife provides her with a means of resistance;

... So I said "it's my baby, and I do decide". If she wanted to read my notes she could see that I was fine. But as the only thing I was there for was a scan then that was the only thing I was going to have done and that I would see my own midwife for my ante-natal checks . I told Jean afterwards when she rang, she (Midwife - Jean) *had a good laugh about it.* (Jill)

Knowledge provided by the midwives in the community also enabled the women to directly challenge the imposition of the medical model in their pregnancy during their contact with the hospital system. Access to alternative knowledge and opinions outside of the institution of the hospital provided the women with additional backing and support in situations of conflict with the hospital system.

Example: Judith booked for a home birth was sent for a scan with a suspected placenta previa. The scan did not indicate a 'placenta previa' but did show the placenta to be low.

Like when the consultant at the hospital said that I might have to go in because the scan was showing a low placenta, I told her that I didn't want to make any decisions there and then until I had discussed it all over with my midwife and my GP who were responsible for my care and who knew everything about me. And she got really nasty - said It would be my fault if the baby died and I would probably hemorrhage at home, and the head wouldn't go down all stuff like that. I was really upset. But I thought blow you, I am not going to be bullied, I am going to ask Jean (Midwife)*what she thought. So I said I was not going to go in until I had time to think it over.* (Judith - Had a home birth as planned - placenta proved not to be a problem)

Limits to control

Finally a qualification needs to be applied to the findings surrounding the degree of control held by the women over the decision making process. Indications were found to

suggest that the *entire* control of both the decision making process and the management of their pregnancies and labours did not rest with the women. The observations and interviews data indicated that the workers' approach contained a process of appeasement to the hospital system which involved them in a degree of deferment to medical definitions of childbirth. The impact of this process was the resulting loss of a degree of control by the women users. In particular this was found to effect the degree of choice over the place of birth, particularly for women who were termed as being 'high risk'. Thus although the full range of options were explained to the women and as already demonstrated women were able to exercise choice. A limit was imposed by the GPs, on the women's ability to demand a home or GP unit birth: Each woman booked for a home or GP unit delivery would be asked at the booking appointment, to accept that in the situation should there be any indication that their birth might not be normal, they then would agree to a transfer to the consultant unit.

> *Example: From first ante-natal appointment with GP.*
>
> *GP- Caroline: We will certainly book you for a home delivery but the one thing we do say is that we can't promise a home birth and that we do ask you to agree to transfer if any problems arise.*

Thus the GPs retained ultimate control over the women's ability to access an alternative to the hospital delivery.

This provides an illustration of what has been identified as a major constraint on the provision of user-centred care, that is the acceptance of a medical or obstetric definition of safety (Arney 1982). Within such a definition the value of the woman's experience can be recognised but is always perceived as secondary to the maintenance of obstetric safety (Arney 1982, Graham 1980). Thus while providers keen to provide an alternative to medicalised care only argue for changed boundaries, such as acceptance of the safety of home births for normal deliveries, there is still an ultimate deference to obstetrical safety. As Arney notes in an assessment of an alternative birth centre;

> "The farm does not violate the rule which insists that birth occurs in a setting where the experiential aspects of birth are balanced against obstetrical safety." (Arney 1982)

The problem is not that of providing safe care but, that the definition of what is safe remains an obstetric one, rather than being woman-defined; thus pregnant woman loses control because she does not define the boundaries of the risks she is or is not prepared to take.

The rule of obstetric safety first and satisfaction second was a rule which the GPs at the practices were observed to be careful not to violate. The GPs' adherence to this rule in two examples was found to cause some conflict between the GPs and the women. In

the first example, the GP refused to continue to cover for a woman (Daphine - North Practice) with a breech presentation who wanted to continue with a home delivery despite the 'medically defined' risks, with the result that the woman delivered in the consultant unit. The second example, relates to a woman (Claire - Park practice) who wanted a home birth and who was considered by the GP and the consultants at the hospital to be too old (41) to have a first baby at home. In this instance the woman maintained that she had a right to have a home birth, to which after extensive negotiations, (in which the midwife was found to play a key role) the GP conceded and she delivered at home. The degree of dissatisfaction the women affected by this rule felt is explored in chapter 7. The point to note here is that the GPs in stating that, they would not be prepared to book a woman for a home or GP unit delivery whose pregnancy did not conform to certain norms of a 'safe pregnancy' were demonstrating limits on their acceptance that the woman herself should be in control of the management of her care. Furthermore there were also some indications that the GPs were assuming responsibility for the women's decisions and interpreting the outcome within medical definitions, an example of this is provided by the GPs response to one woman (Maggie) who had fought for a GP unit delivery and in labour had to be transferred. The GPs response was to this was to interpret the situation in the light of the reaction from the hospital not from the woman herself.

> *Well we certainly got our fingers burnt with that one, the consultants are not going to be pleased. But I suppose we redeemed ourselves with Claire who is even older.* (GP - Simon)

The position of the midwives towards the woman defining the boundaries of risk was found to differ from the GPs in certain respects. It was noted in chapter four that the midwives adopted the view that the woman should hold the ultimate veto over the management of her care, irrespective of the midwifes professional opinion. Thus although the midwifes expressed similar concerns to the GP in the two examples given above, both the midwives involved were observed to act as advocates for the woman's view in negotiating with the GP. In addition in both cases the midwives were observed to inform the woman that she had a 'right to a home birth'. Although in both cases they suggested a compromise ultimately the decision was still seen as resting with the woman: In the first example the midwife came into the consultant unit with the woman and attended the delivery, in the face of some hostility from the hospital midwives. In the second instance despite her reservations the midwife agreed to attend the delivery, after obtaining a compromise of some acceptance of medical safety:

> ***Question**: How do you feel about Claire's delivery?*
>
> *Well I do have reservations. However as I said to Caroline (GP), it is her perfect right to insist on a home birth. So I went and had a chat with her and said that I was happy to do it if she that was how she felt, and would*

> *she agree to another midwife being there, I think it is easier if there is two of you. Anyway she wanted that, and she was quite willing to be transferred in labour if there were any problems so that was Ok. (midwife-Jean)*

Thus within the model held by the midwifes, the decision in these situations was seen as being ultimately the woman's responsibility although they did advocate a process of negotiated control.

CONCLUSION

This chapter has identified the central features through which the workers attempted to provide a user-centred form of maternity care.

The starting point of the analysis was a consideration of the workers' attempt to construct the environment of the clinics so that they constituted jointly owned territory. The alterations made in the spatial organisation of the clinics were considered to have facilitated a departure in the women's conduct from the passive behaviour which has been found to be indicative of traditional ante-natal clinics. Furthermore the informal structure of the clinics and the high allocation of time to the women fostered the development of a positive relationship between provider and user. Flexibility in terms of both access and the content of the care enabled the women to have a personalised and individualised service and open access to professional knowledge.

The chapter then examined the nature of the patterns of interaction and communication between the women and providers. Within chapter four an expectation was noted among the workers that their role in providing information to women was to enable them to exercise a greater degree of choice and control. Overall, the care provided at the practice was observed to facilitate and support a culture of access to information. In addition the majority of instances of observed interaction between providers and users, portrayed the workers attempting to function to respond to the women's definitions of need rather than orientating their care to meet medical demands. In the main interactions between workers and the women and particularly the midwives could be interpreted to conform to Dazingers' (1978) 'educative category' "When both parties participate in the sharing of expertise." (1978:363)

The significance of the care provided is that in certain key ways the care was structured to facilitate and reinforce the women users' involvement in the decision making process. The women were incorporated into the care as 'health workers' in the sense that they were acknowledged by the workers as having a valid contribution to make both to the provision of their own care and to the further development of the midwives clinical practice. In addition the observations indicated that the care provided at the practice built up and supported the women's sense of control over the process and management of their maternity care. From the point of view of the women's users authority within the

provision of care, the evidence suggests that the perceived support of the workers provided some of the women with a basis from which to directly confront the imposition of medical definitions of their situation. The central lynch pin of the model of care was therefore the quality of the relationship between provider and user and particularly between woman and midwife, and the degree to which it consituted a partnership. Instances were observed which provided a means for women to exercise some control over the management of their pregnancies and women users were able to contribute to the definition of the focus of the interaction and jointly set the agenda.

One of the key features of the model of care identified in this chapter was the degree to which the midwives were of central importance to the provision of care. The role and status of the midwife in the interaction came not from a professionally based power over women users, but from the women themselves.

The data suggests that midwives and women may subscribe to central core beliefs concerning pregnancy and as a result demonstrate consistently similar definitions as to the most appropriate management of pregnancy and labour. This tendency is further explored in chapter 7.

However, an important qualification needs to be added to the largely positive view presented: The chapter also identified a clear difference between the manner of the GPs and the midwifes from both practices in their interactions with women. Although the GPs were identified in chapter four as possessing a similar frame of reference to the midwives, the observational data presented in this chapter indicates a difference between aspects of the practice of the GP and the midwives. In the GPs' interactions with and approach towards women users, socialised types of medical professional behaviour were found to influence and affect the nature of the interaction. Thus clear limits were found on the extent to which the GPs adopted a user-centred approach, a difference which is all the more marked given the fact that all the GPs were women actively commited to challenging the traditional relationship between medical practitioner and user. Evidence also suggested that the women perceived this difference with the subsequent effect on the nature of their relationship with the GP. In particular the women were found to regard the GP as less approachable and accessible than the midwife. This difference between the GPs and midwives suggests that part of the power relationship between users and provider is located in socialised patterns of professional behaviour, which are difficult to challenge and to break down even for female GPs committed to such a challenge.

Although the GPs operate within the same framework as the midwives, significant constraints were identified in their ability to provide women with control over both the direction of the doctor/woman encounters in the clinic and more generally over the the management of their care. Constraints imposed by the system limited and regulated the degree to which the GPs at the practices could respond to the most radical

demands of the women. These factors and the constraints on the midwives are part of the focus of the next chapter which further explores the elements which serve to either support or constrain the workers from implementation of a user-centred approach.

However, having raised the issue of conflicts, this is not intended to detract from the manner in which the care provided was found to largely correspond to the workers' frame of reference identified in chapter four. Instead, having identified components of a model for care which could, in its divergence from the medical model, be said to be predominantly user-centred in nature. The aim in drawing attention to the constraints was to explore the boundaries of the model. Overall, conflict could be said to be very much more a peripheral than an intrinsic feature of the relationship between provider and user.

CHAPTER SIX - IMPLEMENTING AN ALTERNATIVE PHILOSOPHY - SUPPORTS AND CONSTRAINTS

Introduction

This penultimate fieldwork chapter explores some of the factors which either support or constrain the workers ability to innovate and implement a user orientated approach. The chapter does not aim to provide a comprehensive analysis of these factors, but instead to explore those areas identified during the course of the research as influencing the implementation of the workers' model of user-centred maternity care. The chapter examines the effect of the health care system and in particular the constraints imposed on the workers' practice by the overarching dominance of the medical model and the hospital system for the provision of care.

On a micro level, an assessment is provided of the degree to which the operation of the workers as members of PHC teams contributed or hindered the implementation of good practice. The chapter analyses the co-ordination and relationship between team members and the impact of different positions of power and powerlessness within the structures of the team.

On the macro level, the chapter draws together causal issues such as the effects of the hospital system, the workers' management structures and the influence of the health care politics; which again either support or constrain the implementation of a user centred model.

The chapter is divided into two sections: the first is concerned with the catalysts for the workers' philosophy and form of maternity care provision. It explores the factors that enabled or fostered the implementation of their model for good practice. The second section highlights those areas which functioned to limit and constrain the implementation of user-centred care.

SECTION ONE - THE FACTORS ENABLING GOOD PRACTICE

The development of an alternative means of providing care to women was not simply a matter of the individual personality of the workers. Clearly personal commitment is a contributor, but in addition other factors facilitated and maintained the provision of the user centred approach provided at the practices. It is these factors which form the focus of the first section.

Feminism and Radicalism

This subsection identifies the degree to which the GPs and midwives felt their practice and in particular their commitment to providing care which met the needs of women was influenced by the women's movement or contact with alternative health care politics. All the workers were asked if they felt any political movement had specifically influenced their practice, in particular the feminism and alternative or consumerist movements in health care, were discussed with the workers.

For the three female GPs, (interviewed on this subject) feminism was felt to be a motivating force in their attempts to provide women with a user-centred approach. Feminism and in particular the feminist critique of health care was something which they felt generated an overt politicisation of their practice. Contact with the women's health group was an active feature of the GPs personal lives and working practice. Their commitment to providing a user-centred care stemmed from their understanding of the critique of the medicialisation of childbearing and reproduction. In practical terms, this had impacted on the organisation and management of the practices in certain key ways: Resulting in attempts to re-organise the clinics to create an accessible atmosphere and the GPs initial commitment to providing home births.

In sharp contrast to the GPs, and with only one exception, the midwives did not feel that feminism was a factor influencing either their practice or lives.

> *Feminism? I don't know, no I wouldn't say so. I mean I believe in equality but I wouldn't say that I was a feminist no.* (Midwife - Alison)

> *Fem what?* (Student midwife- Claire)

This perception of feminism as having a little or no relevance to their practice was all the more significant given the midwives' commitment to providing health which empowered women and whose many components could be said to corresponded to a feminist perspective health care.

If the midwives philosophy of care was not consciously informed by a feminist ideology *'radical midwifery'* was perceived by the midwives as a major factor defining their approach to their practice. However although the radical midwifery movement can

be situated broadly within the women's health movement and certainly some radical midwives do identify themselves as feminists (Salvage 1985) for the midwives interviewed radical midwifery was seen to stem from within the tradition of midwifery. The Radical Midwives were a group of midwives set up during the early 1980's to promote the traditional with-woman role of the midwife, and to re-establish the midwife 'as a practitioner in her own right,' the association is also actively involved in issues surrounding the politics of maternity care (Salvage 1985:127). For the community midwives interviewed, adopting a form of practice which conformed to radical midwifery was seen by the midwives as a fundamental part of the traditional practice of the midwife. Thus they perceived themselves in adopting a user-centred form of practice as aiming to undertake the full role and responsibilities of the midwife. For the midwives interviewed The Association of Radical Midwives and the movement of radical midwifery, was significant as they represented a means of direct challenge to both the medical model and the established nursing hierarchy which was identified as causing and reinforcing the erosion of their traditional role to that of an 'obstetric nurse'.

> *I think radical midwives were formed because so many of the new school midwives came in with new ideas and found that they were just banging their heads against a brick wall. That is really why ARM was set up, because in the old days midwives just worked in the hospitals and accepted hospital policy and didn't ever question anything.* (Midwife - Cath)

In terms of the influence on their practice radical midwifery was seen by the midwives interviewed to constitute a responsive flexibility, and to contain a central emphasis on user control over the decision making process.

> **Question.** *Would you say that you are a radical midwife?*
>
> *Yes. In that I would listen to different views and am not that set in my ways and will accept change and being willing to be flexible. That is what I think is meant by a radical midwife, thinking what the patients want is right and that is what you should do.* (Midwife - Alison)

Through the existence of such a group, the midwives felt empowered to assert their traditional role as independent practitioners and supported in their attempts to direct care towards a user centred approach. Radical midwifery was felt by the midwives who had trained since the movement had been set up to have, provided them with the support they needed to challenge the medicalised model of care contained in the curriculum of their training. In particular it provided the confidence and support to provide women with an individualised response in the face of pressure to adopt routine procedures.

> *As a student and a newly trained midwife I was very influenced by their beliefs and writings and the philosophy behind the movement, they gave me a lot of support when I first qualified. (Midwife-Moria)*

Question. *What kind of support, can you think of anything specific?*

Well like that, high technology solutions are not necessarily the best ones or the right ones now I already knew that. But given the pervasiveness of it in hospital, the technology approach was so common and so widespread that it was near impossible to question and you were working and training in that situation that it was near impossible to say, 'I know this procedure is not necessary for this woman, in this particular circumstance and I am not going to use it' but we did say that because of the back-up from the radical midwives, because there I met a different kind of midwife from the ones I had come across in the hospital. I think really it was just that we are trained practitioners, the old cliche but because of ARM and what they did we can get on and do it. (Midwife-Jean)

This assertion of the traditional autonomy and responsibilities of the midwife was felt to form the core of their practice. Midwifery was seen as a craft which radical midwifery attempted to reassert the value of. In doing so the midwives advocated a with 'woman role' because that was perceived as fundamental to the role of the midwife. Subsequent subsections of this chapter discuss the factors which further contributed to the assertion or reassertion of this role for the midwives, such as the networks of support available to them and the process of training students.

Informal networks of support

One of the most important sources of support for the midwives was a network of other midwives working in the community as well as some who worked in the hospital who were seen as '*one of us* ' who were like minded in terms of their approach to pregnancy and childbirth.

This network of midwives proved very important for them, in circumventing the hospital and their own midwifery management's policy. One major example of this process in operation is the case of post-natal care, the organisation of which was found to be dissatisfying both from the midwives and the women users point of view. A major source of dissatisfaction for many midwives throughout the UK has been identified as being caused by the fragmented nature of their involvement in care (Walker 1985:48). Although the midwives interviewedwere able to provide continuity of care in their work through the practices ante-natally and for care during labour, post-natal care was organised by the hospitals according to a different system. For post-natal care the midwives were required by their own management to operate a patch system, which meant that if they looked after a woman ante-natally and attended her delivery but she lived outside their patch area they were not allowed to provide post-natal care. This was felt by the community midwives to be an inappropriate system for organising post-natal care for three main reasons. Firstly, this system contradicted the midwives belief that continuity of care was one of the most important aspects of care they provided and one which constituted a key strength of midwifery practice. Secondly, the midwives felt that

this loss of continuity of care was dissatisfying for the women, who having seen the same person throughout their pregnancy and had that person deliver their baby were then confronted with a different midwife post-natally. The midwives also found it dissatisfying from this point of view as they were losing contact with women they had built up a relationship with. Finally, the midwives expressed a certain amount of resentment at the blanket imposition of a rigid means of organising care and the resulting loss of flexibility and autonomy within their practice.

In response to this issue, the network of like minded midwives provided a means of resistance to the imposition of the hospital system on their autonomy of practice. This network offered the midwives an opportunity to negotiate around the rigidity of the organisation of post-natal care. Therefore if a woman was transferred to one of *their* midwives they would simply swap, or even more subtly ask each other to cover for women when they were busy and it would just happen that these would be the women the other midwife would have delivered.

The minority of midwives from the hospital who were in this network would also involve themselves in a similar process of circumventing hospital procedure. For example if a woman had to be transferred to the consultant unit, the midwife on the *inside* as it were would telephone the community midwife so that she could at least 'pop in and see how the woman was doing' which in practice frequently resulted in the midwife being able to provide considerable support to the woman throughout her labour. However the number of these midwives in the consultant unit were felt to be a minority. While official collaboration and liaison between the hospital and the midwives to improve continuity of care was even more limited, as providing information to the community was not seen by the hospital as an essential part of it's function. While their own management it was argued did not see continuity of care as a priority.

> *Just because I have delivered someone, it isn't seen as a good enough reason for me wanting to see them post-natally.* (Midwife - Alison)

The difference between midwives and their management on this issue of continuity of care was significant and centred around differences in the perceived value and definition of continuity of care. Midwifery managers were perceived as being solely concerned with midwifery's professional standing and authority in relation to the medical profession, instead of the midwifes one to one relationship with the pregnant women. Midwifery managers were therefore felt to be removed from the practice of midwifery with little commitment to or even understanding of the type of care the community midwifes were trying to provide, this issue concerning the quality of midwifery management is returned to in a later subsection.

Given these perceived problems with their management for advice and support in a supervisory framework the midwives turned to the other midwives in the network. In this sense the network functioned at both a local and national level for the midwives. At a national level the Association of Radical Midwives provided, information on clinical practice and the use of non-interventionist strategies for the management of care. In addition contact with the association extended the midwives links with other midwives practising in the same manner. At a local level the midwives would share information and provide advice on the management of practice, as well as support through providing a forum to discuss difficulties such as, births which had caused them problems.

The GPs also had a similar support network in a local home births group of GPs providing GP unit and home births to women. This group functioned in a similar way to the midwives network in terms of informal peer supervision, as the GPs shared problems and gave advice to each other over the the most appropriate management of deliveries.

This sharing and evaluating of each others practice was also found by Peterson (1983) to occur among lay midwives in the United States. Peterson found these networks of support set parameters of acceptable and unacceptable practice, providing a framework from which the midwives could determine a code of conduct for their own practice.

> "A midwifes individual practice were set within a framework of collective norms and were subject to common scrutiny ... The midwives were not isolated workers but rather existed in networks of local state and national dimensions with others in these networks." (Peterson 1983:280/81)

Consequently it has been argued, DeVries (1982), Peterson (1983) that, in the absence of formal support and control such networks function as informal structures of social control; regulating and reinforcing the members practice and creating conformity to certain definitions of alternative practice. The findings from this study suggests that the operation of networks of support among the midwives and GPs interviewed served a similar function, as that identified by Peterson (1983). Thus although they were working within the official health care system their form of practice deviated from main stream practice sufficiently to require an alternative system of support. Thus these networks provided support where their official management structures failed to prove to be appropriate to meet their needs. Furthermore the construction of both the midwives and GPs practice was set and reinforced through their discussions with the other midwives and GPs.

> **Question** *Can you describe what happens at the meetings? What sort of things do they cover?*
>
> *All sorts really. Sometimes we have speakers, who will talk about new types of practice - like a while back we had someone come and talk about delivering in water, that sort of thing. Ways to improve and then really advice, talking over the things we have done - like sometimes you might have had a bad delivery and need to talk about that.*

Thus the groups were felt to assist in defining the appropriate boundaries of their model of care in that they were felt to collectively support certain actions but to also define the point where medicalisation had to be acceded to. Thus there appeared to be a collective view that breech births should be delivered in hospital, while primagravida women should be given the option to deliver at home.

Training

One feature in the maintainence of the the approach to maternity care provided by the community midwives was the active midwifery resistance to medical hegemony over midwifery based knowledge. An illustration of this can be seen through the midwives response to training of students. Midwifery training particularly in the community is largely under the control of other practicing midwives in that students are apprenticed to an individual midwife for the entirety of their community placements. For the community midwives, a central element in the transmission and re-emergence of the midwifery model was the training of student midwives. The training of students within the community was felt by the midwives to pass on skills, knowledge and experience which provided the students with expertise from their particular midwifery store of knowledge. This transmission of midwifery based knowledge was felt by the midwives to be an important means in halting the erosion of their role. Through working on the community in their type of practices, students were felt by the midwives to gain knowledge of an alternative form of care provision to the medicalised maternity care they would have experienced within the hospital system; such as, the management of normal deliveries in the home and the provision of a user-centred as opposed to task centred maternity care. Observing and listening to other midwives was the major way students were expected to learn the *craft of midwifery*. Explicit within this 'alternative training curriculum' was an assertiveness training in defending midwifery practice. The qualified midwives felt that imparting an ability to be assertive and challenge the medical model was an essential aspect of the training;

> Example: During examination of a woman.
>
> Midwife Jean: (to student) *Well now how many weeks does it feel to you?*
>
> Student: *Well I think 30 weeks?*
>
> Midwife Jean: *Now how many weeks have you been with us? Four weeks? I think it is time that I taught you to be assertive. It is 30 weeks. It stands you in very good stead for all the awkward doctors you are going to meet at the hospital.*

A second element in the midwives' training curriculum related back to their view of women users as active health workers in their own care; as such key participants the

women were also midwifery teachers. In this view the woman users has a store of knowledge and expertise to impart to the trainee midwife. Thus a major aspect of the skills the midwife should acquire was how to listen effectively to women.

> *When I have students I can always tell the good midwives from the not so good by the way they listen to women. I see midwives who just don't listen to the women at all.* (Midwife- Alison)

The community midwives also advocated for themselves a continuous process of reappraisal and updating for their own practice, based on listening to the women. Rather than achieving a single professional qualifications, training was perceived as a continuous process of learning to respond to women's needs.

> *Listening to them* (women users) *I mean really listening to what they say and how they feel is the most important learning process for a midwife.* (Midwife - Jean)

Working on the community

Midwifery practice in the hospital is required to orientate itself to demands of the established hierarchy and the medical division of labour,

> "Words and actions and uniforms define an individuals status in the social system of the hospital. Rules and prohibitions dictate and limit behaviour and interaction." (Lomas 1978:174)

The priorities directing their practice become those of the institution and the priorities of the hierarchy within that institution. Those of lower status are regulated in terms of policing their bodies and their activities. The presentation of their selves and public face (Goffman 1959) is extensively regulated. Thus a doctor may conform and dress according to certain conventions of acceptability, but is unlikely to be told explicitly the type of make-up that is appropriate or the sort of tights they should wear as nurses would. Midwives and nurses public face and presentation of self is extensively regulated within the hospital system.

Nursing and those occupations derived from nursing are notoriously status conscious and great lengths are taken to display rank in the code of coloured belts, stripes on hats, badges different coloured dresses and differently styled caps. These are the outward visible trappings through which the hierarchies of the institution are maintained and reinforced; both the internal hierarchy of nursing and the inter-professional hierarchy of the institution. Furthermore the concern with the presentation of hierarchical status through uniforms emphasises one further groups place within the hierarchy, that of the patients; as separation between the professional and the user of the service is also perpetuated (Salvage 1985:32). All the community midwives had worked at some time within the hospital system and the majority felt that the regime of the hospital had

constituted a major constraint on their ability to practice midwifery fully in the sense of *with-woman midwifery* which is centred around the woman's needs as opposed to *obstetric-midwifery* which is task-centred in nature. The impact of the pre-occupation with their outward presentation of 'status' was felt by the midwifes to prevent them from focusing on improving the quality of their care, as their energies were channelled into maintaining and presenting their position within the hierarchy .

> *In hospital I was always aware of my uniform and my hat. You used to spend so much time on whether your earrings were right or if your stockings were the right colour. Like on the community I try and make myself look presentable of course, but that is not a priority any more. You are not worried about what somebody might say to you if you have gone to work with the wrong earrings on, you are more concerned with getting that information over to a person who you see as an equal.* (Midwife - Cath)

Working on the community provided the midwives with a freedom from the level of surveillance by their management which occurs in the hospital, as they were largely working independently without being constantly visible to management. In addition they were removed from the hierarchical structures of the hospital and thereby also removed from the requirement to display their status in the hierarchy in their interactions with other professionals and other midwives. Instead they could adopt a more autonomous role, working within the definition of that of an independant 'practitioner'

This freedom working on the community provided, particularly in terms of a more autonomous practice was also felt by the midwives to be a determining factor in their ability to to break down professional barriers and develop an equal relationship with the women. The midwives felt that this autonomy coupled with the complete continuity of care, that working on the community also made possible, enabled them to provide an individualised response to the women.

> **Question.** *What is it that you like most about working on the community, why do you work on the community?*
>
> *I have found that since I have been on the community I have found that I can remember every single women that I have delivered because you know them all as individuals as a family unit. I have kept in touch with most of them as well whereas the ones I have looked after I the hospital they were here one day and gone the next and you never had any feed back from them. So me the most rewarding aspect is getting to know the women.* (Midwife - Cath)

Thus it was the degree of independence and autonomy of practice which the community midwives had which was felt by the midwives to be a major feature in enabling them to respond to meet women's needs.

The Primary Health Care team - Positive aspects

The degree of collaboration and participation in patterns of joint working between members of the PHC team was identified in chapter two as key factors in any alteration in the pattern of care provision.

This subsection draws together the degree to which a well integrated team based approach to providing care was advocated and implemented by all the workers interviewed. In particular the section focuses on the degree of autonomy of the midwife as a PHC team member and the role of the GP as a facilitator in creation an integrated and egalitarian PHC team.

A. The role of the GP

A key part of the effective functioning of the PHC team was identified by the GPs to be dependant on the development of equal status and value being given to the skills of all team members. In much of the work done in the past on the PHC sector and GP practices a detailed picture has been provided of worker interaction based on a sexual division of labour and a hierarchy with the Doctor at the top rather than a fully integrated PHC team;

> "General practitioners tend to see the primary Health care team as a group of auxiliary workers whom they are to organise and direct. While these workers might have skills of their own they were merely partial duplicates of the more routine skills of medicine which the medical profession had sloughed off." (McIntosh and Dingwall, 1978)

The GPs at the practices expressed a commitment to challenge such a form of structuring their clinical practice and their relationships with other members of the PHC team.

It has already been demonstrated (see chapter four) that, the GPs recognised the skills of the midwife to be of central importance in terms of providing care to women while at the same time acknowledging the peripheral nature of their own skills. The GPs' approach in terms of central aspects of the provision of maternity care was found to include a substantial deferment to the knowledge and expertise of the midwife;

> *My role is one of support to the midwife rather than actually providing the care as that is more the midwifes role, because she will be doing most of the care in labour.* (GP - Caroline)

Support for the midwife to achieve a central role in the provision of care is exemplified by the GPs manipulation of the hospital system to achieve midwifery based deliveries. It is indicative of the structurally dominant position of the status of the GP that the decision to offer GP unit deliveries was entirely dependant on the general practitioners agreement despite the fact that the midwives conducted the majority of deliveries at the unit frequently without the presence of the GP.

> *I use the GP unit as a way of enabling the midwives to do the deliveries it should really be a midwives unit rather than a GP unit.* (Simon - Male GP)

Our role in using the GP unit is really to act as midwife facilitators and enable the midwife to use her skills to the full. (GP - Louise)

Thus by use of their power base within the system, the GPs enabled the midwife to provide continuity of care and to practice using all her skills. Although one result of this was that the midwife was therefore dependant on the GPs continued co-operation to maintain her practice.

From an early point in the study, the evidence suggested that the community midwives exercised a high level of autonomy and role discretion, undertaking the main responsibility for the provision of care to the women throughout their pregnancies and post-natal period. Although the approach of the GPs supported and fostered the autonomous position of the midwives, the midwives were also found to be active in the assertion of the importance of their role.

The nature of the relationship between GP and midwife was identified by the GPs from both practices as contributing to an improvement in the quality of care. Both the GPs and the midwives from both practices felt they worked within a partnership arrangement, whereby each felt able to call upon the different skills each possessed. An illustration of the status of the midwife in relation to the GP is provided in the next subsection through a discussion of the autonomy of the midwife and how confrontations or differences of opinion between the midwives and the GPs were observed to be managed.

B. Autonomy and confrontations

The community midwives were found to exercise a great deal of autonomy within their own clinical practice and were not subject to direct control by the doctors over the content of their practice. In addition as demonstrated in earlier chapters of this thesis, they had rejected the medical frame of reference for dealing with pregnant women and as a consequence their practice was in the main, not constructed according to medically dictated policies.

This position of both practical clinical and ideological autonomy exercised by the midwives could be explained in terms of the policy of the GPs towards promoting and facilitating such a form of practice. However this does provide a full explanation, the midwives own definition of their role and concern to assert that role was a key factor. The midwives defined the character of their role as constituting a 'practitioner in their own right', a status which they felt carried with it a responsibility to the women and for management of their own clinical practice. Thus although the practice of the GPs helped foster the development of a team based approach, perhaps rather uniquely in health care provision, much of the policy towards maternity care was generated by the midwives themselves. As already noted, their own practice and policy on care provision was developed from discussions among themselves and with the women users.

In certain instances the model of care held by the midwives conflicted with the medical profession's view and direct challenges to the doctor's authority from midwives were observed. While the following example occured between the midwife and a GP who was not one of the radical GPs included in the study;[1] the example illustrates the midwife's readiness to assert her clinical authority and judgment, to ensure that the woman user achieved her aim of a GP unit booking.

> ***Example.*** A woman (Hazel - she was one of the 10 second time mothers who was later interviewed after her birth)) whose blood pressure was slightly raised, was being seen by one of the doctors whose policy was to oppose home and GP unit deliveries, he had been called into the clinic by the student midwife who had been taking the clinic in Alison's absence.
>
> At this point the Community Midwife (Alison) returns after answering a call.
>
> Dr. (to community midwife) *I felt that she needed to be seen by the consultant and be transferred to the consultant unit.*
>
> Midwife. *No.* (Midwife puts her arm around the woman who is crying).
>
> Dr. *What?*
>
> Midwife. *No that won't be necessary. She is a GP unit booking and I do not not see any need to transfer her.* (To Hazel) *What have you been doing, chasing after Samantha all night?*
>
> (Note: Knows name of little girl - daughter)
>
> Hazel. *Yes, I said that when I came in, that she has been playing me up all night, and I was in a real state because I knew it could push me blood right up. And I was that worried about getting into a state that I did. And then they said I had to go in to the hospital. I don't want to be transferred.*
>
> Midwife. *There is absolutely no need for you to go into hospital, because I can easily visit you at home. Now it is important that you rest though, because high blood pressure can be quite serious. Is there any way that you can get a break from looking after Samantha? Your mother lives quite near doesn't she, because you must put your feet up really.*
>
> Hazel. *Yes, mum can have her, that's no problem. I was going to ask her anyway until Jim gets back.*
>
> Midwife. *Oh.* (Seems to notice Dr is still standing there) *Thankyou for your help Dr Cameron, but it will be ok as I will visit her at home tomorrow.*
>
> Dr. *Oh well that is it then.*
>
> Midwife. *Yes thankyou again.* (Dr leaves). *Stupid idiot.* (To Hazel). *I am sorry about that.*
>
> (Note: Firmly sides in with the patient, by apologising)

An incident of this nature which directly challenges medical authority is one which breaks all the rules of Steins' (1978) conception of doctor nurse interaction consisting of a highly ritualised game in which the nurse must act in a passive manner and manipulate the

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1. This GP was from one of the other two practices which were housed in the health centre.

interaction with subtle recommendations in order to have any effect on the situation, thus indicating that the midwife has changed the rules for interaction between the medical and nursing professions.

However, although the midwife was prepared to act in a manner which challenged that doctor it could be argued that such an incident would be an atypical one. Certainly such direct confrontations were rare, two reasons are suggested from the data for this; the first is that the GPs included in the research were commited to to enabling the women to have home births and GP unit deliveries and would therefore have opted to monitor the woman's blood pressure at home. However while the previous chapters have demonstrated the GPs commitment to demedicalising childbirth they have also pointed to the tensions this creates in terms of the GPs role and status and some of the limits to their ability to respond in a user-centred. Thus it is possible that such an explanation does provide a complete means of understanding the observed conflicts between medical and midwifery models for the provision of maternity care. The second reason relates to the fact that, in the main the doctors were peripheral to care provision and the midwife was the main provider of care. This is not to say that the relationship between the midwives and the doctors was antagonistic but instead the GPs acted more in a general advisory capacity or simply as a means for the midwife to access the facilitates of the hospital and it was up to the midwives or the women to decide when to call upon them, when they defined medical expertise as likely to prove useful. Observations indicated that the midwife would usually either identify or suspect an abnormality which she would then decide if the problem she had identified warranted the GPs involvement, thus small changes in a woman's urine, or small raises in the woman's blood pressure were not observed to warrant the midwife calling in the GP; while suspected breech presentations or the woman going more than one week past her due date were grounds for calling in the GP. The following example illustrates the midwifes' control of the decision to involve the GP.

> Midwife Jean: *Yes. I think that is definitely a bottom you know.*
>
> Daphine: *Oh no. Really?*
>
> Midwife: *Ummm, yes, I am afraid it really does feel like a breech. I think I would suggest that you had a scan as that would tell us for sure. What do you think?*
>
> Daphine: *I thought it was you know, but a scan is ok by me.*
>
> Midwife: *Look, is it alright if I just call in Caroline* (GP) *to see what she thinks? because I just like to check then if need be she can organise a scan.*

Thus the midwives held (with the women's participation) control over the definition between abnormal and normal pregnancies and births. Arney (1982) has argued that this

control over the boundary between normality is crucial to the maintenance of the midwife as the main provider of maternity care.

> "Critical to the midwife's existence was her control over the boundary between normal births and abnormal ones." (Arney 1982:48)

Thus control over the boundary between normal and abnormal births could also be interpreted as supporting the definition of the midwife as a 'practitioner in her own right.'

In terms of the interactions between the two groups, midwives made decisions with the doctor concerning both individual cases and more generally the practices policy towards care provision, in a manner which differed from the subtle suggestions that Stein (1978) identified as characterising nurses interactions with doctors .

> ***Example.*** Discussion over accepting women not registered with the practice for maternity care. (Doctor - Simon; Midwife - Jean)
>
> Dr. *Well we are so busy at the moment that we can't really accept any more women, unless they are already registered with us, because I am worried that we must do our best by the ones that we have already taken on. What do you think June?*
>
> Midwife. *Well Simon I agree that the delivery load is very heavy, and the clinic seems constantly packed, but it is mostly seasonal. We always seem to be busy this time of year.*
>
> Dr. *Yes that true, well how about just closing the books for a couple of months and then reviewing the situation?*
>
> Midwife. *That is alright by me, with the one proviso that I really must insist on, that is if a woman comes to us and we say no then we have to make sure that she gets in with another one of the home birth practices, and if she isn't happy then we should take her on. We also shouldn't turn away any women who we previously did a delivery for and who wants us again.*
>
> Dr. *Yes, that seems to be a good way of approaching the problem.*

The interactions observed in this research would more appropriately be interpreted as joint decision making between perceived equals in line with Hughes (1988) who found that in situations where nurses operated with a greater degree of autonomy such as accident and emergency departments they also exercised a central role in diagnosis and decision making.

Overview: From the interviews with the community midwives from several other comparable practices it became apparent that all of the midwives considered themselves to be *radical midwives*, in that they were concerned to reassert the traditional role of the midwife. This commitment to developing assertiveness and reasserting their traditional position has led them to develop an explicit opposition to the medical model.

> *I do feel responsible for what occurs in here and for making sure it is safe because although the Doctor is the one responsible in law and therefore we should work as a team, because it is good to be able to have them there as a back up. I do feel very responsible for, well I don't think I should see myself as responsible for the patients ,but I have a responsibility to them. I do see the clinics as mine.* (Midwife - Heather)

The degree to which the midwives felt that their responsibility was **to** the women and not **for** them, situates the midwives ideology of care as being firmly opposed to the medical model; while also changing the traditional power based relationship between user and provider.

A large part of the midwives' ability to construct an alternative relationship between provider and user stems from the structural organisation of the community practices. The community midwives are not handmaidens to the doctor or part of a hierarchy the maintenance of their position within which occupies a large part of their energy. Within the PHC sector the potential for independent practice is much clearer, as they are less constrained by hospital routine and the functioning of a hierarchy which promotes the medical model of reproduction (Kirkham,1986) Thus within the community where the midwives possess more freedom to work as practitioners in their own right (Brooks, Long and Rathwell 1987).

Finally support for an association to be inferred between the provision of user-centred care and the autonomy of the midwives role coupled with a supportive working relationship with the GP is provided by the work of West and Farr (1988) and West (1989). They identified that where colleague and supervisory support are high then innovation was also likely to be high.

> "Social support and good leadership relationships are related to innovation. (West 1989)

Secondly if this is combined with autonomy within their role, or role discretion where the worker is supported to develop their practice then innovatory health care is more likely to occur .

> "Innovation is most likely to occur when individuals feel that they are in a safe environment in which they can introduce and attempt to apply an idea without risk of personal censure" (West and Farr 1988),

SECTION TWO - CONSTRAINTS AND LIMITATIONS

Throughout the thesis so far, certain key limitations on the workers and notably the GPs ability to implement a form of maternity care which confirms completely to their ideological framework. This section concludes the exploration of these issues within the thesis and draws out some additional elements for consideration.

West and Farr (1988) in their analysis of innovation in health care indicated that negative factors which paralleled their list of supportive components, would logically function to block innovation. Thus, time constraints, work overload, poor managerial practices and poor relationships within the team coupled with low levels of role discretion were identified as likely to act as constraining factors, preventing innovation: It is the observed impact of some of these factors on the workers' ability at the practices to provide user-centred care which are discussed in this next section.

Doctors control of midwives practice

The first issue relates to the issue of who has ultimate control of the direction and provision of care.

Although the midwives in their clinical practice were not subject to direct control by the GPs, and were found to have adopted a clinical practice which was orientated to conformity to midwifery rather than a medical approach. Independent practitioner status was something the midwives had adopted in their working practice, it was not something which was given official recognition by the health system outside of the surgeries in which they were based. Instead official recognition was ascribed to the GP. The GPs as those listed on the obstetric list and those who 'officially' used the GP unit and provided home deliveries, held the control over the ability of the midwives to practice in the role they were trained for and orientated to carry out.

> "The success of an innovation has little to do with its intrinsic worth (whether it is measurably effective as determined by controlled experimentation) but is dependant upon the power of the interests that sponsor and maintain it despite the absence or inadequacy of empirical support." (Mckinlay 1981)

The power in this case is that of the GPs'. Thus the doctors still held ultimate power and authority over the midwives ability to provide a choice for women and to define their practice. Any changes in the GP or a change in priorities of the GP currently in practice could therefore have prevented the midwife from undertaking the form of work she was currently engaged in. This meant that although the midwives interviewed defined their role in terms of refusing to be handmaidens to the doctors the ultimate decision over the degree of choice over home births was the doctors. A consequence of this was that it was up to the doctors to support the midwives' commitment to home births and GP until

deliveries and if the doctor refused then the midwife could not offer them to women at that practice.

Constraints of the workers role

It has already been noted that the doctors recognized and felt the constraints imposed by professionalism much more than the midwives. In that unlike the workers' based within the nursing tradition a woman or user orientated means of communication required the doctors to relinquish the prestige attached to their expertise to lose the public professional face upon which their high status is based. This was despite the fact that the doctors expressed a genuine commitment to challenging the balance of power and found such a form of interaction the most satisfying means of interaction. But as will be seen in the next chapter such a relationship between user and doctor proved to be problematic for the women as well.

> *There was this one woman who I had got to know very well, and she had to have a cesarean and I became involved in the negotiations with the consultant over that and as a result I got to know her very well. She asked me to be with her, and I sat and talked to her and I managed in that situation to forget that I was a doctor and to sit and talk to her in labour about her family and stuff. That was a really positive experience for both of us. I think that is what I wanted to recapture and I can't because my hands are completely tied by who I am and what I am.* (GP - Louise)

Thus the medical practitioners were faced with a difficult issue to resolve in that although wishing to challenge the traditional balance of power between user and provider, the value of their role and expertise was constructed from that power relationship.

The constraints and limited experience of the midwives were observed to stem not from the nature of their traditional role but from trying to practice according to the definitions of that role within a system which was not oriented to support user-centred care. Lack of time and the pressures of a heavy case load were mentioned by all workers' as affecting the quality of their clinical practice. However, this was particularly felt by the midwives.

> *Independent midwives have a burn out rate of two years.* (Community Midwife - Cath)

> **Question.** *how do you decide what is a problem for the women?*
>
> *Well just by listening to them really and seeing what doesn't fit a pattern for them, but it is so easy to miss something just because you don't have the time. Like I would really like to have tried to find out what was worrying that last woman, but all the time you are aware of other women waiting out there who all have needs and worries and although you would like to really respond to one woman it can be very difficult.* (Ann - Community Midwife)

Providing holistic care which responds to women's social and psychological needs requires a large investment both in terms of time and emotional commitment which infringes on the workers' personal life. All the midwives interviewed made their home telephone number available to the women, which although enabled the women to obtain advice and support very readily it also resulted in the midwives never being able to totally leave work.

> *I think the community is very, very demanding. I think if women accept you as a friend then women do turn to friends in that way and I wouldn't really want the relationship to be any different it is just that it can really drain you because you have to do so much if you want to do the job properly.* (Midwife - Ann)

> *I do find it very difficult and I think if my husband wasn't so supportive then I couldn't do the job I do because it is so draining and demanding on my time. At the moment I find that very stimulating but in the future I might want a quieter practice.* (Midwife - Jean)

For the midwives one of the main problems was not felt to be caused by the demanding nature of the work but by the absence of support from their own line managers. Innovation and working to improve care for women was not perceived by the midwives as being valued by their own managers. Managers were commonly understood to be concerned with rigid routinisation of care and protection of divisions within the hierarchy and unconcerned with issues such as continuity of care; which was felt to be a complete a complete reversal of the community midwives priorities.

> *The most dissatisfying thing is lack of continuity in the post-natal period I mean I can ask to see a woman just because I have delivered a woman this is never considered by managers a good enough reason to see them post-natally.* (Midwife - Alison)

Managers of the service were perceived by the workers as effectively functioning to block improvements in quality of care particularly in the areas of user satisfaction.

> *I also think days off and holidays could be improved so that we can switch them around so that we can keep our continuity and that consideration is given to us being covered by a midwife sympathetic to home births. I can arrange that myself and do but it is all added pressure on you when we should be getting support from the people who are managing the system. Like you get all this extra pressure just because you want to make the service better for the women in your care. If you didn't bother they would be as happy if all the women were dissatisfied.* (Midwife - Cath)

> *Given the time and initiative we could really make things superb for the women but we can't do everything by ourselves we need support and that support from our managers just isn't there. They aren't concerned about quality of care in the same way as us who see the women all the time.* (Midwife - Doreen)

Thus in providing innovatory care the midwives felt themselves to be under pressure from the demands of their work, while at the same time, having little support for their work, from their own management structure. This experience also fits with the experience of Rothman's lay midwives who found that the ability to innovate becomes difficult to sustain when unsupported by collegues and managers.

> "They know that to many people including some of their colleagues and many of those in charge of their licensing what they are doing is marginal and questionable." (Rothman 1982:227)

Constraints imposed by the system

Workers within the welfare field conduct their clinical practice within a health system which not only fails to actively challenge inequalities but maintains and reproduces such inequalities based on, class race and gender. The very basis of professional power comes as a concession of the state and the ruling elite (Illich, 1976, Wilding 1982) As Wilding notes to secure the necessary support from the state to validate their authority,

> "Members of the occupation have to prove their trustworthiness and reliability in relation to their expertise and to dominant social values. professionals have to show that, by their social standing or through their work they help to support and maintain and strengthen the existing economic social and political order." (Wilding 1982:12)

The case of Wendy Savage (Savage 1986) reveals only too graphically what can happen when a professional does not abide by the mores of the ruling elite but actively challenged them by attempting to provide women with control and consequently power over reproduction. The fear of this kind of reprisal from the system was a very real constraint on the workers' commitment to providing women with a service which was based on users expressed need rather than need being determined by either professionals, the health system or the state.

In providing an alternative service the workers all felt a pressure to make sure that they had complied with the hospital procedures to protect themselves from being negatively sanctioned by the hospital. The GPs felt this pressure most over the position of offering home or GP unit births which helped perpetuate the concept of birth and pregnancy as events which ultimately carried a high level of risk.

> *I mean I am quite scared when I do the ante-natal clinics because I really want to do GP unit and home deliveries and home deliveries and I really don't want to miss things. When I write my referral letters I am really conscious that I have to do it well and that If I make some boob then people are going to say , Oh who is this person doing GP unit deliveries and I feel the weight of doing it well.* (GP - Louise)

> *We don't take risks and with out being too restrictive we just have to be very careful but you need to be absolutely sure that what you are doing will look safe. I always know what I do is safe that isn't the issue. Like it is not about making one mistake it is if we lost a mother or a baby not*

> *because of a mistake but just because that is all we would need to bring the wrath of God down from the consultants.* (Community Midwife -Jean)

Conditioning of training was also an important factor in perpetuating the medical model which workers' especially the GPs felt they had to overcome.

> *Like some-times if I am not really needed or the woman wants me there then I will be there and just sit on the stairs and read a book if I am not needed. It can be a little scary to tell the truth because I have been trained to be so aware of all the things that can go wrong.* (GP - Caroline)

PHC Team and constraints

> "As more specialised knowledge and increasing access to the technology of medical investigation became available to general practitioners, it was inevitable that they would seek to shed lower status activities and widen their spheres of competence and influence." (Reedy 1977)

The ideology that medical practitioners constitute the dominant member of the hierarchy within the PHC team, the *father figure* (Garmarnikow 1978) of primary health care pervades accounts of team based approaches to care provision, with the role of other workers' being understood in terms of the extent to which they can alleviate the doctor from trivial tasks (Bowling 1985). However as already noted both midwives and GPs felt that their relationships within the PHC team were highly supportive, as each had different skills which complimented each other. However problems and tensions were identified within the team which could be interpreted as potentially having an impact on the provision of care and certainly impacted on the development of the well woman clinic at one of the practices.

Problems of status and role ambiguities were an issue for the practice nurse from the North practice. Problems which were in part created and intensified for the practice nurse by her lower status in the hierarchy as being solely that of a nurse. Nursing unlike midwifery or health visiting has no additional status attached to it's role within the hierarchy. Midwives traditionally have the autonomy and authority to act as independent practitioners, which provides an acceptable basis from which to construct an alternative form of working relationship to the traditional power relationships between themselves and the medical practitioners. For the practice nurse however whose traditional accepted role within general practice has tended to be supplementary to and supporting of the doctor to develop a new role and relationship with the medical profession is more problematic. For the nurse in doing so is, without legal or official backing for such an autonomous role, midwifery has a legal role and traditional responsibilities which defines their position as that of an independent practitioner, role which although they have had to reassert, is still acceptable.

At the Park practice the practice nurse did not encounter problems over her role definition and responsibilities with the GPs. Who collaborated with her in an attempt to develop a nurse practitioner role, particularly in areas of reproductive health care to women, thus the nurse provided a well woman clinic, which covered a range of areas from smears and pregnancy tests to counselling. However the autonomous nature of her role was in part justified by the general practitioners in terms of her additional qualification as a midwife.

> *I mean there is no question of us saying to Kim, you must do this or can't do that we work as a team, but then Kim is a midwife as well so it is easier for her to act in an autonomous way , it is more acceptable I suppose.* (GP - Maria)

However this role proved to be less acceptable to the receptionists. The development of her role as a counsellor and supporter of women, generated conflict between the nurse and the receptionists as the type of care she provided conformed to conventional accepted practices of low status tasks.

> *Well the problem is that they don't really think that what I am doing here in the well woman clinic is important, the others here just think that I am just wasting time, like the way the receptionists just acted. I was in seeing a woman who really needed to talk about a problem and half way through her appointment they buzz me and say that some-one has just arrived and needs a dressing changed. and they will say it in a tone of voice which says that I should stop what I am doing with the patient and go and see to the others because I spending too long. They would never dream, ever of buzzing one of the doctors like that, when they were seeing someone, I mean can you imagine it? and they buzzed me twice.* (Practice Nurse - Kim)

However for the practice nurse at North practice, this issue of role definition and responsibility brought her into direct conflict with the GPs over her increasing refusal to accept the traditionally prescribed status of the practice nurse.

> *I wanted some recognition for what I do, because even though this is a radical practice I am still treated as a nurse and even more significantly some of the GPs here are still very much into being* ***The Doctor*** *just because they don't wear the white coat doesn't mean they are not into the status thing.* (Practice Nurse - Pat)

Thus the problem was not an issue concerning the appropriate or inappropriate nature of the extension of her role, but rather that she directly challenged the entrenched power relationships between members of the PHC team.

> *One of the doctors here actually told me that he found me very threatening when he first came here. Because I had or seemed to have such a good relationship with the patients and because I didn't act like A Nurse, a bit too sure of myself and he didn't know how to handle that, because the nurse doesn't act like that. I think that is it really, although they say they want a nurse practitioner and stuff what they really want is some-one who will keep quiet about it. It was alright for me to do what I was doing as*

> *long as outside my office I was still the nurse, Because although this is a radical practice I am still treated as the nurse who is employed by them.* (Practice Nurse - Pat)

By demanding recognition both financial and in terms of an increased value being put on her form of clinical practice the nurse not only challenged traditional relationship between doctor and nurse, but challenged the adequacy of the medical practitioners to deliver the form of care that women users needed and felt to be most appropriate to their needs. The practice nurses demands for recognition were not simply based on an individual need for increased occupational status but were also situated very much within a user driven model of expressed need.

In the survey conducted of women users' views at the practice, the majority of women expressed a preference for a nurse based service in that they felt that they were able to discuss their problems openly and importantly felt very strongly that they would receive a better reception from a nurse rather than a doctor the most frequent comment being that a nurse would have more time and would listen to what they had to say.

> *She had time for me I was a bit nervous about coming as I wasn't sure if I was wasting her time or being a nuisance for coming, it is nice to know that your not.* (23 - Well Woman Clinic)

This strong feeling from the women that the nurse would be more likely to listen to them is even more significant than similar findings identified by previous research (Stilwell 1984) as the nurse was working in a practice where patients acknowledged and appreciated the radical nature of the doctors practice which, facilitated a more open and equal relationship.

> *Well I like to see the nurse for thinks like this , but the doctors here are very good Sara is much nicer than my last doctor, I mean he used to like, have the prescription written before got there. never looked at you.* (16 - Well Woman Clinic)

Being listened to and given time, were features identified by Stilwell (1984) as critical to the development of practice nursing which was responsive to women's needs. Women users felt that the fact that the nurse was a woman and she would be more likely to be sympathetic, to understand their circumstances was a common feature running through all the women's accounts of their interaction with both the nurses and the midwives.

CONCLUSION

In line with analysis of the factors likely to support innovatory work in the health field developed by West and Farr (1988), supportive relationships within the team enabled the workers to feel confident and to practice in a manner which differed from the dominant medicalised organisation of maternity care.

The findings discussed in this chapter suggested that a part of the midwives ability to construct an alternative relationship between themselves as providers and the women as users stems from the structural organisation of the community practices. Firstly, the role of the community midwife was not one of handmaiden to the doctor but instead the midwife was able to practice in terms of her day to day clinical practice within the definition of a practitioner in her own right. Secondly, the midwives did not have to concern themselves with the functioning of the hierarchy within the hospital and thus felt they were freed from the majority of the concerns created by the hospital system. This resulted in the midwifes' feeling that on the community they were more able to prioritise the users' needs and to direct their energies towards improving the quality of the care they provided. Thus within the PHC sector the potential for autonomy could be much higher as workers may be less constrained as they are removed from hospital routine and the functioning of a hierarchy which promotes the medical model of reproduction.

However, certain constraints were also identified which limited the workers ability to develop their practice in a user-centred way. For the midwives and GPs, potential sanction by the hospital system was a real and active limitation on their practice, imposing a boundary on the degree to which they could provide women with complete control over the management of their care. The midwives were further constrained by the absence of support from their own line management and while clinical support was provided through contact with the radical midwifery movement, the midwives still felt negated by the apparent lack of value ascribed to user-centred care by their own management. Finally the constraints on the practices nurses provides a useful comparison which could illustrate the strength 'practitioner status' provides the midwives in terms of their ability to structure their own clinical practice.

CHAPTER SEVEN - THE WOMEN'S VIEW

Introduction

The thesis to this point has identified a workers' philosophy which was clearly user-centred and a practice which despite certain constraints largely conformed to that philosophy.So far the womens accounts presented in chapter five indicated a largely positive response to the care they received. Attention in this chapter will focus solely on the women's view of this care. The discussion centres around the specific aspects of care the women identified as being of key importance to the achievement of a positive outcome and their view of the most appropriate role needing to be taken by each worker in order to meet their needs. Thus this chapter aims to explore the model of 'ideal' maternity care held by the women to compare with the worker's model provided in the previous chapters. A central theme of feminist research is to provide a vehicle for women's experiences and women's interpretations of their needs and experiences, and for those experiences to be incorporated within sociological analysis (Harding 1987).

In terms of defining women's health needs this chapter is concerned with women's self identified needs for maternity care. What it is that they as users of the service feel constitutes good quality care.

Working class women - a brief note

one of the major criticisms of previous research has been that the potentially different needs and different perceptions of ideal maternity care between working class and middle class women has not been taken on board by feminist work (Nelson 1983, McIntosh 1986). It has been suggested that the feminist critique of male dominated medicalised maternity provision is solely a middle class phenomenon and therefore inappropriate to the needs of working class women.

> "The heavy emphasis on personal experience in much of the childbirth literature has resulted in the emergence of a single critique which presumes to speak for all women ... Middle class feminists who have urged a new vision of childbirth are out of touch with the needs of working-class women. Working class and middle class women have different attitudes towards childbirth during pregnancy, different experiences during childbirth and different post-partum evaluations of their childbirth experiences." (Nelson 1983:284-5).

Nelson (1983) and McIntosh (1986) both argue that working class women not only have different experiences of the maternity care system from middle class women but also possess fundamentally different attitudes towards pregnancy and childbirth. These

differences in attitude, Nelson, argued generated different models between working class and middle class women as to what constituted the most appropriate model of care to meet their needs. If this is true then middle and working class women are likely to value and desire fundamentally different forms of service provision, which could be expected to be evident in women's accounts of their needs and expectations of maternity care. Martin (1989) however, indicates that the issue of class based differences may relate more to a different ranking of priorities forced on black and working class women. This difference in ranking is caused by the nature of the racist and class based system in which women experience pregnancy and must manage their reproductive lives, rather than the possession of fundamentally different attitudes towards pregnancy and childbirth.

> "For a white middle class woman the salient issue may be to stall going to hospital so the clock cannot be started; for a white working class woman stalling may be an issue but behind it lurks the larger issue of finding a way to pay for prenatal, obstetrical or infant care; for a black working class woman the issues of stalling and paying may be crucial, but even if she contends with them, she may have to find a way to avoid downright mistreatment or to manage to have matters explained to her at all." (Martin 1989:155)

Cartwright (1979) identified that working class women expressed a need for information but were less likely than middle class women to have accessed that information. Thus because working class women need more information from providers and lack confidence it may not safe to infer that they would not benefit from changes in the nature of care provision or from a change in the balance of power between user and provider.

This raises an important question: could a model of care provision address the needs of both middle and working class women if certain key aspects such as the changes in staff attitudes or provision of full information to women are prioritised. Therefore, the extent to which working class women identified different needs from middle class women is a further feature of the analysis of the women's accounts presented in this chapter. However because of the nature of the sample, ie a small sample including working and middle class women and women from a very broad range of ages a comprehensive class based analysis could not be attempted. Thus this analysis of the data in this chapter focuses on those elements which were common to all the women.

SECTION ONE - THE WOMENS VIEW OF THE WORKERS - WHO DO WOMEN WANT?

This section deals with the womens view of who they want to to provide their care: male or female; midwives or doctors.

Male or Female health workers?

The potential impact of the gender of a health worker to alter women's experience, usage and access to health care, is of central importance to the feminist analysis of health care. In addition the issue has significant implications for the planning of policy to address women's health care needs and for the gender order of the current professional organisation within the health service. It was for these reasons that the issue of the gender appropriateness of the workers was discussed in detail with all the women interviewed, from all four samples (30 first time mothers, 10 second time mothers, 31 users of well woman clinic well woman at the North practice, 12 Asian women users of well woman clinic well woman run by practice at Asian community centre) In the following discussion their comments will be taken as a whole except where clear differences were identified between the groups.

For the women receiving maternity care, due to changes in both the practices, two thirds of the women experienced care by both male and female GPs during the course of their pregnancy. The remaining third received care only by women. All the care received by the women from the well woman clinics (including the women from the Asian community centre) was from the same female practice nurses. Overall consistent views concerning the most appropriate gender for a worker were found to be held by the women irrespective of who actually provided their care.

During the initial interviews all the women were asked questions concerning who they would prefer as the main provider of care a man or a woman. These were then, followed by a discussion of the reasons for their choice and the degree to which the gender of the worker was in reality a priority issue which concerned them.

In terms of the women's preferences over the gender of their health workers, differences were found in the strength of emphasis women placed on the workers' gender between intimate physical examinations to the more interactive and communicative aspects of their health care. For internal examinations, and cervical and breast screening, all the women clearly wanted such examinations to be performed by another woman.

> *I feel that if you have got a cold then it doesn't matter seeing a man, but for the things that you come here for then having a woman is important.*
> (05 Well woman clinic)

This was found to hold true across all groups, of women receiving maternity care irrespective of such factors as age, class or race. Data from the well woman clinics and the 12 interviews from the Asian women's health day provide additional support for this position.

Question: Who would you prefer to see giving your care at the clinic a woman or a man?

Well Woman clinic - North

A woman	A man	don't mind	Total
25	2	4	31

Well Woman clinic - Asian women's health day

A woman	A man	Don't mind	Total
12	0	0	12

Main Sample - Pregnant Women (both practices)

A woman	A man	Don't mind	Total
28	1	1	30

Any intimate medical examination is a breaking of every-day taboos and codes concerning the body and personal privacy, the power relationship between patient and professional will certainly affect the management of that interaction. Moreover this is exacerbated when a cross-gender dimension is added. The patriarchal gender order and the specific patriarchy of medicine as an institution become additional factors in the equation, for women examined by male professionals. As a result women examined not only by powerful professionals but by powerful male professionals are likely to be highly disadvantaged in the interaction: black and working class women even more so. For many of the women interviewed this translated into embarrassment and a feeling that being examined by a man was simply unacceptable. For the majority of women embarrassment caused by the presence of male doctors was the dominant factor in wanting another woman to perform such examinations.

> *I am much more comfortable seeing a woman than a man. (Well woman clinic -19)*

> *I am very shy and uncomfortable with male doctors. (Well woman clinic - 30)*

The overwhelming majority wanted a woman worker for all examinations because they felt a woman would approach the examination with greater sensitivity and understanding of their feelings. The women anticipated that another woman would empathise with their

situation because she would be likely to have gone through a similar experience and therefore have a greater insight into their feelings.

> *Well a woman definitely, she will have had internals herself wouldn't she? She will know what it is like. So you would hope that she would be a bit more, well caring about how she went about it.* (Sally)

> *She has the same problems and knows what you are talking about.* (Well woman clinic 31)

> *Like a woman might have been through it herself and understand more. Like even if she hasn't, then she will, so like she will care what she does because she knows.* (Sue)

In terms of the well woman clinic, the guarantee of a woman worker for intimate examinations was for many of the women a determining factor in their attendance: Having a female health worker for examinations was mentioned as a specific reason for attending the well woman clinic by 22 women and for 17 women a guarantee that they would only be seen by a woman was the main reason for attending.

> *'Cos at the hospital you don't get any choice and that's why a lot of women don't go isn't it because they are afraid it might be a man.* (Well woman clinic 07)

The male GPs both expressed a personal commitment to developing a sensitive approach to providing women's health care as an alternative to the traditional patriarchal relationship between male workers and female users, a commitment which was supported by the women's accounts as they generally considered the male GPs to `be sympathetic and approachable. However the women without exception maintained that for personal and intimate examinations a woman was the only appropriate provider of care. This preference for women workers based on a perception of greater empathy with them as women, remained constant even where the women felt that their male GP provided sensitive care:

> *Oh God I would be so embarrassed if Andrew* (her GP) *did them, I would just die, oh God no. I mean thank God he doesn't do them and Sue does them all. I have had them done by a man and I have hated it.* (Nicola)

> *Like with the last doctor he was alright and he tried. It is better with a woman. Like men just sit there and look at you and they think that they understand and some try to but I don't think they can understand much. They don't understand what you are going through, they can't know so how can they care?* (Janet)

Women workers were seen as possessing a greater degree of empathy with women users than a male worker would ever have - by virtue of both their biology and their experience as women.

Although two of the women wanted the process to be as unemotional and detached as possible, as they found having an examination done by any professional they knew and liked would have increased their embarrassment. As a result these women welcomed the detachment from their body that an unemotional professional provided. This suggests that professionals need to be highly sensitive to different responses required from them by women, although even these women stated that they preferred a woman to a man for such examinations.

In terms of other aspects of their care the preferences expressed by women composed a less clear cut picture in terms of the gender of the worker. For the majority of the women the gender of the workers was less of a priority issue than the approach of the worker and their relationship with that worker.

> *As long as they are nice I don't mind.* (Annie)

> *If it's a sympathetic man then I would soon as have a sympathetic man than a nasty woman, so I don't mind.* (Sharon)

However, for many of the women any degree of sympathetic response from health workers was felt to be either increased with a woman worker or entirely dependant on that worker being a woman. This view was certainly held by the three women interviewed who described themselves as feminists, however it was not confined to these three women and neither was it confined to the middle class women; instead this view was found to be held across all the groups of women interviewed and all the samples.

The women in the main mentioned two related reasons for this view. Firstly they felt that they would only be able to relate openly to another woman. Secondly, a woman worker by virtue of her shared experience was felt to be much better placed to provide that care. In particular they felt a female professional as a woman would discuss their health with them in a more open dialogue and would enable the examination to be informative in a way which a male professional would not be able to do. The women felt that the interaction would be informative because a woman would be more likely to give them the time necessary for a detailed exchange of information to occur. The underlying reason why the women felt a woman worker would provide more time is a difficult issue to untangle, is it that there is a perception that women workers time is in some way less valuable than a man's, or that a woman worker would value them more and provide them with more time, or finally is it the women felt that they could ask more from a woman more than a man as she is less likely to be intimidating. It is possible that all these factors cross cut each other and form part of the reason for the women's feelings, although rather than patriarchal attitudes such as women workers time being perceived as less valuable the women users viewed women workers positively providing a form of care which was superior in fundamental ways from the care provided by even a sympathetic male worker.

However among the women there were a couple of exceptions to this rule which are worthy of a brief note. Two women expressed the view that women can be more likely to adopt a negative response than a male worker;

> **Question.** Who would you prefer to see a man or a woman, or don't you mind?
>
> *Well women can sometimes be worse than men can't they? A bit hard.* (Daphine)

However when this issue was followed up in detailed with the women, their accounts of their actual experience of women doctors and health workers, did not support this belief.

> **Question.** Has that ever happened to you, where you have found a woman to be worse, or say unsympathetic?
>
> *No, all the doctors I have seen have been really good, like the lady docs here are really good, but like they can be worse can't they, you know what I mean?* (Daphine)

In fact, none of the women were able to identify actual incidents where a female health worker had acted in a negative manner, one woman in response to the above question did recite an incident where she had experienced an unsympathetic response but this turned out to be, from a male doctor rather than a woman. This is not to suggest that women as health workers are never unsympathic to the needs of other women, as there is evidence which points to ways that they can be, (Kitzinger 1988:10-11). However the women's comments were not found to be grounded in their actual experience of women health workers but instead it appears that on this issue among both women workers and women users alike a patriarchal myth is in operation. This myth reinforces a negative view of women workers irrespective of a lack of any grounding of that view in reality and its presence highlights a problem women health workers face in promoting care for women by women. If women health workers are to act in key determining role in the provision of care to women then active challenge to this myth will be a feature of the process of developing that role.

In summary, the majority view expressed by the women was a strong preference towards care being provided by women health workers. In the final analysis the findings identify a clear view among women that other women provide a sympathetic response which is generated by shared experiences and therefore make a unique contribution to womens health care as health providers. The power relationship between male providers and female users was explicitly acknowledged by the women in their expressed preference for a female worker. Male workers, even ones who attempt a sympathetic

response and were seen by the women as providing good quality care, were still identified by the women as limited in their ability to fully understand and respond to their needs.

During the course of their pregnancies, the majority of women experienced care by female workers, the exceptions being encounters with the hospital and some care by male GPs at the practices. Given that almost all of their care was provided by women workers, the research provided an opportunity to examine if there were any differences in the relationship between women workers and women users from different professions and how women users of the service perceived women workers from each profession. The next subsection details the differences the women felt existed between women workers from different professional groups illustrating that professional and institutional power does much to foster the unequal nature of the relationship between provider and user.

Doctors vs Midwifes and Nurses?

There were no negative views expressed by any woman to the adoption of the midwife as the dominant professional and key provider of maternity care. This finding is contrary to the belief that deference to the medical profession is so entrenched in health users consciousness that change in health care delivery is problematic as other professionals lack the same degree of credibility as 'the doctor'.

In fact, the professional most wanted by women to provide their care was the midwife who they perceived as the expert in all areas concerned with pregnancy, delivery and childcare. Only two women made an explicit distinction between the midwife possessing expertise in normal reproduction and the doctor possessing expertise concerning abnormalities a distinction which was made by the workers to justify the divisions in their roles, status and levels of responsibility.

> *I would like the GP there, just in case things were to go wrong. Because I think they can deal with things if there is an emergency. If everything is alright I think you only really need the midwife but just in case having them both would be good.* (Rosie)

Significantly the women felt the midwife to be the expert in all aspects of care as the women tended to push this further than the midwives would themselves, feeling that the midwife possessed all the skills they would require to cope with any situation which occurred in their pregnancy or labours. Thus in all but one of the interviews the midwife was the overwhelming and instant response from the women to the question: "Who would you prefer to see, or have give you your care the midwife or the doctor, or don't you mind?" Two reasons were provided by the women for their choice:

(1) Workers and the Power Relationship.

The first was that the midwife would be more committed to putting forward their point of view and would actively protect their interests. The women expressed a strong belief that midwives identified with them and valued their needs in a manner which was superior to any alternative relationship with a medical professional, irrespective of the actual quality of care and general approach provided by that doctor.

Question. Who would you rather see the doctor or the midwife?

> *The doctors here are very nice really much better than my last place, but they are still doctors you know. Well with the midwife she is your midwife isn't she?* (Brenda)

> *Oh yes nurses are nicer, nurses are less formal than doctors even nice ones like here.* (well woman clinic 17)

In expressing suspicion of even sympathetic doctors the women articulated an open acknowledgement of the antagonistic relationship between the medical model of reproduction and the model held by themselves as women. An individual doctor may adopt a sympathetic role but the power basis of the relationship between users and medical practitioners maintains the potential for control. In doing so the women are reflecting consumer trends towards the rejection of the medical model (Romalis 1985:184). Given the predominantly working class composition of the sample the findings suggest that dissatisfaction with the medicalisation of reproduction is not simply confined to a few middle class women, as suggested by Short (1980).

(2) Workers and who has the expertise?

The second justification for the midwife as the main provider of care was based on a belief that, the midwife possessed a greater base of expertise and knowledge in matters concerned with pregnancy and childbirth.

> *The midwives are much more experienced than the consultant. I know that he is the consultant in his field, but he isn't doing as many deliveries as the midwife every week. So he obviously isn't going to have the knack or the patience that a midwife will have.* (Nicola)

> *The midwife. Its not that the doctor isn't nice. It is just that the midwives do deliveries all the time and they see pregnant women every day so they must know more about it.* (Cheryl)

In terms of the various merits of the skills of the workers the women voiced a strong belief in a health workers expertise and knowledge which was outside that of the traditionally dominant professional, the male doctor. The women were not simply subscribing to the biomedical skills of a different professionals but also valued an alternative expertise possessed by the midwife. The women in describing the merits of

the midwife identified and valued alternative birthing skills held by the midwives (Stacey 1988:241). These skills and practices were derived outside of medically based knowledge, but were instead based on the midwives experience and interactions with women.

Workers and the provision of care

For some of the women interviewed, care provided by midwives and nurses represented a clear alternative to the sickness model held by medical practitioners. The women identified the focus of the role of midwives and nurses as being a concern with health as opposed to an ill-health model. For these women, midwives and nurses were more appropriate and skilled to provide maternity and preventive health care by virtue of possession of an alternative knowledge not concerned with abnormality and pathology.

> *The midwife definitely. The midwife is there to deliver babies that is her only job. Whereas the doctor does all different things. Like and the doctor is just there to see that nothing goes wrong whereas a midwife is your best friend she is there to make sure everything goes right.* (Belinda - Post Natal)

> *Seeing a nurse is more to do with your general health. Doctor is about sickness so seeing one means that you are ill.* (Well woman clinic -03)

From the well woman sample 24 women out of 31 felt that a nurse would provide them with more time. A common perception among the women was that midwives and nurses would have more time available for them than a doctor.

> *You can't really talk because you can't really take up a lot of the doctors time.* (Well woman clinic - 12)

> *Doctors have an awful lot of patients to see to.* (Well woman clinic - 21)

Part of the perception of the doctor as busy, relates to the status and valued ascribed to the position of the doctor, which results in the creation of a culture where the doctors' time is considered not only more valuable than the users time but also more important than the users needs. However the women were also critical of this culture, despite accepting the situation, their strategy for coping was to access alternatives to meet their needs, in the form of other health care providers, as they perceived that midwives and nurses would not only have more available time but would be more wiling to give them that time,

> *Doctors just tend to run you through.* (Well woman clinic -07)

> *Like doctors just come in, look you up and down go "yes, yes off you go you're ok" and off you go. So I am fine with the midwives here 'cos they chat to you they tell you what's what.* (Amanda)

Significantly, the women tended to express these views very early on in their pregnancies and usually during the first interview. Although the women had knowledge and experience of the role of doctors outside of ante-natal care, only a few had any direct contact with a midwife before their pregnancy. In discussing with the women their views of the midwives, two main explanations for this situation were found. Firstly the women felt that they established very quickly with the midwife a high degree of rapport and that the midwife conveyed empathy with their situation from their first encounter with the midwife.

A high degree of empathy was also identified by the women who used the well woman clinics as being a feature of their encounters with the practice nurses which they valued. The women in particular noted that not only did the nurses provide time and explanations but listened to them as the basis from which respond to their needs.

> *She really listened to me, she just sat there and listened I couldn't believe it.* (Asian woman, women's health day)

Secondly many of the women came to the clinic with a view that the midwife was more likely to provide appropriate care to meet their needs. This perception came from within their own community and personal friends or kin networks, in that the women possessed a positive view of the potential contribution midwives would make to their experience of pregnancy and labour. In addition the linkage in the women's accounts between the midwife being not only an accessible professional but an approachable woman was a feature of the women's view of the midwives. Given that the women experienced care by female GPs the fact that the midwife was viewed as the more approachable woman, provides a valuable comment on the women's relationship with both professionals.

> *The doctors don't tell you as much as the midwives, they explain things a lot more. Well the midwives and nurses are girls like us, aren't they? They will sort of chat to you more than the doctor.* (Sandra)

Here class, gender and professional hierarchies converged to constrain the development of a positive relationship between the women and the GP, because the women perceived a clear demarcation in terms of social distance, between themselves and the midwives on one side and the doctor on the other. The GP irrespective of her biological sex was in fact a member of a male elite, thus in terms of her relationship with the women users she could never be simply 'a girl like us.'

In terms of the users view of the role of the medical practitioner, it was the lack of medical intervention or interference in clinical terms that women valued as a role for the doctor. Rather than requiring the doctor to adopt the traditional medical role of the expert using clinical skills to actively intervene and control the situation the women welcomed a much more passive role for the GP. The value of the GP was seen in terms of their

caring role and the degree of emotional support they provided, the very roles which the medical model actively devalues by ascribing such supporting roles as low status duties to be delegated to ancillary workers.

> **Question.** *What about the GP - was he there at the delivery?*
>
> *Oh yes he was great. I was a bit worried about having a doc there, but he just sat in the corner ands slept all the way through it. He just let us get on with it. So I thought I must be doing alright if he can sleep through it. The midwives just woke him up to check her over when she was born and we all had a cup of tea.* (Elaine post-natal - Home birth)

Where the doctors had a role in the delivery the aspects of involvement that the women remembered and felt to be appropriate activities for the GP were, providing support or holding them and after care such as doing the stitches or checking over the baby, but not actively managing the the delivery.

> ***Question.*** *What did the GP actually do?*
>
> *Well she was really nice. It was dead funny because when he was born I was standing up and Bill (husband) and Louise the GP were holding me, while Alison (the midwife) delivered him and sort of handled things. Well Louise is only short isn't she, well I think I must have half strangled her 'cos I was holding on really tight.* (Jane post-natal)

A useful indicator of their feelings concerning health workers was the women's attitudes to the role of each worker during labour, as this was a time when most women felt they would have greatest need of assistance while at the same time would be at their most vulnerable. Who each woman would like to be with her during labour and how she felt the people with her would be assistance was an issue that was discussed in depth with all the women.

The maximum number of people most women wanted to be at the delivery was 2-3 people. A few women stated 4, and 5 women stated before the delivery they didn't mind. However after the delivery three of these women stated they only wanted a very few people to be with them.

In terms of the people the women actively wanted to be present, the midwife and a non-professional such as their partner, mother or friend were consistently mentioned by the women as the people they felt would provide them with the most support. The women's answers in the majority of cases, were ordered with their lay supporter first and the midwife second. Within this context the midwife was nearly always named, such as in Daphine's answer.

> **Question.** *Who would you like to be there with you at the delivery?*
>
> *Frank* (Partner) *and Jean* (Midwife). (Daphine - Planned home birth)

In asking the women why they felt the midwife would be of value, the following issues characterised the women's responses.

a) Support.

b) Reassurance - as you know that you can trust her judgement.

She is nice and will be nice to me.

She knows what I want.

c) Midwife is competent to do the delivery.

However, fewer women mentioned the doctor as an individual they would like to be present, a more typical response was that they weren't sure if the GP was going to be present or not, as no-one had mentioned the GPs presence. Typical positive responses to the GP being present consisted of:

It's okay he doesn't seem the type to interfere. (Amanda)

It might be good if anything went wrong. (Elaine)

Among those women booked for a GP unit delivery or a home birth where the issue of the presence of the GP was of direct relevance, ambivalence more typically characterised the women's approach to the GP being present than any other response.

In terms of the GPs involvement overall in care provision the women did not advocate the removal of the GP as a provider of maternity care, with the midwife being the sole provider of care. While the women wanted minimal involvement of the GP, they nevertheless advocated a clear role for the GP. The women sanctioned two narrowly defined roles for the GP one was that of a technical adviser for problem solving which either they or the midwife felt was outside the realms of normal maternity care or when a prescription needed to be signed. The other was that of a caring supporter during labour, an additional carer but whose role was peripheral to that of the midwife. This was true despite their recognition that the doctor also retained power in terms of a effective veto over their place of birth. (see workers chapter and model chapter for a detailed discussion of this issue).

Thus the model of maternity care held by the women was quite restrictive in terms of the appropriate parameters of the doctors role. Rather than being the central kingpin of the PHC team, the doctor was seen by the women as a technician with some value as a supporter or aide to the midwife, but certainly only one member of the decision making team and a somewhat peripheral one at that.

SECTION TWO - THE WOMEN'S VIEW - ASPECTS OF CARE

In chapter 5 the women's view of the quality of information provided by workers and the impact of that information in terms of providing increased control were discussed. This section further examines the women's view of the care provided. It draws out additional areas that the women felt were central components of user-centred maternity care.

Continuity of care

The desire for continuous contact with one health worker who would be responsible for the main element of their care was of primary importance for all but two of the women. In response to the question concerning the aspects of maternity care they felt to be the most important, the term continuity of care was spontaneously used by approximately two thirds of the women, suggesting a more detailed knowledge of the issues surrounding maternity care than might previously have been imagined. Throughout the pregnancy, from the first interview onwards, to know the person who would be attending their delivery was of central importance for the majority of the women of who chose either a GP unit of a home delivery. At each interview the desire for continuity of care would be used consistently by these women as a basis for their decision making over key aspects of their care such as the place of birth.

> **Question**. *Why did you choose a GP unit delivery?*
>
> *I didn't really want to have my baby in a hospital where I didn't know anybody and where they didn't know me ...* (Jackie)
>
> *I mean I am aware of not wanting too much intervention but I think the main thing in wanting a GP unit delivery is that I don't want to be in a room full of strangers in my greatest moment.* (Laughing) (Dawn)

Why then did continuity of care and developing a personal relationship with providers hold such a significant place within the women's model of ideal care? An illustration of perhaps the main reason is provided in Sandra' comments below: Continuity of care ante-natally was perceived as enabling her to receive good quality care post-natally at a time when she anticipated needing the greatest support. Thus continuity of care was felt to provide quality care.

> *Like they* (the midwife) *have got to look after you when you come out and you will be at home so it's better to get to know them, 'cos in the weeks to come they will come to know that I am really scared that I won't like and will want to send it back.* (Sandra)

One of the perceptions of the women was that in having continuity of care they would be developing a relationship which would enable the medical practitioners to fully understand and respond appropriately to their needs as individuals.

The provision of 'safe care' was an important feature of the women's definition of ideal maternity care and was also a factor in determining the women's view of the significance of continuity of care. Safety was defined in two ways by the women. Firstly the women desired the acheivement of a good outcome in terms of a healthy baby, and consequently required the detection of factors which indicated any degree of abnormality within their pregnancies or labours. Secondly the majority of women also considered the competence of the health care provider, in that they needed to be assured that the system of maternity care would provide them with safe and competent care. Thus the issue of encapsulating their experience of pregnancy and birth within a form of care which was seen to be safe and thus achieving a positive outcome in terms of their health and their babies was for all women a priority. A common feeling particularly among those women who had some experience of consultant based care within the hospitals, was that being known by the practice and workers, would improve both the safety and quality of the care provided. This view formed part of a general feeling that being known as an individual by health workers would result in the workers caring more for them. With respect to this issue the women displayed an astute awareness of the manner in which the fragmented nature of care in the hospitals prevents the workers from becoming involved in their cases on a personal level.

> *Well I hope that having it at home and with this practice gets you better care than in the hospital ante-natal clinic and labour ward, because here the slightest thing you have felt is noted down and remembered because they know you. Whereas in the hospital you are just one of a faceless thousand and you wait for hours just to see the midwife for a few minutes. Like they know you here, you really feel that they care what happens to you.* (Judith)

Thus one of the women's major criticisms of fragmented care is that it was likely to cause a lowering of the quality of care and thereby increase the risk potential of their experience. In contrast, continuity of care was felt by the women to increase their safety.

Reassurance

Reassurance was seen by many of the women to be a particular feature of maternity care at each stage of their pregnancy, labour and post-natal experience. In particular the ability of workers to provide reassurance was valued by the women as a clear means of establishing the normality of their experience, from their weight in pregnancy to their ability to cope with their baby once born. Confirmation of normality was for the women a key issue in terms of defining the quality of their experience in several key ways.

Reassurance was felt to be supported and maintained what was for many of the women a fragile confidence.

> *It's just reassuring to know that everything is alright just that.* (Sally)

> *Between times you do get worked up and worried about things just little things and then you come here and find out everything is alright.* (Sandra)

The women found the approach and manner of the midwife in these situations provided the information from which choices could be made concerning the appropriate courses of action for them to make. However the evidence from the interviews also suggested that irrespective of the content of the information, whether it conveyed good news or bad, the women still required the information and expressed the view that such information was found to be reassuring. In addition the provision of full information was felt by the women to reinforce their sense of trust in the workers;

> *Like when I had the threatened miscarriage they were really good. They told me everything, what may or may not happen and what would happen in the hospital and that prepared me for it all, even hearing the bad news was good in a funny sort of way. I just thought well I am OK here they are going to be straight with me.* (Karen - post-natal)

Furthermore a connection could be inferred between the degree of reassurance provided and the development of a positive relationship between the midwife and the women; which again illustrates the significance for the women of having continuity of care.

> *Like knowing her* (midwife) *has just given me so much reassurance. Just that really. Just knowing that there is some-body there you can go to and ask about anything, like knowing that there is just one person who you can go to. Like and knowing that she will be there for you in labour, I feel really happy about that.* (Sally)

Most women expressed some sense of apprehension regarding the birth. In common with Nelson (1983), working class women appeared to be more apprehensive than middle class women. However this type of concern and apprehension diminished during the pregnancy and many women were observed to develop increasing confidence concerning the approaching labour. One possible explanation for this was due to the form of relationship they had established with health workers and the open form of communication between the midwife and the women.

She is just friendly she is lovely that midwife isn't she makes you feel right relaxed you know and gives you a bit of confidence.

Question. *Confidence?*

Yeah like you don't feel frightened any more. Because it is pretty frightening in the beginning, like I was frightened about what was going to happen when I had it was it going to be normal, but it just relaxes you when you come to see some-body who is cheerful. Because like I got the nerves bad. (Sally)

Technology and intervention

Essentially the women's approach and views towards the use of technology in their pregnancy centred around two issues. The first related to appropriate rather than routine use of technology, from ante-natal screening to induction to use of forceps and monitoring in labour women felt that their use had to be appropriate to their own individual needs and circumstances rather than being part of a routine procedure. The second was that decisions concerning the use of technology or any form of intervention must involve their participation in the decision making process.

In practice the findings suggest that women also operated with a ranking of the acceptability of a procedure according to its invasiveness and the potential risk associated with the procedure. Thus with the exception of only one woman all agreed without much thought to having the blood test for spina bifida, although the implications of the test were explained fully to the women As Roberts (1984b) notes the traditional dichotomy has been seen as a simplistic choice between two forms of childbirth a natural woman controlled or technological medically managed one.

> "The presence or absence of technology is seen as a crucial difference between the two, since technology confirms the abnormal character of childbirth and both ensures and legitimates the power of the doctor. The absence of technology is seen to facilitate the normalness of childbirth and the power of women to control it." Roberts (1984b)

Over the issue of ante-natal screening, within the medical literature it has been suggested that the use of technology such as ultrasound scanning would alter parents relationship with their unborn child resulting in a change in the cultural approach to both pregnancy and childbirth.Some studies of the impact of ultrasound scanning have suggested that seeing a scan image of a foetus enables women to identify earlier with their unborn child (Oakley 1984)

> "When a mother undergoes ultrasound scanning of the fetus, this seems a great opportunity for her to meet her child socially and in this way, one hopes to view him as a companion abroad rather than as a parasite." (Dewsbury 1980:481)

However, scanning has now become a common place event during ante-natal care which in some hospitals is part of the routine ante-natal processing of all women. As such the management and implementation of the scan is no longer performed by pioneering specialists but instead is a routine standard procedure performed within the hospitals. As such ultra sound scanning as part of the routine procedure will be performed within the same model as all other care. The routineisation of the procedure has resulted in the scanning being administered in a depersonalised and uninformative manner, the special care and attention that formed the basis of the approach to scanning when it was an innovative and pioneering treatment has therefore been removed with it's routine application.

> *Not being able to see the screen was bad as well because all the way through I had been able to ask any questions that I wanted, my body had been mine own. If Jean is doing anything she will explain everything before she does it . After a while they did say did I want to see the baby. I wouldn't' say it was a wonderful experience because you can't see much on the screen it's all a messy blur. Jean tells you more from feeling the baby, I got more of a feeling of a baby than I did from the scan.* (Elaine)

> *I got about 30 seconds to look at this baby that is supposed to be mine you know and it is supposed to be an exciting experience and I had looked forward to it for ages as people had said 'wait till you see it on the scan. But I felt disappointed that I had only that amount of time I didn't want to ask a load of questions. I just wanted to look at it.* (Sandra)

Thus the form of relationship between provider and user was found to have implications for the use of technology in childbirth. The main impact was that the women felt enabled to make use of technology and forms of intervention, when they defined the need. Many of the women they felt because of their trust in their midwife they felt able to consider the various merits of intervention without being predominantly concerned with preventing routine or inappropriate use of such intervention. Thus the womens' concern about the use of technology was not so much about the intervention and the technology itself instead the women were concerned about the context within which it would be applied to them, a context they felt they needed to have control over.

> *I think getting to know Jean really it is a question of trust because I now feel that if she uses those things it is because she sees it as absolutely necessary and she doesn't do it as a routine, previously I was concerned that because I didn't know the person they would routinely do things without considering my view. Whereas I don't think that would happen now, as I don't think she would do things without considering my view , my view before hand and my view at the time. So that has made me less fervent as time has gone on whereas others at the classes have been made to be more fervent because they have to be, like some have said they can't stand it and are only staying in the bare minimum that sort of thing.* (Julie - home birth)

As one woman who had used pethidine stated:

> *Well I just got stuck, I was completely exhausted, and I had really lost it I just felt locked into this pain it is hard to describe. Alison said look I know you didn't want pain relief but I think a small amount of pethidinewill help you over that block and it did really help. (Patricia- post-natal)*

Thus overall the women felt empowered as they felt they had established through the relationship the workers at the practices and particulary the midwives a greater degree of control over the technology surrounding pregnancy.

Choice - The example of the place of birth

One of the most important choices pregnant women make which is fundamental in determining the management of their pregnancy and the form of experience that they will have is the choice over where to have their baby.

> *"Frequently within general practice when a woman visits her doctor for the first time after becoming pregnant, the GP will simply book her for the nearest consultant unit, and in some enlightened cases a choice would be offered between different consultant units or shared care,* (Beech 1986)

Prior to their contact with the practices very few women were aware of their rights with regard to choice in maternity care in fact the majority of women interviewed were unaware that they had any rights at all. While one woman who had desperately wanted a home birth nearly failed to obtain one due to the lack information provided by her own GP. In common with many of the women being able to exercise choices was a radical departure from the form of health care they had as women previously experienced and had been socialised to expect.

> *Well the first time I went she said* (Own GP) *well I will book you for the Jessops you are having your baby in the hospital So I wasn't given any choice at all. She just said that's the way it is going to be.*
> *I mean I am still surprised, when it comes down to it to get a home birth. I thought you had to just do what they said.* (Elaine)

The dominance and success of the medical profession as controllers over women's lives is dramatically revealed in Elaine's belief that,*you had to do what they said*, which is made even more poignant by the fact that such a view proved to be a common feature of the women's' accounts. The researcher also had frequent experience of this phenomenon in social discussions concerning the research, in that few people believed that women would be **allowed** to have their first child at home. This illustrates the success of the medical profession as the new moral controllers of women's lives, in that few women would have questioned the right and authority of the medical profession to exert such control unless they had been allied by professionals within the system. The working class women interviewed in particular, were found to possess less knowledge of their

rights and tended to express the belief that they had to accede to medical authority in their lives. Although to all intense and purposes the working class women were also very likely to be expressing fact, that in many areas of their lives such as over reproductive health they have no alternative as the medical profession controls their access and usage of services.

Certain elements in terms of care provision were found to be dominant factors in causing the women to opt for a particular place of birth. As already noted continuity of care and particularly having a worker who they knew with them during labour were such factors. As these were felt to be the best way to access good quality support during labour - which was a priority for all the women. In addition, the issue of safety was a feature of all the womens choices irrespective of where they chose to have their baby.

Home Birth and GP Unit

Several key factors emerged as causing women to opt for a home birth. A significant and surprising factor in their choice for a home birth was that contact or awareness of the natural childbirth movement was only explicitly mentioned by two of the women in choosing a home birth. Firstly, many of the women who opted for a home birth feared the restrictions and loss of control that would be imposed on them within the hospital system. Women felt within their own environment they would be able to maintain control.

> *In my own home I can do what I like, I can give birth virtually how I want I don't have to lay on my back ... No one is going to be able to make me. I want to do what ever I have to do to get through, I want that freedom, it's how I have always felt.* (Jill)

> *Well (in hospital) I think if you are surrounded by a big group of people, they are all going to be making decisions and you aren't going to have any say in what is going on and you will be just strapped up there.* (Daphine)

Secondly, in contrast with the medical vision of hospital comprising the safest place for birth, many women, in opting for a home birth expressed the view that care within the hospital was actually of an inferior quality to the care provided in the community and a home birth. Having a worker with them who knew them and was familiar with the progress of their pregnancy was felt to enhance their sense of security regarding labour. For some of the women this belief emerged as a direct result of their contact with the hospital.

Question. Why did you change to the GP unit?

> *Well at the hospital any worries I had were just not dealt with at all in any way and some-times I came out feeling quite upset. Like over my back pain I had asked my sister first and she said it could be because the baby was lying on a nerve so I asked the doctor at the hospital, and he asked the midwife and they said it could just be my muscle and they were umming and arring around and then I said well my sister said it could be because the baby was lying on a nerve and they went yes that's it then. I thought blimey, I could have said anything and they would have agreed and I could see the midwife was embarrassed but she couldn't question the doctor and I could see he wasn't going to ask any-one else , so Ithought well I am not having me and my baby having this sort of care it isn't safe. I thought well I might as well not be getting any ante-natal care it is just rubbish. So I didn't go back there.* (Catherine)

There was remarkably little difference in views concerning safety between women who opted for the GP unit or home birth. The reasons for opting for a GP unit delivery over a home birth tended to be social in origin, such as feeling their home was unsuitable for a home birth, eg. they lived in rented accommodation, in a shared house or with their parents. For a few of the women having the availability of the full range of obstetric care provided an added sense of security which should not be under played. For these women the GP unit provided an important way to access continuity of care, and as natural a birth as possible, whilst retaining the option of readily available intervention in an emergency.

Hospital birth

In opting for a hospital birth, again the issues of safety and support were paramount. Women felt that in hospital they would access safe care. In addition many of the women who wanted a hospital delivery did so because they wanted an epidural. However, those who opted for a hospital delivery were a minority (see Chapter 3).

Working class women and Choice

A commonly espoused view concerning consumer dissatisfaction with maternity care provision is that such women are unrepresentative of the majority, and that only a few middle class women would be interested in natural childbirth. The findings of this research contradict this view, certainly the workers did not perceive the form of care they offered to be exclusively meeting the needs of middle-class women.

> *One of the things that the consultants are always saying to me at the Jessops is that only women who want home births or natural childbirth are middle class, left wing women, CND-supporting vegetarians and that the majority of ordinary women would be horrified at the thought, let alone actually wanting a home birth but one of the things that I find is that, that just isn't true and that very few of the women I get fit into anything like that view.* (Midwife - Jean)

For the working class women the structures of their working environment and generally weak position within the labour market of themselves and their families was a major source of problems. Severe material constraints on their lifestyle, diets and housing conditions restricts their choice over care and their access to services within the health care system (Graham 1984).

Choice was restricted in terms of place of delivery in that although choice over place of delivery existed in theory many of the women in the flats felt that the restrictions of their living conditions limited the choice.

> *Well I would have liked a home birth. Like once Alison* (Midwife) *said about it and all and I knew I were allowed. If anything were to go wrong, I know how long the ambulances take to get here, and coming down stairs, is just no good. But if I lived like in the houses I would have liked it.* (Francis)

Working class women were also likely to face hostility from relatives and friends if they choose to do anything which did not conform to local norms, one woman who had opted for a home birth was being harassed by her family who opposed her decision.

> **Question.** Are you getting any help or advice from your family? Or mum?
>
> (Laughs a little) *No, we aren't speaking. They keep ringing up and coming round saying I am stupid and the baby is going to suffer. John had to tell them not to come round any more. So we don't talk to them.*
>
> **Question.** Why don't they want you to have a home birth?
>
> *They just want me to go into hospital and have it like all my cousins they think I am being stupid.* (Daphine - Interview 1)

Women's Experiences in Labour

While not attempting to draw a simple a simple division between the findings from womens experience do tend to indicate just such a dichotomy - in terms of unmet need in the hospital. Some of the womens experiences of labour at home or in the GP unit have already been documented in the thesis so far. It is useful at this point to provide a brief comparison between women who experienced these forms of care during labour and those who delivered in the hospital. The three main differences to note are those of safety, support and information.

From the few women who delivered in hospital their experience did not always indicate the primacy of safe care which they expected.

> *You just didn't feel that they checked to see if anything they were doing was right ...When he was born they fussed about him and kind of forgot about me then one of the nurses said 'I can hear dripping has someone left a tap on?' and she turned round and there was blood everywhere and all I can remember was them rushing around me ...* (Sarah)

By contrast, the indications from the women who had home or GP unit births was of a careful attention to their needs which resulted in a greater feeling of safety and security. The simple fact that no woman at home or in the GP unit was left on her own forms a sharp contrast with the experience of those who delivered in hospital.

Within the hospital not only is the care fragmented preventing the development of a positive equal relationship between staff and women, women are not individuals situated within a social context but instead work objects who are processed by the system (Stacey 1976). Within such a context it is no longer necessary to provide a full explanations and choice as they will not be seen to be required by the work object (Kirkham 1987). Thus women's accounts of the hospital consisted of unvoiced dissatisfaction, hospital workers were polite and pleasant but did not meet their needs.

> *They were quite pleasant it was just that they never sat down and explained what was happening or what might happen and I was crying out for information, but wasn't able at that time to say so.* (Charlotte 2nd time mother)

> ***Question.*** *Did they make you lie down?*
>
> *No, they didn't make me, they suggested, that I did.* (her emphasis) *It was more subtle than making me. I actually think they didn't know any better, because they were very nice. But then people just sort of came and went you didn't have that special one to one relationship.* (Zoe - 2nd time)

Overall, the most significant difference in the accounts of women who experienced home births vs hospital births was the degree of social and emotional support offered to them by the providers of care. In the case of the homebirths in the study, women stated that they were given comfort when they needed it. Practical remedies were used in conjunction with caring and support which were the central features of the management of labour and childbirth.

> **Question.** *How much did the people who looked after you help you in labour?*
>
> *... after a while the pains got quite bad and Jean (Midwife) suggested that I lie in the bath for a while. So she ran me a bath and I sat in that. I felt that I didn't want to be alone at that stage, so we all sat in the bathroom and chatted. I was quite funny really. After that Jean rubbed my back for ages. ... After she was born, Jean gave me a bed bath and I felt really special. We all had a glass of fizzy wine, because it was Christmas. And then everyone went home and we got some sleep.* (Judith - Post Natal - Home birth)

By contrast, the response to labour in hospital was very mechanistic. Thus rather than a bath being used as means to relax a woman, in conjunction with support from the providers of care it becomes the sole response.

> *... at four o'clock I couldn't stand it any more and had to walk down the corridor, because there was no one about. So I found these two nurses in this little office and I said I was in pain, and they were coming every three minutes. They said 'Oh go and have a bath, you will be alright'. I said 'I am frightened, I am terrified'. I said 'I am really frightened', and they said 'Oh, you will be alright, just go and have a bath - you will be alright'. So I laid in the bath for a while - I was worse. And I kept telling them, and they just didn't do anything at all. I thought they would have a bit more feeling than that, I thought they would care. But they don't. It's just a job to them.* (Francis - Post Natal - Hospital Delivery)

A final point worth noting was the sense of shared solidarity and support women gave to each other in the hospital setting: unable to gain the support they needed from the hospital staff one woman was able to gain it from another woman in labour.

> *Like the only person who helped me was the woman in the next bed. I couldn't relax because I was so frightened. Like, she was holding my hand and saying now don't forget to do your breathing and calm down and telling me how to do it, and she was holding my hand and saying now don't forget to do your breathing and calm down and stuff and she carried on doing that even when they drew the curtains around to see to her. I will never forget what she did, never, never, but it weren't her job to help me was it? Because she was in a bad way herself.* (Francis - Post Natal - Hospital Delivery)

The midwife-woman relationship

This penultimate section draws together the feature that the women identifed as core components of their positive relationship with the midwife.

The workers chapter detailed the midwives rejection of the traditional distance of the unemotional and uninvolved professional. The midwives identified their role definition and status as coming from the users themselves rather than from a professional authority which is supported in terms of a power relationship. In terms of their relationship with the women the midwives were observed to break down professional barriers in several key ways. If the midwives stated they adopted the role of a 'friend with knowledge' the women recognised this alternative approach to traditional user and worker relationships and clearly felt that the midwife understood their needs and empathised with them. The women recognised in their relationship with the midwife a personal commitment to them by the midwife and significantly this role constituted for the women one of the aspects of their care provision which they valued most.

Question: *You have said you preferred the midwife, what is it about the midwife that you liked?*

Oh attitude. Jean (Midwife) *loves babies. I think she loves women who have babies. She will put her arm around you or pat your arm that sort of thing. Like when I cried my eyes out because I had to go into hospital, she was like a friend - really nice.* (Jill)

This personal commitment was displayed in two ways. Firstly, the midwives were frequently observed to touch and comfort the women during times of distress. Physical contact as a means of comfort or an expression of sympathy with the woman was one of the ways the midwives displayed a rejection of the role of an unemotional uninvolved professional. Secondly, this personal commitment resulted in the need on occasion for direct confrontation between the midwives and medical practitioners of the hospital system, (this issue is further explored in chapter 6) Thus the women felt that the midwife had the role of an advocate, in that they would be prepared to defend the women's interests in situations where they would be unable to, do so.

What was really good was the way Jean and Moria (another community midwife) put themselves on the line for me they both came in with me. When I knew that the hospital midwives could get at them for that. (Belinda - Post Natal)

I was really pleased with Alison (Midwife). *Like one point the hospital sister, she was nice, but she had a very different approach to all the others- like she was saying to me, "I think you would be much more comfortable on the bed dear" and I kept saying "but I don't want to go onto the bed" and she was going "well I really do think you would be more comfortable on the bed dear" and Alison said to her each time, "I think that Janet wants to manage it her own way and that we should let her". I remember feeling that it was alright because she would support me and that felt really nice.* (Janet - Post Natal)

One of the aspects women valued relates to the midwives perceptions of pregnancy. For the majority of the women although going through pregnancy with a wanted child, many felt the need for their pregnancy to be seen as a positive event by their health care providers. They welcomed the midwives support for what they were doing as an affirmation of the positive aspects of their choice to have a child. The attitude of the midwife towards pregnancy, was felt by many of the women to have enhanced their sense of going through a unique and positive experience.

Midwife - Alison: *Have you ever been pregnant before at all?*
Sue: *No.* (Smiling)
Midwife: *So this is your first baby? Oh lovely.*

Sue To researcher after clinic. *She* (Midwife) *is nice isn't she I felt that she was really pleased for you. Really pleased.*

Macintyre (1976, 1977) found that health professionals tended to apply a simplistic and moralistic single/married distinction to identify problematic pregnancies, with reproduction being regarded as "natural, normal and instinctive for married women but not for unmarried" (Macintyre 1976:176). Furthermore Macintyre found that hardly any account was taken of the women's interpretation of their situation.
The midwives and GPs at the practices were observed to elicit the women's definition of their pregnancy during the first ante-natal encounter and to adopt that as a basis for responding to the women's pregnancy.

> **Question:** Did you feel that the staff treated you differently because you are single?
>
> *No. She was just nice, I was a bit worried that they might be a bit off really with me being single. But they weren't at all they just made you feel really good about it.* (Brenda)

Overall the midwives actions were interpreted by the women as being non-judgemental towards their situation. None of the women felt that the midwife acted in a manner which implied criticisms of their lifestyle. For Belinda another single parent, the supportive positive response from the midwife towards her single parenthood was felt to a valuable element of her care which functioned to enhance her confidence.

> *Oh Jean* (Midwife) *was really good, people tend to think because you are on your own that you have been dumped, they never think that I might have actually wanted her. But Jean wasn't like that she never ever said anything like that. They were all good at the surgery, there was none of this Miss Rother which I got at the hospital, I was just Belinda and she was Jean. It was a boost really.* (Belinda - Post Natal)
>
> *Well she was just really nice and encouraging, nothing specific, she makes a lot of you, which she probably does for every woman that goes into that room but that doesn't matter she just makes you feel good and I probably needed that more than most with being on my own.* (Claire)

One further indication of the positive relationship that existed between the women and the workers was the role humour played in their interactions. Oakley (1980) noted that humour in interactions between male medical providers and female users functioned as a means of effectively blocking communication. in terms of the provision of reassurance humour was found to be a constant feature of the interactions between the midwives and the women. Humour in the interactions between women and workers at the practices was contrast to the form was a constant feature of those interactions and was observed to be used as a means of diffusing tension or anxiety.

Finally, a key element of the women's response to the midwife can be interpreted as having a high degree of trust in the midwife.

Oh attitude - you know how every-woman has a mother well it is like she is your own, it is hard to say but you really trust her. (Jill)

... like she would make you feel really special. You could trust her. (Sarah)

The relationship between midwife and the women was demonstrated earlier in chapter 5 to have a positive impact on degree of control the women were able to exercise over the processes of reproduction, through the provision of information. Here again a relationship of trust between the women and midwife was demonstrated to possess important implications for the degree of control the women possessed.
Firstly, the relationship provided important coping mechanisms for the women.

Question: *What got you through that pain?*

Oh the midwife. Focussing on her and keeping eye contact with her, because I knew that if she was happy then everything was alright. (Ann)

The second issue relates to the way the midwives approach giving advice to the women. The boundaries of the provider and user relationship within the medical model, are set very much by the professionals authority over the patient. Particularly in vulnerable circumstances such as labour or the early post-natal period the woman within the medical model is almost entirely alone within the system stripped (literally) of both her ordinary social networks support and own her own individual identity she is almost entirely dependant on her medical attendants for support. As a result women's self confidence and esteem particularly in labour and during the early post-natal period can easily be undermined by professional pronouncements on their ability to cope (Kirkham 1987). Thus professionals to support and maintain a woman's sense of control need to exercise considerable awareness of their power over women. From the women's accounts the midwives were not perceived by the women as undermining their status or authority as parents, but as complimentary and supportive to their role.

Like afterwards she was really good, like she really gave me confidence with him (baby) *Like she would always come in and say, "Oh you are doing really well". No matter what it was and that would make you feel really good.* (Elaine post-natal)

There was never any time when you felt she told you what to do. Like bathing her (baby) *Sue came in and did it with us so when we did it on out own, we knew we were doing alright. You never felt that you were being shown anything or that she was taking over.* (Cheryl post-natal)

Finally one last point relates to the womens role in the relationship: Changing working practices and traditional relationships between users and providers is not only challenging for the workers, it also challenges accepted and established roles and relationship for the women. In order for women to possess control over their reproductive lives it

necessitates not only that providers cease to exercise professional dominance but also that women are no longer passive but active agents in the decision making process.
As Bromberg (1981) there is comfort in the paternalistic father figure of the doctor, despite the unequal power relationship, the image of the omnipotent caring professional is a very powerful one even when reality conflicts with that image. This challenge was explicitly acknowldeged by one woman. However ultimately she found the challenge to be something which enhanced her positive feelings about her care. The extent to which other women find this so is something that requires further research.

> **Question**. *Why did you say that this practice was very different from your last one?*
>
> *The attitudes , the general consideration for peoples feelings and thoughts the shared decision making. It is actually all a bit daunting at first, because it is so different to every where else, it is so unusual to everywhere else. That you have to think oh I have to make the decision now. That is really daunting at first , but it is also very reassuring.* (Judith)

The negative views and limits of the practices

Chapter 5 and chapter 6 noted the limits to the workers ability to provide the women with control over their care. The discussion identified the degree to which the workers felt they had to offer some appeasement to the hospital and medical definitions of risk over who could have home or GP unit deliveries. In addition the manner in which the GPs tended to opt to retain ultimate control over the definition of acceptable risk was highlighted. This sub-section focuses on the women's perception of this, through a discussion of the experience of those women who were directly affected by these process.
This section illustrates the dissatisfaction that was caused by the breaking down of the joint partnership between provider and user. This conflict was manifested over several related but separate issues: Firstly conflict occurred through the reassertion of professional dominance in the relationship by the GP defining the extent of the womens risk . The women in such situations clearly felt that their control and involvement in the decision making process had been suspended.

> **Question**: *How do you feel about having to change to the Hospital?*
>
> *Like they don't do twins or breech deliveries at home or in the GP unit, and I was thinking about that and it is wrong very wrong of them to make that rule. Because that is it, you get no choice.* (Daphine)

Furthermore as Daphine went on to state this suggested a lack of commitment to the whole process of enabling women to exercise control and choice over the direction of her maternity care; because ultimately 'they did not believe in it"

Question: *What about the safety argument?*

Well I don't believe that because Odent delivers twins and breeches it was on that video, and he has never had any problem. I don't think that is it, because the GP unit should be alright, it is like they do home births and all this stuff but they don't really believe in them. (Daphine post-natal)

Question: *Do you feel that you made the right decision ultimately to have a home birth?*

Absolutely. I said to Caroline (GP) *afterwards 'well my aged uterus worked alright didn't it?' and she just looked.* (Claire)

Finally the situation of Maggie[1] illustrates the difference between the GPs and the women's view in terms of the nature of a good outcome.

Question. *As you had to be transferred in labour did you feel that you would have preferred to have gone to the consultant unit straight away?*

No actually I was really, really pleased that I had had a go and the first stage had been so nice, and I was transferred really late so I feel that really I had the best of it and that had been really nice. (Maggie)

This contrasts with GPs perception that they had 'got their fingers burnt' by allowing a woman who had ultimately needed transferring to be booked for a GP unit delivery. In expressing such a view the GP did not take any account of the woman's definition of the situation but instead acceded to the medical definition held by the hospital and accepted that Maggie's labour should have been defined as abnormal from the beginning. Maggie however did not adopt such a view, to her the labour had proceeded normally and had only become abnormal at the point of transfer from the GP unit. The early stages of her labour she had defined as normal and had as a result been appropriately responded to through spending the early stages of her labour in the GP unit.

The significance of these instances while not being typical of the nature of the interactions between the users and providers at the practices is that they illustrate the boundaries of the model of care provided and the points at which the model acquiesces to the medical model.

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1. The background to this situation is detailed in chapter 5.

Conclusion

Overall the perceptions of the women towards the care provided at the practices were highly supportive of both the structure of the care provided and their role within the provision of that care.

In terms of the role of the workers, the majority of women felt that women workers were more likely to provide an appropriate response than a male worker. The women tended to express the view that this likely-hood of a more positive response from other women was grounded in knowledge which stemmed from a shared biology and a sensitivity which emerged from shared experiences.

In terms of their priorities for care, the women essentially valued the same core components that the workers had prioritised as essential features of their care in chapter 4, such as continuity of care. In addition the women valued the impact of the care on their feelings about their pregnancy, thus the women felt that the form of care provided at the practice gave them considerable confidence and reassurance.

However the most appropriate worker the women identified to provide that care was the midwife. The women felt that it was the midwife who possessed the skills and expertise to constitute the main providers of care. Thus the definition for maternity care provision held by the women was ultimately quite restrictive in terms of the appropriate parameters they ascribed to the doctors role.

CHAPTER EIGHT - CONCLUSION

There are two sections to this chapter. The first highlights the central findings of the thesis. In the second section areas for future research are discussed.

The first section is not intended to provide a summary of the main conclusions in each chapter. Instead this chapter aims to provide the reader with an indication of the most significant findings - the substantive core of the research.

SECTION ONE - A USER CENTRED MODEL

> "It is these four issues, what is the nature and context of reproduction, how is success measured and how is it controlled that lie at the heart of the conflict between mothers' and doctors' frames of reference." (Graham and Oakley 1981:52)

The starting point of the analysis presented in this thesis was an identification of the workers' ideological perspective or 'frame of reference' (Graham and Oakley 1981); that is, the values and attitudes towards pregnancy and maternity care held by the midwives and GPs and to a lesser extent the practice nurses. The aim was to identify the nature of the frame of reference held by workers who were attempting to construct an alternative form of care to the medical model. This provided an opportunity to 'test out' the concept that such workers would possess a frame of reference towards both women and the provision of maternity care which would prove to be fundamentally different from that of the medical model. As a result, detailed consideration was given to depicting the core components of their frame of reference.

1. Core Components

1.1 View of Women

Working within the field of women's health was ascribed a high status by the workers at the practices. In opposition to the biomedical view and the patriarchal culture within which health care to women is delivered, the workers felt that the predominantly woman-focused nature of their working environment formed one of the most positive aspects of their work.

1.2 Women and their context

Within the medicalised model of maternity care, pregnancy and labour are removed from any sense of being embedded in the woman's social context; the woman is defined solely in terms of her status as a pregnant patient (Oakley 1980). However, the workers at the

practices expressed a commitment to constructing the definition of each woman's need based on a 'whole person assessment.' The development of an understanding of the way her pregnancy fitted into her social and working context was identified by the workers as constituting a necessary prerequisite in order to respond to women's needs in an appropriate and individualised manner.

1.3 View of reproduction

Within the frame of reference held by the midwives and GPs, pregnancy was perceived as a natural event akin to any other physiological process, in which their role as care providers should be to act as facilitators supporting and assisting the natural process of birth and labour. As a result of this definition of pregnancy and childbirth, two effects were found.

Firstly, the adoption of a sick role by pregnant and labouring women was seen as inappropriate; the standard against which normality or abnormality is defined was that of other pregnant women. Secondly, associated with this, intervention was seen as a last resort, whose application is only justifiable in situations of abnormality.

In addition, the workers expressed a rejection of the medical model's dichotomy separating woman and foetus. Within the workers' model the needs of the woman and the needs of the foetus were perceived as being inextricably linked.

1.4 Reproductive Success

Within the model of user-centred care held by the midwives, the criteria for a successful outcome were constructed from a broad range of factors, including an assessment of the emotional and psychological experience of the woman.

However, although the GPs articulated the same ideological commitment to normality and advocated the same broadly defined criteria for reproductive success as the midwives, as GPs they felt that, the practical implementation was far more problematic. The constraint was felt to stem from within their training and professional philosophy which unlike midwifery was orientated towards the pathological rather than the normal. This issue of professional constraints on the GPs was found to underpin much of the interaction between the GPs and the women and is explored further in a later sub-section of this chapter.

1.5 Expertise

The medical frame of reference asserts the dominance of medical knowledge and skills over all other forms of expertise. This necessitates that women's expertise, knowledge and abilities are systematically devalued. However, within the model adopted by the workers and the midwives in particular, the construction of expertise was felt to be a two-

way process in which both health worker and user were perceived as contributing to the growth of their knowledge concerning the experience of reproduction.

2. Priorities

Following from the analysis of the components of the workers' frame of reference, certain key priorities of maternity care could be taken to be derived from their ideological perspective. These were felt by the workers to constitute the basis for the most appropriate organisation of care which would meet women's needs.

2.1 Rejection of task centred care

Within the approach identified at the practices, the status ascribed to different aspects of care suggested a different set of priorities to those which have been found to operate within the medical model. In particular the 'medical hierarchy of tasks' were found to be reversed, in that the relative value of the different aspects of care was defined in terms their potential orientation to meeting the needs of users' in a holistic manner, such as responding to the woman's needs for comprehensive information, and providing support. Furthermore, incorporation of the woman's self defined needs was felt to constitute a central element of any acceptable model of care delivery.

2.2 Flexibility

One of the measures used by the midwives to judge the quality of their midwifery practice was their perceived ability to respond to women in a flexible and open manner. Rigid, set responses were felt to deny the uniqueness of each woman's labour and individualised experience.

2.3 Choice and Control

Overall, the workers' view of their role in the provision of choice to women was defined as one of facilitating increased user choice.

The devolving of decision making to women users as a means of enabling them to exercise greater control over their own pregnancy and labour was felt by the workers to form a central feature of their model. Information in the workers model was seen as functioning to expand the woman's knowledge base.

The findings from this research also suggests that the workers are involved in facilitating and maintaining the role of the user as a co-participant in the interaction.

2.4 Empowerment

Related to the workers' view that a part of their role was to facilitate user choice and control over their health care was the issue of empowerment. A commitment was

expressed towards adopting a policy which would enable women themselves to prioritise aspects of the management of their own health care. Providing women with the knowledge of how to obtain the service they as users wanted was seen by the workers as a legitimate part of their practice.

3. The Midwives' Approach - The midwifery model

The midwives' definition of the most appropriate role to adopt in caring for a woman in labour was found to be associated with their view of pregnancy and birth as consisting of a natural process rather than a pathological condition. For the midwives a central element of sound midwifery practice was providing a means of supporting a woman in labour in as passive and non-directive way as possible. Technological or medical intervention were seen within this midwifery model as having a role only in the management of abnormality.

Thus the midwives held a different conceptual model of pregnancy and of women's health needs from the medical model. Among the midwives interviewed, this results in their clinical practice being founded upon a series of core convictions which can be divided into three distinct areas of reference. The first is concerned with the midwife's perception of the function of the role of midwifery. The midwives all implicitly rejected the role of *the expert* in matters relating to pregnancy and childbirth in their interactions with women. Instead, their specialist knowledge was given equal weighting with the women's own experience and knowledge. The midwives founded their relationship with the women on a status which came from their friendship and rapport with the women, rather than on one based on detached professional authority. Their practice was based on the traditional *with-woman role* of the midwife. Associated with this rejection of a clinical practice based on professional codes of practice is the view held by the midwives that they did not feel bound to actively manage or control the situation in order to justify their presence. Thus the midwives' worth came from the women's definitions of their value; if for example, women value moral support and physical comfort more than the ability to manage pain in a more technological manner, that is sufficient to affirm the value of her role.

Linked to the midwives' view of their professional role is the second aspect from which the midwives construct their clinical practice - this is concerned with the frame of reference they hold of pregnancy and their view of women as users of the service. The fact that the midwives did not adopt a professionally based criterion for their expertise resulted in the development of a very different relationship with women. This involved a recognition of a body of knowledge which came from the users' experience which the midwives then incorporated into their practice. The midwives also asserted that women possess fundamental rights over their health care and bodies. The most important of

these was seen to be the right to make informed choices and decisions concerning the management of their health care.

Finally, within the midwifery model, pregnancy and childbirth are seen as natural events and women are believed to have the ability to labour naturally. A direct consequence of this is that the midwifery model is founded on a lack of interference in the natural processes of pregnancy.

A significant influence on the midwives was the character of the tradition of midwifery, which is best encapsulated in the literal 'with-woman' definition of the midwife. For the midwives, a user-centred frame of reference, which involved empathising with the women, was perceived as something which was intrinsic to the traditional practice of midwifery. Identification and solidarity with the women was felt by the midwives to form a natural constituent of midwifery practice.

Thus one of the central findings of the research was the existence of a normative model held by a group of female workers and notably the midwives, for the provision of health care to women which was opposed to the medical model.

4. The Nature of the Model and the Contribution to the Sociology of Maternity Care:

This next sub-section details the nature of the model of care identified by the research and discusses the contribution of the work to the development of the sociology of maternity care. In particular, this section considers how far the research develops and challenges the perspectives in which it is grounded.

Graham and Oakley's (1981) analysis of the medical frame of reference identified women's and providers' approaches to maternity care as consisting of diametrically opposed models. An analogy would be that of two circles on a page, one circle representing the medical model held by providers and the other the model held by pregnant women. Within the situation of conflict Graham and Oakley identified, the circles are at opposite ends of the page. The attempt at providing user-centred care documented throughout this thesis could be interpreted as having moved the two circles from that extreme position of conflict, to the point where considerable convergence occurs between the models held by the three main parties is indicated (GPs, midwives and women). All the parties, women, GPs and midwives were found to subscribe to common sets of attitudes and values concerning the core components of the structure of user-centred maternity care. The importance of certain fundamentals of care such as, continuity, access to information and the importance of a positive relationship between provider and user were agreed by all parties. Thus in terms of the women's view the workers' approach towards care provision was largely vindicated. The significance of the care for the women was that in certain key ways it was structured to facilitate and

reinforce the users' involvement in the decision-making process. In the past, as noted in chapter one, feminist analysis has tended to focus on the patriarchal nature of the health system in preventing women from exercising any measure of control over their own health care. This study has in part provided an extension to that analysis by considering the impact of women's active participation in the provision of maternity care. The theoretical work of the thesis has therefore presented a model of service provision which enables and fosters the empowerment of service users.

In addition women users in the main also advocated care provided by female practitioners. Female users tended to express the view that women workers possessed by virtue of a shared biology and shared gender experiences a more empathetic approach to the provision of care than male workers. The findings also indicated that, women felt that midwives possessed the relevant skills and expertise to constitute the main providers of care. Midwives were identified by the women as largely holding the same beliefs concerning pregnancy and labour and as demonstrating a consistently similar view to them concerning the most appropriate management of pregnancy and labour. Thus to return to the analogy of the models of women and workers within the user-centred approach as consisting of overlapping or converging circles; the greatest degree of overlap was found between the midwives' and the women. Furthermore, that was taken to the point where midwives and women's perspectives on pregnancy could be said to operate almost within the same frame of reference. Thus overall, this research presents an alternative view to that of the strict dichotomy between user and provider which was indicated within the feminist work on medicalised maternity care within the hospital that was carried out in the early 1980's. The findings presented in this thesis through the analysis of the components of the alternative model of care, provides a theoretical framework which indicates the mechanisms through which convergence rather than competition between users and providers definitions becomes possible.

In terms of the role of the GP, the model of maternity care held by the women was quite restrictive concerning the appropriate parameters of the GPs role. Instead of being seen as the central provider of care assisted by several handmaidens, the GP was seen by the women as a technician with some value as a supporter or aide to the midwife but certainly only one member of the decision making team, and a largely peripheral one at that.

However, conflict was not found to have been entirely removed with some divergence occurring between the women and the workers, and notably between the GPs and the women, over the maintenance of the definition of normality in situations which are medically defined as being associated with higher degrees of risk, such as breech births. Ultimately the GPs attempted to retain the right to define the boundaries of the woman's risk-taking. Thus conflict between women and providers occurred at the

boundaries of the workers' model centred around the points at which the workers models overlap with the medical model. The intensity of conflict was therefore greater between the GPs and the women than between the midwives and the women by virtue of the formers' higher degree of conformity with the medical model. Thus although the form of care provided was not found to have completely excluded the potential for conflict, within the model of care conflict no longer constituted the central feature of the interaction between provider and user. Instead conflict is interpreted as having been marginalised, and has become a peripheral rather than a central feature.

The model identified by this research therefore rejects the simplistic feminist or even liberal feminist assumptions about the nature of women's role as providers of health care to women; and in particular that women health workers' will automatically provide women with a more sensitive and responsive form of maternity care. The research identified certain key mechanisms through which women workers may be constrained and socialised into a more medicalised form of care provision. Thus it seems likely that as Dale and Foster (1986) have argued, it is problematic even for women health workers committed to providing user centred care to meet the ***most*** radical demands from women. Within the provision of maternity care entrenched professionally-based modes of interaction may function to prevent women users and members of the medical profession from achieving a truly equal relationship. In addition attempts to demedicalise childbirth may also falter on the stumbling block of safety and risk-taking, as Peterson (1983:281) argues the "unequivocal cultural demand for medical safety in childbirth may indeed lead to co-optation."

However despite these constraints the findings also indicate that the nature of the care provided constitutes more than just a tentative attempt to demedicalise childbirth, resulting only in a more humanised care orientated towards acceptance of medical authority. Support for this claim comes from the overall high degree of convergence that was found between the priorities for care held by both the women and the workers - particularly the midwives - in addition to the degree to which the care was found to empower the women to exercise greater control.

Overall the frame of reference held by the workers could be said to possesses a potential to create and implement innovative practices and policies which are sufficiently divorced from the patriarchal nature of medicalised reproductive and maternity care to alter the form of this care provision for women. Through the inclusion and analysis of the role women practitioners play the research shows the way women and women-dominated professions can act as innovators within organisations, thereby addressing a gap in feminist health research which in the past has tended to focus on the mechanisms of subordination.

SECTION TWO - THE FUTURE

The research presented in this thesis highlights a number of areas which are likely to be worthy of further and more detailed exploration.

Firstly, the thesis did not aim to comprehensively analysis or address a number of areas which could usefully be considered by further work. These would be likely to include:

1. An exploration of the policy implications of the model of maternity care detailed in the thesis. The findings from the research could have important implications for the resourcing, organisation and training of labour power within the Primary Health Care Sector which could be addressed. Similarly a project could undertake to construct a policy model for the delivery of health care to women which would be appropriate to meet women's needs.
2. Further work could also be undertaken to explore the relevance of the model to a more broadly based sample of women users, particularly women from ethnic minorities.

Secondly, within any research project it is almost invariably the case that some interesting data are not employed in the final presentation of the findings. Further analysis of the data supported by follow-up projects could be one means of discussing the issues raised by such data. In particular there were several issues for which the data provided only very short intriguing vignettes which were not comprehensive enough to draw out a detailed analysis from; the needs of lesbian women and mothers and issues surrounding pain in childbirth were two such issues

Finally, specific projects arising from the findings could address the following issues:

1. Further research could usefully explore the possible extension of the analysis - In particular, the relevance of the user-centred model of care identified in this research as a basis for the provision of women's reproductive health care, beyond the area of maternity care could be undertaken.
2. The role of nurses within the PHC team as providers of health care for women. In conducting this research it became apparent from the analysis of the interview data from the health workers and women users that there was a need to further evaluate

the relationship between women users and other women health workers. In particular the role of the practice nurse and family planning nurse could potentially be vital in enabling women to have access to health information.

3. The role of the GP. In addition the research highlighted a number of questions requiring to be evaluated concerning the role of the GP.
4. To further analyse and determine the content of health information provided to women, by women workers.
5. To consider the impact of innovative development within the PHC sector on the delivery of health information to women.
6. To further analyse the extent to which the PHC team as a whole and relationships between workers within the team determine the mode of service provision, including the degree to which gender of workers interacts with professional interests.

REFERENCES

Ackerman, B. (1986) Midwives - past, present and future. In Claxton, R. (ed) *Birth Matters: Issues and alternatives in childbirth.* Unwin, London.

Alberman, E. (1984) Statistical compariosn of home and hospital confinements.In Zander L and Chamberlain G *Pregnancy care for the 1980's.* The Royal Society of Medicine and MacMillian Press

Arber, S. & Sawyer, L. (1985) The role of the receptionist in general practice: A dragon behind the desk? *Social Science and Medicine*, Vol 20, No 9, pp. 911-925.

Arms, S. (1975) *Immaculate Deception: A new look at women and childbirth in America.* Boston. Houghton Mifflin.

Arney, W. R. (1982) *Power and the Profession of Obstetrics.* University of Chicago Press, Chicago.

Ashford, J. (1978) Policies for maternity care in England and Wales. In Kitzinger S, Davies, J. (eds)*The Place of birth.* Oxford University Press.

Association of Radical Midwives. (1981) The Role of the Midwife. *ARM.* London.

Association of Radical Midwives. (1981). Midwives at Pithiviers. *ARM Newsletter.* June

Association of Radical Midwives. (1986) The Vision. *ARM.* London.

Association of Radical Midwives. Information leaflet. *ARM.* London.

Bailey, R (1976) Mayes Midwifery. A Textbook For Midwives. Bailliere Tindall. London.

Bakketeig, L. & Oakley, A. (1986) Methodological issues in the evaluation of perinatal care. In Phaff, J, M, L.(ed) *Perinatal health services in Europe.* Croom Helm.

Baldamus, M. (1972) The role of discoveries in Social Science. In Shanin, T. (ed) *The rules of the game.* Tavistock, London.

Banks, M., Beresford, S., Morell, D., Waller, J. & Watkins, C. (1975) Symptom recording and demand for medical care in women aged twenty to forty-four years. *International Journal of Epidemiology.* 4(3) pp.189-95.

Banta, D, H. (1986) Evaluating technology for national Health policy. In Phaff, J, M, L.(ed) *Perinatal health services in Europe.* Croom Helm.

Barret, M. and Roberts, H. (1978) Doctors and their patients: the social control of women in general practice. In C & B Smart (eds) *Women, Sexuality and Social control.* London, Routelege Kegan Paul.

Beales, G. (1976) Practical sociological reasoning and the making of social relationships among health centre participants. In Stacey, M (ed) *The Sociology of the National health service.* Sociological Review monograph 22. University of Keele.

Beech, B. (1982) *The work of the Association for Improvements in the Maternity Services.* Paper presented to 4th human relations in obstetrics seminar, Glasgow.

Beech, B. A. & Claxton, R. (1984) *Health Rights Handbook for Maternity Care.* Local Government Health Rights Project. London.

Beech, B. (1986) Know your rights: a parents' guide to birth. In Claxton R (ed) *Birth Matters. Issues and alternatives in childbirth.* Unwin. London.

Bell, C and Newby, H (1972) *Doing Sociological Research.* Allen and Unwin. London

Blondel, B., Pusch D. & Schmidt. (1985) Some Characteristics of ante-natal care in 13 European countries. *British Journal of Obsterics and Gynaecology.* June, Vol 92, pp565-568.

Bogdan, R., Taylor, S (1975) *Introduction to qualitative research methods. A phenomenological approach to the social sciences.* Wiley. London.

Bolton, A. (1985) Midwifery Education. *Assocation of Radical Midwives Newsletter,* No 26 pp9-11.

Borman, K. LeCompte, M. & Goetz, G. (1986) Ethnographic and qualitative research design and why it doesn't work. *American Behavioural Scientist,* 30, 1, Sept. pp42-57.

Bowling, A. (1981) *Delegation in general practice: a study of doctors and nurses.* Tavistock, London.

Brewin, C. & Bradley, C. (1982) Perceived control and the experience of childbirth. *British Journal of Clinical Psychology.* 21, pp263-269.

Briggs, B. (1985) Abolishing a medical hierarchy: the struggle for socialist primary health care. *Critical Social Policy* Issue 12, pp 83-88

British Medical Association (1986) BMA Cervical Screening in Great Britain, as summarised *British Medical Journal,* Volume 293, October 11, p960.

British Medical Journal - Editorial (1980) High risk groups and cervical cancer. *British Medical Journal,* 281, 629-630.

British Sociological Society. Equality of the Sexes Committee. (1987) *Workshop on Women and research, Report. BSA.* November.

Brooks, F., Long, A. and Rathwell, T. (1986) Midwives Career Patterns. *Research and the midwife conference proceedings.* London

Brooks, F., Long, A. and Rathwell, T. (1987) *Midwives perceptions on the state of midwifery.* Nuffield Centre for Health Services Studies Report, University of Leeds.

Broverman, I., Broverman D., Clarkson F. (1970) Sex role Stereotypes and clinical judgements of mental health. *Journal of Consulting and Clinical Psychology.* Vol. 34, No 1, pp 1-7.

Brownbridge, G., Herzmark, G., Wall, T. (1985) Patient reactions to doctors computer use in general practice consultations. *Social Science and Medicine.* Vol 20. No 1 pp 47-52.

Bunker-Rohrbourgh, J. (1979) Pregnacy and childbirth. In Bunker-Rohrburgh, J. *Women Psychology's puzzle.* Chapter 14. The Harvester Press. USA.

R. Burgess (ed) (1982) *Field Research a source book and field manual.* London

Byrne, D., Mccarthy, P., Keithly, J. & Harrison, S. (1985) Housing class and helath: an example of an attempt at doing socialist research. *Critical Social Policy.* Issue 13 Summer.

Caldeyro-Barcia, R. (1980) Physiological and psychological bases for the modern and humanised management of normal labour. In *Recent Progress in Perinatal Medicine and prevention of Congenital Abnormality,* October 21-22, Tokyo, Government of Japan. pp77-96.

Calnan, M. & Johnson, B. (1985) Health, health risks and inequalities an exploratory study of womens perceptions. *Sociology of health and illness.* Vol 7. No 1, pp55-73.

Calnan, M. & Moss, S. (1984) The health belief model and compliance with education given at class in breast self-examination. *Journal of Health and Social Behavior.* Vol 25 (June) pp198-210.

Calnan, M. (1988) Towards a conceptual Framework of lay evlaution of health care. *Social Science and Medicine.* Vol 27. No 9 pp 927-933.

Cameron, J. (1985) Midwifery in the real world. *Nursing Mirror.* 161, 16, 42-43, October 16.

Cartwright, A. & Anderson, R. (1977) Patients and their doctors. Report on some changes in general practice between 1966 and 1977 for the royal commission on the NHS. *The Journal of The Royal College of General Practitoners.* Occasional Paper, No 8.

Cartwright, A. (1979) *The dignity of labour? A study of childbearing and induction.* London, Tavistock.

Cartwright, A. & Anderson, R. (1981) *General practice revisited: A second study of patients and their doctors.* Tavistick Publications. London.

Cartwright, A. (1988) Unintended pregnacies that lead to babies. *Social Science and Medicine.* Vol 27, No 3 pp249-254.

Chalmers, A (1982) Epidemiology and the Scientific Method. *International Journal of Health Sciences.* vol 12, no 4, pp659-666.

Chalmers, I. & Richards, M. (1977) Intervention and causal interference in obstetric practice. In Chard, T. & Richards, M. eds *Benefits and Hazards of the New Obstetrics*, London, Heinemann.

Chalmers, I. (1978) Implications of the current debate on obsteric practice. In Kitzinger S, Davies, J. (eds) *The Place of birth*. Oxford University Press.

Chamberlain, J. (1983) Cancer education co-ordinating group: *Report of working party on screening for cervical cancer,* Belfast, 10 June.

Claxton, R. (ed) (1986) *Birth Matters: Issues and alternatives in childbirth.* Unwin, London.

Clyne, D W (1980) *A Concise Textbook For Midwives*. Faber and Faber. London

Comaroff, J. (1977) Conflicting paradigms of pregnancy: Managing ambiguity in ante-natal encounters. In Davies, A & Horobin, G (eds) (1985) `*Medical encounters the experience of illness and treatment.* Croom Helm.

Community Health Council. (1981) *Findings on ante-natal care from Community health council studies*. N.P.E. Unit, Radcliffe Infirmary, Oxford.

Cooper, I. (1984) Midwifery team allocation. *Midwives Chronicle and Nursing Notes*. October pp.vi-iv.

Crawford, R. (1977) You are dangerous to your health: The ideology and politics of victim blaming. *International Journal of Health Services*. Vol 7, Number 4, pp 663-680.

Critical Social Policy - Editorial. (1982) Birth rights radical consumerism in health care. *Critical Social Policy*. Issue 2. pp62- 65.

Currie, E. (1987) A taste of Currie - Interview by B. Campbell. *Marxism Today*, March. pp23-25.

Dale, J. & Foster, P. (1986) Welfare professionals and the control of women. In, *Feminists and state Welfare*. Chapter 5. Routledge and Kegan Paul.

Dale, J. (1986a) Feminists and the development of the welfare state - some lessons from our history. *Critical Social Policy*. Issue 16, Summer, pp57-65.

Dalley, G. (1983) Ideologies of care - A feminist contribution to the debate. *Critical Social Policy*. Issue 8, Autumn, pp72-81.

Danziger, S. (1978) The uses of expertise in doctor-patient encounters during pregnancy. *Social Science and Medicine*. Vol 12, September. pp359-367.

David, M. (1985) Motherhood and social policy - a matter of education? *Critical Social Policy*. Issue 12, Spring, pp-28-43.

Devitt, N. (1977) The Transition from Home to Hospital Birth in the United States, 1930-1960. *Birth and the Family Journal,* 4 No2 (Summer): 47-58.

DeVries, R. (1982) Midwifery and the problem of Licensure. In Roth, J (ed) *Research in the Sociology of Health Care: A Research Annual*. Volume 2. Greenwich CT: Jai Press inc.

Dewhurst, J. (1984) Which way forward for obstetrics? In Zander L and Chamberlain G *Pregnancy care for the 1980's*. The Royal Society of Medicine and MacMillian Press.

Dewsbury, A (1980) What the Fetus Feels. *British Medical Journal* . 16 February pp481.

DHSS and CPAG (1978) Reaching the consumer in the ante-natal and Child Health services. Report of a conference. 4th April.

DHSS and CPAG. (1978) Reaching the consumer in the ante-natal and Child Health services. Report of a conference. 4th April.

Dingwall, R. & Lewis. (1983) *The Sociology of the professions, Lawyers, doctors and others*. Macmillian Press.

Dingwall, R. (1980) Problems of teamwork in primary care. In Lonsdale, S. Webb, A. & Briggs, T. (eds) *Teamwork in the personal social services and health care*. Croom Helm.

Donnison, J. (1977) *Midwives and medical men: A history of interprofessional rivalries and womens rights*. London, Heinemann.

Dowling, S (1984) The provision of community ante-natal services.In Zander L and Chamberlain G *Pregnancy care for the 1980's*. The Royal Society of Medicine and MacMillian Press.

Doyal, L with Pennel, I (1979) *The Political Economy of Health*. Pluto Press. London

Doyal, L. (1985) Women and the National Health Service: the carers and the careless. In Lewin, E. Olesen, V. *Women health and healing*. Tavistock.
Dunkelman, H. (1979) *Patients Knowledge of their condition and treatment: How it might be improved*. MacMillian Press.
Dunn, J. (1988) A double act. *New Society* 5 February.
Dunn, P. (1976) Obstetric delivery today: For better or for worse? *The Lancet*. April 10, Vol 1, pp790-793.
Ehrenreich, B. & Ehrenreich, J. (1978) Medicine and Social control. In Ehrenreich, J (ed) *The cultural crisis of modern medicine*. Monthly Review Press. London.
Ehrenreich, B. & English D. (1979) For her own Good: 150 years of experts advice to women. Pluto Press. London.
Ehrenreich, B. & English D. (1981) The sexual politics of sickness. *In Conrad P and Kern R (ed) The sociology of health and illness critical perspectives*. St Martins Press. NY
Ehrenreich, J. (1978) Introduction to, The cultural Crisis of modern medicine. In Ehrenreich, J (ed) *The cultural crisis of modern medicine*. Monthly Review Press. London.
Elis, N. (1986) Firm reply to a weak agenda: GMSC's response to the governments agenda for discussion. *British Medical Journal*. Vol 293, 26 July.
Enkin, M. (1984) Family-centred obstetrics.In Zander L and Chamberlain G *Pregnancy care for the 1980's*. The Royal Society of Medicine and MacMillian Press.
Feree, M. M. & Hess, B. B. eds (1987) *Analysing Gender : A handbook of social science research*. Sage.
Ferree, M. M. & Hess, B. (1987) *Analysing gender a handbook of social science research*. Sage.
Finch, J. (1984a) Community Care developing non-sexist alternatives. *Critical Social Policy*. Spring, pp6-18.
Finch, J. (1984b) It's great having some-one to talk to' the ethics and politics of interviewing women. In Bell, C and Roberts, H. (eds) *Social researching. Politics, Problems, Practice*. Routledge and Kegan Paul. London.
Fish, D. G. (1966) An Obstetric unit in a London Hospital. Unpublished PhD Thesis London School of Economics.
Fisher, M., Marsh, P., Phillips, D. & Sainsbury, E. (1986) *In and Out of Care*, Batsford, London.
Fisher, S. (1984) Doctor-Patient Communication: A social and micro-political performance. *Sociology of health and illness*. Vol 6, Number 1, March, pp1-29.
Fitzpatrick, R, & Hopkins, A.(1983) Problems in the conceptual Framework of patient satisfaction reserach: An empirical exploration. *Sociology of health and illness*. Vol 5, number 3, November pp 297-311.
Fleury, P. M. (1967) *Maternity care: Mothers experience of childbirth*. London, Allen and Unwin.
Flint, C. & Poulengeris, P. (1986) The know your midwife scheme. *Report*. St Georges Hospital Tooting.
Flint, C. (1982a) Where have we gone wrong? *Nursing Mirror*, Nov 24, pp26-29.
Flint, C. (1982b) A radical blueprint. *Nursing Times*, Jan 14, pp1-7.
Flint, C. (1985) *Address given to Association of Radical Midwives conference*. (Notes taken during conference). June, London.
Flint, C. (1986) A different face every time. *Nursing Times*, 14 May, p26.
Flint, C. (1988) On the brink: midwifery in Britain. In Kitzinger, S. ed. *The Midwife Challenge*. Pandora, London.
Francis, H. (1985) Obstetrics: A consumer oriented service? The case against. *Maternal and Child Health*, 10, 3, March, pp69-72.
Frater, A. (1978) 20 years of women choice. *Marxism Today*. March, pp36-39.
Frohlich, J and Edwards, S. (1989) Team Midwifery For Every-one. Building on the Know your Midwife Scheme. *Midwives Chronicle and Nursing Notes*. March. PP66-67.

Friedson, E. (1970) *Professional Dominance*. New York, Atherton.
Gamarnikow, E. (1978) Sexual division of labour: the case of nursing. In Kuhn, A. & Wolpe, A. *Feminism and materialism: Women and modes of production.* Routledge and Kegan Paul, London.
Gans, H. J. (1968) The Participant observer as a human being: Observations on the personal aspects of fieldwork. Reprinted in R. Burgess (ed) (1982) *Field Research a source book and field manual.* London
Garcia J. (1984) Women's views of ante-natal care. In Enkin & Chlamers (eds) *Effectiveness and Satisfaction in Ante-natal care.* Heinemann.
Garcia, J., Corry, M., MacDonald, D., Elbourne, D, & Grant A. (1984) Mothers views of continous electronic fetal heart monitoring and intermittent auscultion in a radomised controlled trial. *Research and the Midwife conferenece proceedings.*
Gibson, P (1974) Setting up in a Health Centre. In Bloomfield and Follis (eds) *The Health Team in Action.* BBC Yoevil.
Gillett, J. (1985) Antenatal care; The midwife's role. *Senior nurse*. Vol 2, No 1, January 2/9, pp24-29.
Gilligan, C. (1978) *In a different voice: Psychological theory and women's development.* Gower, London.
Glaser, & Strauss, A. (1967) *The discovery of grounded theory*. Chicago, Aldine.
Glaser, & Strauss, A. (1968) *Time for dying*. Chicago, Aldine.
Goffman, I. (1959) *The presentation of self in every day life*. Garden City, New York. Doubleday Anchor.
Goldthorpe, N. O. & Richman, J. (1974) Maternal attitudes to unintended home confinements. *Practitioner*, 212, 845-53.
Goldthorpe, N. O. & Richman, J. (1974) Reorganisation of maternity services - a comment of domicilliary confinements in view of the experience of the hospital strike, 1973. *Midwife and health visitor*. September, 10, 265-270.
Gordon, L.The politics of birth control,1920-1940: The impact of the professionals. In Ehrenreich, J (ed) *The cultural crisis of modern medicine.* Monthly Review Press. London.
Gould, M. (1980) When women create an organisation: The ideological imperatives of feminism. In Dunkerlay D and Salaman, G. (eds) *The international yearbook of organisation studies.* London, Routledge and Kegan Paul.
Graham, H. & Oakley, A. (1981) Competing ideologies of reproduction: medical and maternal perspectives on pregnacy. In Roberts, H. ed. *Women health and reproduction* . London, Routledge Kegan Paul.
Graham, H. (1980) *Having a baby: Women's experiences of pregnancy, childbirth and early motherhood.* Unpublished PhD Thesis, York University, Department of Sociology.
Graham, H. (1984) Surveying through stories. In Bell, C and Roberts, H. (eds) *Social researching. Politics, Problems, Practice.* Routledge and Kegan Paul. London.
Graham, H. (1984a) *Women health and the family*. Wheatsheaf Books. London.
Graham, H. (1985b) Providers, negotiators and mediators: Women as the hidden carers. In Lewin, E. & Olesen, V. (eds) *Women health and healing.* Tavistock.
Graham, H & Mckee, L (1980) *The first months of motherhood: Summary report of a survey of women's experiences of pregnancy, childbirth and the first six months after birth.* Health Education Council Monograph No3.
Greenwood, R (1957) Attributes of a profession. *Social work* 2 (July) 45-55.
Haavio-Mannila, E. (1986) Inequalites in health and gender. *Social science and Medicine,* vol 22, No 2, pp141-149.
Haire, D. (1972) The cultural warping of childbirth. In Ehrenreich, J (ed) *The cultural crisis of modern medicine.* Monthly Review Press. London.
Hale, C. (1985) Mothers on the assembly line. *Nursing Mirror*, August 7, Vol 161, 6, 24-26.

Hall, M. (1984) Are our accepted practices based on valid assumptions? *In The Royal Society of medicine. Pregnancy care for the 1980's*. MacMillan Press.
Hall, M. (1986) Critique of antenatal care. *Research and the midwife conference proceedings*. London
Hallum, J L (1976) *Midwifery*. Hodder and Soughton. London
Hammond, P E (1964) *Sociologists at work*. Basic Books. New York.
Hammersley, M. & Atkinson, P. (1983) *Ethnography principles in practice*. Tavistock.
Harding, S (1987) ed *Feminisim and methodology*. Open Univeristy Press. Milton Keynes
Haug, M. (1975) The deprofessionalisation of every-one? *Sociological Focus*. Vol 8, No. 3, August. pp197-213.
Hazell, L (1974/1975) A study of 300 Elective Home Births. *Birth and the Family Journal* 2, No1 (Winter): 11-18.
Health Education Council. (1980) *Pregnant At Work*. HMSO
Heath, C. (1984) Participation in the medical consultation: the co-ordination of verbal and non-verbal behaviour between the doctor and patient. *Sociology of health and illness*. Vol6, number 3, November p311-338.
Henderson, C. (1984) Influences and interactions surrounding the midwives decision to rupture the membranes. *Proceedings of the conference on Research and the Midwife.*
Henschel, D. (1984) What are we expecting of our midwives? In Zander L and Chamberlain G (1984) *Pregnancy care for the 1980's*. The Royal Society of Medicine and MacMillian Press.
Hingstman, L. & Boon, H. (1988) Obstetric care in the Netherlands: regional differentation in home delivery. *Social Science and Medicine*. Vol26, No 1 pp71-78.
Homans, H. (1982) Pregnancy and birth as rites of passage for two groups of women in Britain. In MacCormack C, (ed) *Ethnography of fertility and birth*. Academic Press.
Homans, H. (ed) (1985) *The sexual politics of reproduction*. Gower, Altershot.
Hookey, P. (1980) Primary care and community services. In J Fry (ed) *Primary care*. Heinemann, London
Houd, S. & Oakley, A.(1986) Alternative Perinatal services: Report of a pilot survey. In Phaff, J, M, L.(ed) *Perinatal health services in Europe*. Croom Helm.
Houd, S. (1986) Appropriate Use of human resources in the perinatal period. In Phaff, J, M, L.(ed) *Perinatal health services in Europe*. Croom Helm.
Howell, M. (1978) Pediatricians and mothers. In Ehrenreich, J (ed) *The cultural crisis of modern medicine*. Monthly Review Press. London.
Hubbard (1984) Personal courage is not enough: some hazards of childbearing in the 1980s. In Arditti et al. (eds) *Test Tube Women*. Pandora, Boston.
Hughes, D. (1988) When nurse knows best: Some aspects of nurse/doctor interaction in a casulty department. *Sociology of health and illness*. Vol 10 No 1.
Huntingford, P. (1978) Obstetric practice: past,present and future. In Kitzinger S, Davies, J. (eds) *The Place of birth*. Oxford University Press.
Hyde, B. (1986) An interview study of pregnant women's attitudes to ultrasound scanning. *Social science and medicine*, Vol 22, No 5, pp587-592.
Illich, I. (1976) *Limits to Medicine*. Penguin, Middlesex.
Jackson, J. (1979) Screening in general practice: cervical cytology for higher risk women. *Publ. Health*, London, 93, 300-305.
Jamieson, L. (1984) A midwife's perspective.In Zander L and Chamberlain G *Pregnancy care for the 1980's*. The Royal Society of Medicine and MacMillian Press
Jeffery, R. (1979) Normal Rubbish: Deviant patients in casualty departments. Sociology of Health and Illness, pp90-108.
Jones, S. (1985) Depth Interviewing.In Walker, R. (ed) *Applied qualitative reserach*. Gower
Jordon, B. (1978) *Birth in four cultures. A crosscultural investigation of childbirth in Yucatan, Holland and Sweden and the United States*. Eden Press.

Kaiser, B. & Kaiser, I. (1974) The challenge of the women's movement to Americian gynaecology. *Americian Journal of Obsterics and Gynaecology.* Vol 120, No 5. November

Karpf A, (1988) It's a Natural: Childbirth and the media. In Karpf A, *Doctoring the media: The Reporting of Health and Medicine.* Routledge. London.

Kaufet, P. & McKinlay, S. (1985) Estrogen- replacement therapy: The production of medical knowledge and the emergence of policy. In Lewin, E. & Olesen, V. (eds) *Women health and healing.* Tavistock.

Kesby, O. (1983) Care in labour the need for a midwfery policy. *Midwives Chronicle and nursing notes.* January pp9-10.

Kirkham, M. (1983) Admissions in labour teaching the patient to be patient? *Midwives Chronicle and Nursing Notes.* February p44-45.

Kirkham, M. (1986) A feminist perspective in midwifery. In C. Webb (ed) *Feminist practices in womens health care.* Wiley.

Kirkham, M. (1987) *Care in labour.* Unpublished PhD Thesis. Manchester.

Kitzinger, S. & Davies, J. (eds) (1978) *The Place of birth.* Oxford University Press.

Kitzinger, S. (1978) Women's experience of birth at home. In Kitzinger S, Davies, J. (eds) (1978) *The Place of birth.* Oxford University Press.

Kitzinger, S. (1982) *Change in Ante-natal Care. A report of a working party.* London National Childbirth Trust

Kitzinger, S. (1988a) (ed) *The Midwife Challenge.* Pandora, London.

Kitzinger, S. (1988b) Midwife to Revolution. *The Guardian.* November 23 p27.

Klein, M. Lloyd, I, Redman, C. Bull, M. and Turnbull, A. (1984) A comparison of general practitioner and specailist delivery services. In Zander L and Chamberlain G (1984) *Pregnancy care for the 1980's.* The Royal Society of Medicine and MacMillian Press.

Kloosterman, G . (1978) The dutch system of home births.In Kitzinger S, Davies, J. (eds) *The Place of birth.* Oxford University Press.

Lamaze, F. (1958) *Painless childbirth.* London, Burke.

Laurance, J. (1987) The patient factory. *New Society,* 8 May.

Laurance, J. (1988) No cure for nurses. *New Society,* 12 Febuary.

Law R G, and Friedman, M (1972) *Midwifery.* Staples London.

Leboyer, F. (1977) *Birth without Violence.*

Leeson, J. & Gray J. (1978) *Women and medicine.* Tavisitock. Suffolk

Levy, H. (1978) The military medicinemen. In Ehrenreich, J (ed) *The cultural crisis of modern medicine.* Monthly Review Press. London.

Lewin, E. & Olesen, V. (1985) (eds) *Women health and healing.* Tavistock.

Lewin, E. (1985) By Design: reproductive strategies and the meaning of motherhood. In Homans, H. (ed) *The sexual politics of reproduction.* Gower, Aldershot.

Lomas, P. (1978) An interpretation of modern obstetric practice. In Kitzinger S, Davies, J. (eds) *The Place of birth.* Oxford University Press.

Long, A. (1984) *Research into Health and Illness.* Issues in design, analysis and practice. Gower.

Long, A. F. & Mercer, G. (1987) *Health Manpower: Planning, Production and Management.* London, Croom Helm.

Lupton, C (1990) *The nature and relevance of feminist research.* Research Policy and Planning. Vol 8 no 1 pp20-21.

MacCormack, C. (ed) *Ethnography of fertility and birth.* Academic Press.

Macintyre, S. (1976) To have or have not - Promotion and prevention of childbirth in gynaecological work. In Stacey, M (ed) *The Sociology of the National health service.* Sociological Review monograph 22. University of Keele.

Macintyre, S. (1977) *Single and pregnant.* Croom Helm

Macintyre, S. (1977) The management of childbirth: A review of sociological research issues. *Social Science and Medicine.* Vol 11, pp477-484.

Macintyre, S. (1978) Some notes on record taking and making in an antenatal clinic. *Sociological Review.* Vol 26. No 3. pp595-611.

Macintyre, S. (1979) Some issues in the study of pregnancy careers. *Sociological Review.* Vol 27. No 4. pp755-771.

Macintyre, S. (1982) Communications between Pregnant women and their medical and midwifery attendants.The 1981 sir william power memorial lecture. *Midwives Chronicle and nursing notes.* November, pp387-394.

Macintyre, S. (1984) Consumer reaction to present-day ante-natal services. In Zander L and Chamberlain, G. *Pregnancy care for the 1980's.* The Royal Society of Medicine and MacMillian Press

Malseed, J. (1987) Straw men: A note on Oakley's treatment of textbook prescriptions for interviewing. *Sociology.* Vol 21 No4.1 November pp629-631. With note by Oakley p632.

Manikiem, M. L. (1979) .Communication Patterns of women and Nurses, in .. M.Kjevick, D. L. & Matrinson, I.(ed) Women in Stress: A Nursing Perspective. New York Appleton Century.

Marsh, G. (1985) New programme of ante-natal care in general practice. *British Medical Journal.* Vol 291, September 7, pp646-648.

Martin, E. (1989) *The Woman in the Body.* 2nd edition (first edition 1987) Open University Press, Milton Keynes.

Maternity Services Advisory Committee (1982) Maternity care in Action: Part I - Ante-natal care. First report of the Maternity Services Advisory Committee to the Secretaries of State for Social Services and for Wales. HMSO.

Maternity Services Advisory Committee (1984) Maternity care in Action: Part II - Care during childbirth. Second report of the Maternity Services Advisory Committee to the Secretaries of State for Social Services and for Wales. HMSO.

McCoulogh, M.J. (1984) Preconception care an outline. *Senior Nurse.* vol 1, No 36, December 5, pp 18-20.

McIntosh, J. & Dingwall R. (1978) Teamwork in theory and practice. In Dingwall, R. & McIntosh, J. *Readings in the sociology of nursing.* Churchill livingstone.

McIntosh, J. (1986) Expectations and Experience of childbirth in a sample of working class Primigravdae. *Research and the midwife conference proceedings.* Glasgow.

McIntosh, M. (1981) Feminism and Social Policy. *Critical Social Policy.* vol 1, No 1 Summer.

Mckee, I (1984) Community Ante-natal Care: The Sighthill Community Ante-natal Scheme. In Zander L and Chamberlain G *Pregnancy care for the 1980's.* The Royal Society of Medicine and MacMillian Press.

McKinlay, J. (1972) The sick role - illness and pregnancy. *Social Science and Medicine.* Vol 6, pp561-572.

McKinlay, J, B (1981) From Promising Start to Standard Procedure. Seven Stages in the career of a medical innovation. *Millbank Memorial Fund Quarterly,* 59 374.

Mead, M (1949) Male and Female. Morrow. NY

Meddin, J. (1986) Sex differences in depression and satisfaction with self: Findings from a United States national survey. *Social science and medicine,* Vol 22. No 8, pp 807-812.

Mehl, L (1977) "Research on childbirth alternatives: What can it tell us about hospital practices?" in Stewart and Stewart (eds) *Twenty-first Century Obstetrics Now.* The National Association of Parents and professionals for Safe Alternatives in Childbirth. Chapel Hill NC.

Methven, R. C. (1983) The antenatal booking interview: recording an obstetric history or relating with a mother-to-be. *Proceedings of the conference on Research and the Midwife.* Glasgow.

Mickelwait, P., Beard, R. & Shaw, K. (1978) Expectations of a pregnant woman in relation to her treatment. *British Medical Journal,* 2, pp188-191.

Millman, M and Kantor R, M (eds) (1975) Another voice: Feminist Perspectives in Social Life and Social Science. Doubleday NY.

Mills, J. (1988) An uncaring community. *New Society.* February.

Moore, M, (1978) Antenatal care and the choice of place of birth. In Kitzinger S, Davies, J. (eds) *The Place of birth.* Oxford University Press.
Morgan, B., Bulpitt, C. & Clifton, P. (1984) The consumer approach to obsteric care. *British Journal of Obsterics and Gynaecology.* Vol 90, No 7, pp624-628.
Morgan, D. (1972) The British Association Scandal: The effect of publicity on a Sociological Investigation Sociological Review volume 20 pp185-286.
Morgan, M. Calnan, M and Manning, N.(1985) *Sociological approaches to health and medicine.* Croom Helm. Chapters 1,2,& 7.
Morrin, H (1982) Are we in charge of extinction? *Midwives Chronicle.* January, pp 17.
Morton-Williams, J. (1985) Making Qualitative Research Work: Aspects of Adminstration. In Walker, R (ed) *Applied Qualitative Research.* Gower. Hants.
Moser, C and Kalton, G (1971) 2nd edition *Survey Methods in Social Investigation.* Heinemann Educational Books. London
Munro, A. (1985) Maternity care: a challenge to health authorities. NAHA News, 83, May.
Myles, M. F. (1974, 1975, 1984) *Textbook for midwives.* 2nd, 6th and 8th editions, Edinburgh, Churchill-Livingstone.
Nathanson, C. (1977) Sex illness and medical care. A review of data, theory and method. *Social Science and Medicine.* Vol 11, pp 13-25.
National Childbirth Trust. (1978) Expectations of a pregnant woman in relation to her treatment. *British Medical Journal.* Vol 2, pp188-191.
National Childbirth Trust. (1982) Working Party. Cahnge in Ante-natal Care. London NCT.
Navarro, V. (1977) *Medicine under capitalism.* New York, Prodist.
Navarro, V. (1984) A critique of the ideological and political positions of the Willy Brandt report and the WHO Alma Ata declaration. *Social Science and Medicine.* Vol 18, No 6, pp 467-474
Nelson, M. (1983) Working class women, middle-class women, and models of childbirth. *Social Problems* . Vol 30, No 3, February, pp284-297.
Newson, K. (1982) The future of midwifery. *Midwife, Health Visitor and Community Nurse,* Vol 18. 528-530.
Newson, K. (1984) Commentary. *British Journal of Obsterics and Gynaecology.* Vol 90, no 7, pp609-610
Newson, K. (1984) What sort of midwifery service do we want? In Zander L and Chamberlain G *Pregnancy care for the 1980's.* The Royal Society of Medicine and MacMillian Press.
Newton, R, Webster, P, Binu, P, Maksrey, N & Phillips, A. (1979) Psychosocial stress in pregnancy and it's relation to the onset of premature labour.
Niven, C. (1984) Labour Pain. *Research and the Midwife conference proceedings.*
Niven, C. Gijsbers, K. (1984) A study of labour Pain using the McGill pain questionnaire. *Social science and Medicine,* vol 19, No 12 pp1347-1351.
Norr, K, Block, C, Charles, A, Meyering, S, and Meyers E. (1977) Explaining pain and enjoyment in childbirth. *Journal of Health and Social Behaviour.* Vol 18, September pp260-275.
O'Brien, M Smith, C. (1981) Women's views and experiences of ante-natal care. *The Practitioner* February. Vol 225, pp123-125
O'Driscoll, K., Carroll, C. J. and Coughlan, M. (1975) British Medical Journal, iv 727.
Oakley, A. (1979) The baby blues. *New Society.* April 5, pp11-12.
Oakley, A. (1980) *Women Confined: Towards a sociology of childbirth.* Martin Robertson.
Oakley, A. (1981) *From patient to participant? - The role of the consumer in government reports on the maternity services since 1917.* A paper given at a study day at the National Childbirth Trust, 26 February.
Oakley, A. (1982) Review article on Shelley Romalis (1981) Alternatives to medical control. *Times Higher Educational Supplement,* 8th Aug.
Oakley, A. (1983) Social consequences of obstetric Technology: The importance of measuring *soft* outcomes. *Birth* vol, 10:2 Summer. pp 99-108.

Oakley, A. (1984a) *The Captured Womb: A history of the medical Care of pregnant women*. Basil Blackwell. Oxford.
Oakley, A. (1984b) The consumers role: Adversary or partner? In Zander L and Chamberlain G (1984) *Pregnancy care for the 1980's*. The Royal Society of Medicine and MacMillian Press.
Oakley, A. (1985) From patient to participant: the role of the consumer in government reports.*Conference presentation.*
Oakley, A. (1986) Social Support and perinatal outcome. In Phaff, J, M, L.(ed) *Perinatal health services in Europe*. Croom Helm.
Oakley, A. (1987) Home Birth; A Class Privilege. *New Society*. November 6.
Odent, M. (1984) How to help women in labour. In Zander L and Chamberlain G *Pregnancy care for the 1980's*. The Royal Society of Medicine and MacMillian Press.
Orr, J (1986) Feminism and Health Visiting, in In C, Webb (ed) *Feminist Practices in Womens Health Care*. Wiley. London.
Page, L. (1988) The midwife's role in modern health care. In Kitzinger, S. ed. The Midwife Challenge. Pandora, London.
Paul, J. (1978) Medicine and imperialism. Ehrenreich, J (ed) *The cultural crisis of modern medicine*. Monthly Review Press. London.
Peterson, K. (1983) Technology as a last resort in home birth the work of lay midwives. *Social Problems,* vol 30, no 3, February, pp272-283.
Petchesky, R (1980) *Reproductive freedom: Beyond a woman's right to choose*. Signs 5 661-685.
Phaff, J, M, L.(1986) The Organisation of perinatal serices in the Netherlands. In Phaff, J, M, L.(ed) *Perinatal health services in Europe*. Croom Helm.
Pollack-Petchesky, R (1985) Abortion in the 1980's: Feminist morality and womens health.In Lewin, E. Olesen, V. *Women health and healing*. Tavistock.
Porter M, & MacIntyre S. (1984) What is must be best: A research note on conservative or deferential responses to ante-natal care provision. *Social Science and Medicine*. Vol 19 No 11. pp 1197-1200
Reedy, B. (1977) The Health Team. In Fry, J (ed) *Trends In General Practice*. British Medical Journal. London.
Reedy, B. (1980) Teamwork in Primary health care - a conspectus. In Fry, J. (ed) *Primary Care*. Heinemann, London.
Reedy, B. (1981) Discrepancies in the perceptions of a structural relationship for teamwork -1. *Nursing Times*. Occasional papers, vol 77. No 23. August 19. pp89-95.
Reid, M. (1983a) Review article: A feminist sociological imagination? Reading Ann Oakley. *Sociology of health and illness*. Vol 5, No 1.
Reid, M. (1983b) Lay midwifery in the United States. Proceedings of the conference on Research and the Midwife. Glasgow.
Reid, M., Gutteridge, S. & McIlwaine, G. M. (1983) A comparison of the delivery of antenatal care between a hospital and a peripheral clinic. Report to the Scottish Home and Health department, April. University of Glasgow.
Reissman, C. K. (1986) Medical knowlege about women:beyond bad doctors. *Contemporary Sociology: A Journal of Reviews*. 15, 2. March.
Reisz, M. (1987) Choosing childlessness. *New Society* 19 June.
Renaud, M. (1978) On the structural constraints to state intervention in health. In Ehrenreich, J (ed) *The cultural crisis of modern medicine*. Monthly Review Press. London.
Richards, M. (1978) A place of safety? An examination of the risks of hospital delivery. In Kitzinger S, Davies, J. (eds) *The Place of birth*. Oxford University Press.
Roberts, H. (1981) ed *Women Health and Reproduction*, London, Routelege and Kegan Paul.
Roberts, H (1984) ed *Doing Feminist Research*. Routledge and Kegan Paul. London

Roberts, H (1984a) Putting the Show on the Road: The dissemination of research findings. In Bell, C and Roberts H, *Social Researching Politics, Problems and Practice.* Routledge and Kegan Paul. London.

Roberts, H (1984b) Begging for the needle and the knife. *Radical Community Medicine.* pp 64-68. Summer.

Roberts, H. (1985) *The Patient Patients. Women and their Doctors.* Pandora Press.

Robins, D. (1985) Midwives and mothers? *Parents,* No 112, July, p54.

Robinson, D. (1978) *Patients, Practitoners and medical care: Aspects of medical Sociology.* 2nd edition. Heinemann.

Rodmell, S and Watt, A. (1986) *The politics of health education* : Raising the Issues. Routledge and Kegan Paul.

Rodmell, S. (1986) Prepregnancy care: Whose needs count? In Rodmell, S and Watt, A. (1986) *The politics of health education* : Raising the Issues. Routledge and Kegan Paul.

Romalis, S. (1982) (ed) Childbirth: alternatives to medical control. *University of Texas Press,* Austin.

Romalis, S. (1985) Struggle between providers and recipients: The case of birth Practices. In Lewin, E. & Olesen, V. *Women health and healing.* Tavistock.

Ross, D. (1979) The development of the social sciences In A lsen and J voss (eds) The organisation of knowldege in modern America Balitmore, MD Johns Hopkins university Press.

Roth, J. (1974) Professionalism the Sociologists decoy. Sociology of work and occupations, vol 1, Nol. February, pp6-23.

Rothman, B. (1982a) *In labour women and power in the birth place.* Norton, NY.

Rothman, B. (1982b) Awake and aware, of false conciousness: The cooption of childbirth reform in America. In Romalis, S. ed Childbirth: alternatives to medical control. *University of Texas Press,* Austin.

Rothman, B. (1983) Midwives in transition: The structure of a clinical revolution. *Social problems* Vol 30 No 3 February

Rothman, B. (1984) Childbirth management and ,education; monopoly: Midwifery as (almost) a Profession. *Journal of Nurse Midwifery* Vol 29, No 5, pp300-306.

Rothman, B. (1986) *The Tentative Pregnancy.* Pandora. London.

Rothman, B. (1987) Reproduction. In Feree, M. M. & Hess, B. B. eds *Analysing Gender : A handbook of social science research.* Sage.

Royal College of Midwives. RCM Statement: Towards a healthy nation. - A policy for the maternity services. Midwives Chronicle and Nursing Notes. July , pp218-219

Ruzek, S. (1981) The women's self help health movement. In *Conrad P and Kern R (ed) The sociology of health and illness critical perspectives.* St Martins Press. NY

Salaman, G. (eds) *The International Yearbook of Organisation Studies.* Routledge and Kegan Paul

Salvage, J. (1985) *The politics of nursing.* Heinemann, London.

Savage, W. (1986) *A Savage Enquiry: Who controls Childbirth.* Virago, London.

Scottish Home and Health Department. (1973) *Matermtiy services the intergration of materntiy work.* HMSO

Schatzman, L and Strauss, A. (1973) *Field Research: Strategies for a Natural Sociology. Prentice-Hall,* Inc. New Jersey.

Scully D, & Bart, P.(1978) A funny thing happened on the way to the orifice: women in the gynecology textbooks. In Ehrenreich, J (ed) *The cultural crisis of modern medicine.* Monthly Review Press. London.

Shaw, N S. (1974) *Forced Labour Maternity Care in the United States.* Pergamon Press. NY.

Sheahan, (1972) The game of the name: nurse professional and nurse technician. *Nursing Outlook.* 20, 7, pp440-444.

Sheffield Health Authority, (1988) *Obsetetric and gynaecology services - proposals for future strategy*. Westbrook House, Sheffield.
Short Report (1980) *Second report from the social services committee: perinatal and neonatal mortality*. London, HMSO.
Shuter, M. (1985) The familiar round. A team approach to midwifery. *Nursing Mirror*. November 6, 1985, Volume 161, no 19, pp34-37.
Silverberg, H. (1985) Private mothers and public policy women welfare and the state. *The Cornell Journal of Social Relations*. Vol 18, Part 2 Spring pp 1-12.
Silverman, D. (1987) *Communication and medical practice*. Sage. london.
Sjoberg, G and Nett, R (1968) *A Methodology for Social Research*. Harper and Row. NY.
Smith, D. (1974) Women's perspective as a radical critique of sociology. *Sociological Inquiry*, 44 (1) 7-13.
Speedling, E, & Ross, D. (1985) Building an effective doctor patient relationship: From patient satisfaction to patient participation. *Social science and medicine*, vol 21, no 2, pp 115-120.
Spender, D (1980) Man Made Language. Routledge and Kegan Paul. London.
Spradley, J. P. (1979) The ethnographic inteview. Holt, Rhinehart and Winston. NY
Squire, J (1986) The issues of choice and safety. In Claxton R (ed) Birth Matters. Issues and alternatives in childbirth. Unwin. London.
Stables, K. (1987) Early experience of a birthing room. *Midwives Chronicle and Nursing Notes*. October, pp299-301.
Stacey, M. (1976) The health service consumer: A sociological misconception. In Stacey, M (ed) *The Sociology of the National health service*. Sociological Review monograph 22. University of Keele.
Stacey, M. (1982) Masculine of feminine Power? Action in the public domain.. Paper presented to ISA Conference. Mexico.
Stacey, M. (1982) Who are the health workers? Patients and other unpaid workers in health care. Paper presented to ISA Conference. Mexico.
Stacey, M. (1985) Women and Health The United States and the United Kingdom compared. In Lewin, E. Olesen, V. *Women health and healing*. Tavistock.
Stacey, M. (1988) *The Sociology of health and healing*. London, Unwin Hyman.
Stanley L, & Wise, S (1979) Feminist Research, Feminist Consciousness and Experiences of Sexism. *Womens Studies International Quarterly*. Vol 2 pp359-374.
Stanworth, M. (1987) (ed) *Reproductive Technologies: Gender, Motherhood and Medicine*. Cambridge. Polity Press.
Stein, L. (1978) The doctor-nurse game. In R. Dingwall, & McIntosh, J. *Readings in the Sociology of Nursing*. Churchill Livingstone.
Stephen, W J. (1979) *An analysis of primary medical care an international study*. Cambridge University Press.
Stillwell, B. (1982) The nurse practitioner at work. *Nursing Times*, Vol 78.
Stillwell, B. (1984) The nurse in practice. *Nursing Mirror*, Vol 158, 23 May, pp17-19.
Stimson, G. V. (1976) General practitioners trouble and types of patients. In Stacey, M. (ed) *The Sociology of the NHS*. Sociological Review Monograph 22, Keele Staffs.
Stimson, G. V. (1977) Social and the role of the general practitoner. *Social Science and Medicine*, vol 11, pp 485-490.
Strauss, A. (1987) *Qualitative analysis for Social Scientists*. Cambridge University Press.
Swaffield, L. (1982) What about the mother? The consumers view of ante-natal clinics and classes. *Nursing Times, Community Outlook*. April 14,
Tagliacozzo, D. & Mauksch, H. (1972) The patients view of the patients role. In Gartly, E (ed) *Patients, Physicians and illness. A source book in behavoural science and health*. The Free Press.

Taylor, G. (1984a) Community based specialist obstetric services. In Zander L and Chamberlain G *Pregnancy care for the 1980's*. The Royal Society of Medicine and MacMillian Press.

Taylor, G. (1984b) What are we training our general practitioners for? In Zander L and Chamberlain G *Pregnancy care for the 1980's*. The Royal Society of Medicine and MacMillian Press.

Tew, M. (1978) The case against hospital deliveries: The statistical evdience. In Kitzinger S, Davies, J. (eds) *The Place of birth*. Oxford University Press.

Tew, M. (1985) We have the technology. *Nursing Times*, 20 November, pp22-24.

Thompson, A. (1984) Ante-natal care: an examination of the midwife's contribution. *Research and the Midwife conference proceedings.*

Towler, J. (1982) A Dying Species? Survival and revival are up to us! *Midwives Chronicle and Nursing Notes*, September, pp324-328.

Towler, J. (1984) midwives units' wishful thinking or reality. *Midwives Chronicle and Nursing Notes*. January p3-5

Tuckett, D, Boulton, M, Olson, C. (1985) A new approach to the measurement of patient's understanding of what they are told in medical consultations. *Journal of Health and Social Behaviour*. Vol 26, (march): 27-38.

Turner, B. (1987) *Medical Power and Social Knowldege*. Sage. London.

Turton, P. (1985) Jill of all trades. *Nursing Times*, 24 Sept, 24-25.

Verbrugge, L. (1984) How Physicians treat mentally distressed men and women. *Social science and medicine*, Vol 18, No 1, pp1-9.

Verbrugge, L. (1985) Gender and health: an Update on Hypotheses and evidence.*Journal of Health and Social Behaviour*. Vol 26, (September): 156-182.

Wagner, M. (1986) The medicalisation of birth. In Claxton, R. (ed) *Birth Matters: Issues and alternatives in childbirth.* Unwin, London.

Vidich, A (1955) Participant Observation and the Collection and Interpretation of Data. *American Journal of Sociology*. 60 January pp354-360.

Walker, A. (1982) The meaning and social division of community care. In Walker, A (ed) *Community care The family, The state, and Social Policy.*

Walker, J. (1976) Midwife or Obstetric Nurse: some perceptions of the midwife and obstetrician of the role of the midwife. *Journal of Advanced Nursing*, 1, pp129-138.

Walker, J. (1985) Meeting midwives midway. *Nursing Times*, Oct 23, pp48-50.

Warwick, I., Aggleton, P. & Homans, H.(1988) Constructing commonsense - young peoples beliefs about AIDS. *Sociology of health and illness*. Vol 10 No 3. pp213-233.

Webb, C. (1986) Women as gynaecology patients and nurses. In C, Webb (ed) Feminist Practices in Womens Health Care. Wiley. London.

Weitz, R. & Sullivan, D. (1985) Licensed lay midwifery and the medical model of childbirth. *Sociology of Health and Illness*, Vol 7, No 1. pp 36-53.

Wertz, R. & Wertz, B. (1981) Notes on the decline of midwives and the decline of medical obstetricians. In Conrad, P. & Kern, R. eds The sociology of health and illness. NY, St Martins Press.

West Birmingham CHC (1984) *Women Waiting: Ante-Natal Services in West Birmingham.* West Birmingham CHC.

West, C. (1984) When the doctor is a lady; power status and gender in physician patient encounters. *Symbolic Interaction,* Vol 7, No 1, pp 87-106.

West, M. A. & Farr, J. L. (1988) Innovation at work: Psychological perspectives. *Social Behaviour* , 3.

West, M. A. (1989) Innovation amongst Health care professionals *SAPU Memo number 831*. Sheffield University.

WHO (1966) *The Role and Responsibilities of the Midwife*. World Health Organisation. Geneva.

WHO (1985) *Primary health care in industrialised countries*. EURO reports and studies No 95. World Health Organisation, Copenhagen.

Wilding, P. (1982) *Professional power and social welfare*. Routledege and Kegan Paul.

Willmott, J. (1980) Specialists in birth. *Nursing Mirror*, 8 July, 34-35.

Willmott, J. (1984) The community midwfe and domiciliary confinements. In Zander L and Chamberlain G (1984) *Pregnancy care for the 1980's*. The Royal Society of Medicine and MacMillian Press.

Wiseman, J. P. (1974) The research web. *Urban Life and Culture*. 3, pp317-28.

Zander, L. & Chamberlain, G. (1984) *Pregnancy care for the 1980's*. The Royal Society of Medicine and MacMillian Press.

Zander, L. (1984) The significane of the home delivery issue. In Zander L and Chamberlain G (1984) *Pregnancy care for the 1980's*. The Royal Society of Medicine and MacMillian Press.

Zander, L., Lee-Jones, L., Fisher, C. (1978) The role of the Primary health care team in the management of pregnancy. In Kitzinger S, Davies, J. (eds) *The Place of birth*. Oxford University Press

Zax, M. Sameroff, A. & Farnum, J. (1975) Childbirth education, maternal attitudes and delivery. *Americian Journal of Obsterics and Gynaecology*. Vol 123, No 2. September 15.

Zimmerman, M. (1987) The womens health movement: A Critique of medical enterprise and the position of women. In Hess, B. & MaxFenee, M. *Analysing gender a handbook of social science research*. SAGE.

Zola, I. (1981) Medicine as an institution of social control.In *Conrad P and Kern R (ed) The sociology of health and illness critical perspectives*. St Martins Press. NY.

APPENDIX 1 THE PEOPLE IN THE STUDY.

A. THE WOMEN IN THE STUDY

This appendix refers to the samples of first time and second time mothers who took part in the research. It includes relevant biographical details.
In addition to the details concerning their original booking for the delivery and the class they were ascribed to for the purposes of this research.
Marital Status as for Interview 1.

1. North Practice.

1. Annie: Delivered in GP unit - as planned. Middle class. 26-30. Married. Council Worker. *Husband Council Worker.*

2. Belinda: Planned home birth - but transferred to consultant unit to be induced when 2.5 weeks overdue. Working class. 22-25. Single. Shop worker.

3. Brenda: Delivered in GP unit - as planned. Working class. 26-30. Single. Unemployed.

4. Catherine: Originally consultant booking changed to GP unit. Manager - Middle class. 31-35. Cohabiting. *Partner lawyer*

5. Daphine: Planned home birth - but transferred to consultant unit for breech delivery prior to the birth. Working class. 31-35. Married. Home Help. *Husband Driver*

6. Elaine: Delivered at home - as planned. Middle class. 31-35. Cohabiting. *Partner teacher*

7. Jackie: Delivered in GP unit - as planned. Working class. 18-21. Married.- unemployed *Husband unemployed*

8. Jill: Delivered at home - as planned. Working class. 22-25. Married. *Husband Baker*

9. Judith: Delivered at home - as planned. Middle class. 22-25. Unemployed - Doing voluntary work since graduating. Cohabiting. *partner -social worker*

10. Julie: Delivered at home - as planned. Working class. 22-25. Social Worker. Married. - *Husband self-employed*

11. Maggie: Planned GP unit delivery but transferred in labour to the consultant unit. Middle class. 31-35. Teacher (Secondary). Married - *Husband Teacher*

12. Mary: Delivered at home - as planned. Working class. 18-21.bar worker Married - *Husband unemployed*

13. Sue: Delivered in GP unit - as planned. Working class. 22-25. Cleaner. Cohabiting. *Partner - unemployed*

14. Samantha: Delivered in GP unit - as planned. Working class. 22-25. Cohabiting. Shop worker. - *Partner steel worker*

15. Sarah: Booked for consultant unit - delivered as planned. Middle class. manager in a shop 31-35. Married. - *Husband owns small transport business*

2. Park Practice
(Note: All the Park women lived in high rise blocks of flats with the exception of those marked with an asterisk *).

1.* Amanda: Booked for consultant unit - delivered as planned. Working class. 19. Married. Factory worker. *Husband same factory*

2.* Anita: Delivered at home - as planned. Working class. 22-25. Married. Shop *worker. -husband unemployed*

3. Cheryl: Delivered in GP unit - as planned. Working class. 16-17. Single. At School.

4.* Claire: Delivered in home - as planned. Middle class. 41. Single.

5. Francis: Booked for consultant unit - delivered as planned. Working class. 16-17. Single. Care worker.

6. Dawn: Delivered in GP unit - as planned. Working class. 31-35. Married. Factory worker. *husband council worker -recreation and parks*

7. Jane: Delivered in GP unit - as planned. Working class. 18-21. Married. Cleaner. *Husband- brewery worker*

8. Janet: Transferred in labour - induced at 2.5 weeks overdue - her community midwife attended her delivery. Working class. 16-17. Cohabiting. Left School - Unemployed. *partner training scheme*

9. Patricia: Booked for GP unit - delivered as planned. Working class. 18-21. Married. Home care aid- *Husband Occupation not known*

10.* Nicola: Booked for consultant unit - delivered as planned. Middle class. 31-35. Married. housewife - *husband dentist*

11. Karen: Booked for consultant unit - delivered as planned. Working class. 16-17. unemployed Married. *husband unemployed*

12. Rosie: Delivered in GP unit - as planned. Working class. 18-21. Cohabiting. Packer. *partner bar worker*

13. Sally: Delivered in GP unit - as planned. Working class. 22-25. Cohabiting. Nursery Assistant. *partner -driver (Armed Forces)*

14. Sandra: Delivered in GP unit - as planned. Working class. 22-25. Married. Shop worker. *husband car mechanic*

15. Sharon: Delivered in GP unit - as planned. Working class. 16-17. Single. Unemployed.

B. THE WORKERS IN THE STUDY

The two main midwifery respondents were:

(i) Jean. North. Practiced in hospital for two years before moving to community. Aged 41. Has 3 children.
(ii) Alison. Park. Midwife on community for 3 years, trained in London previously. Worked in a London teaching hospital. Aged 27. No children.

The 6 Radical Midwives were:

Moria - had worked as an independent midwife in the past, now worked in a practice similar to the research practices.

Doreen - Currently working with GPs not providing home or GP unit only access to home deliveries is cover for other midwives.

Angela - worked with supportive GPs fairly autonomously - had been on the community 6 months.

Cath - Had worked on the community for 4-5 years, GPs highly co-operative - ran her own clinic.

Margaret - Had worked on community for 12 years - was able to provide home births but not GP unit.

Ann - had worked for 15 years on the community and worked in a practice similar to the research practices.

Student midwives - Claire and Jenny

The GPs: The GPs in the study were:

North practice

Caroline.
Andrew.

Park Practice

Maria
Louise
Ann (left early in project)
Simon (Left early in project)

APPENDIX 2 - QUESTIONS AND THEMES FROM THE INTERVIEWS:

A QUESTIONS TO WOMEN

Themes explored: The interviews with the women would normally start with the women being asked for a description of what had happened to them so far - what incidents they felt were important, thus for example the post-natal interview tended to start with an account of labour.

Then their feelings about the care so far would be explored - normally these two discussions would either raise or lead onto the majority of the others themes which the researcher wished to explore, as well as raise additional ones.

Specific areas included:

These do not represent actual questions but instead the types of areas included.

1. Where did the women decide to have their baby - any consideration of alternatives?

influence of natural childbirth movement - if any.

Did they know about the options available over the place of birth and were they explained? - if so by who?

2. Feelings about the workers - who do they prefer and for what aspects of their care? Men vs women was also discussed in-depth.

3. How important has the midwife been? - How important has the GP been? how do they define the function or nature of each professional?

4. What are their sources of support?

5. Issues surrounding interaction between women and providers: what had been explained to them? -

Did they feel able to able questions what questions did they ask - any they didn't. Who would they go to for a question to be asked - what did they feel about the information provided. Anything not discussed with them they would have liked to have talked about?

6. Care during labour

7. Care throughout how did they evaluate it - eg good and bad points

8. Support outside health system.

9. Ways of improving the care.

10 The organisation and structure of the clinics - including issues such as the environment of the clinics to waiting times.

11 Future intentions - what would they opt for in the future

12. View of being in a research project.

Questions to Women as they appear in the text - exact questions

All from chapter 6

Why did you say that you preferred the midwife?

You said that the two clinics (hospital and practices)were very different in what sort of ways was there a difference?

What would you say you was the reason for liking the midwife so much?

Did you ever read your notes?

Did you ask any questions at the ante-natal classes?

Did you ever feel that you were being given too much information, like being told things you didn't need or want, or things that weren't helpful?

What sort of things have they talked about with you?

Looking back over the care you had, what would you say was the best aspect?

Do you feel that you have been able to ask all the questions that you wanted to?

That is different to what you have found elsewhere? (NB follows on from last Q - about ability to ask questions)

Did they make you? (ie have an epidural)

You have said you preferred the midwife, what is it about the midwife that you liked?1

Did you feel that the staff treated you differently because you are single?

What got you through that pain?

B: QUESTIONS TO WORKERS

The themes explored were concerned with the definition of their practice: How they perceived the care they provided. How do they define the role of the different professions involved in maternity care provision . Issues surrounding their view of the women users - definitions of pregnancy, class and race. How they managed conflicts with women. Issues surrounding their working practice and relationships with other team members were explored, in particular their support systems. Political beliefs and involvement in health care organisations. How conflicts and definitions over status were handled within the team.

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1. This question was asked at the post-natal interview to women who had stated they preferred to see the midwife or that the midwife was the best aspect of their care. Although all women were asked what they felt about the midwife.

Specific areas included:

(not necessarily specific questions asked in this wording)

1. Can you tell me about what you feel is the most important aspect of the care you provide to women?
   (a) Ante-Natally.
   (b) During Labour. Would you ever instigate a decision for pain relief?
   (c) Post-Natally.
2. What do you mean by support? (to women)
3. What is the value of the care you provide to the women at the practices - what is the value of your role specifically ? This was usually followed by consideration of details such as, what do they feel is the value of continuity of care?
4. What do they think midwives offer to women? What do GPs offer to women?
5. Do they do home deliveries? Why?
6. Where do they feel is the best place for a woman to have her baby? Where is the safest? Do they feel hospitals are safe?
7. Networks of support - management structure Do you feel that you get support from other midwives?
8. What about Health Visitor's? Historically there has been a reputation of antagonism between the two - would you say that is true? How could contact between HVs and midwives be improved?
9. What do you think is the difference between :
   (a) midwives and nurses?
   (b) midwives and doctors?
10. Would you say that you are a radical midwife? How do you feel about the ARM proposals for consultant midwives?
11. What about your relationship with the medical profession?
    (a) Do you work as a team?
    (b) How do you see the doctor's role.
12. How could the care you provide and your role be improved?
13. Views on the nature of care - such as management of childbirth - intervention
14. View of the hospital system.
15. View of women - how are conflicts between themselves and women managed.

Questions to Workers as they appear in the text:

Do you think that having had children yourself affects the care you give?

(from Chapter 6)

How do you feel about the majority of your work being solely with women?

What would you say are the most important aspects of the care you provide?

What do see as the most important aspect of your role as a midwife?

Can you tell me about what you feel is the most important aspect of the care you provide to women?

From what you have been saying you seem to value developing a personal relationship with the women, why do you feel that is important?

Can you think of an example of the way this helps? (ie getting to know the women)

I have noticed that you spend a lot of time talking to the women about their home lives, and that type of information. Do you think that ...

Apart from requests from the women themselves, what aspects of intervention, including pain relief, do you offer yourself or do?

Where do you draw the line, or do you, over conflicts between what patients want and what you feel is safe?

Can you think of specific examples that the woman want? (ie of things that M can do that make them feel confident)

Have you ever or would you ever instigate the decision to have pain relief? Have you ever suggested pain relief before a woman has?

Can you describe you ideal midwife?

What do you feel are the main priorities of your care?

How much impact do you feel that you have as a health worker on women's health?

I have noticed that you never really mention NCT classes - is there any reason for that?

APPENDIX 3 - THE WELL WOMAN QUESTIONNAIRE

Dear

Over the next few weeks on the mobile well woman bus we will be conducting a research study on the effectiveness of the well woman clinic. This is in order to provide a means for you and other users to express how they feel about the clinic and to see if it is providing what women want from such a clinic. We are therefore asking if you would mind filling in the attached questionnaire and briefly going through some further questions with the researcher after you have attended the well woman clinic.

If you do decide that you would like to help with the study all your answers will be treated in the strictest confidence and in the writing up of the results no individual will be identified. The findings will also be available to users of the well woman clinic.

Thank-you for your help.

yours sincerely,

Fiona Brooks (Researcher)

❑❑❑❑

QUESTIONNAIRE FOR WELL WOMAN CLINIC.

PART ONE

ABOUT YOU :

TIME AT THE CLINIC =

First some brief details about you. (All your answers will be treated in the strictest confidence)

1. What is your age?

under 16	❑
16-20	❑
21-25	❑
26-30	❑
31-35	❑
36-40	❑
41-45	❑
46-50	❑
51-55	❑
56-60	❑
over 60	❑

What type of accomodation do you live in?

Rented/ privatelandlord ❑
Rented/council housing ❑
Owner occupation ❑

Are you?

Married / living with a partner ❑
Single ❑
Widowed/divorced ❑

What is your current occupation? (if unemployed please state normal or previous occupation **as well**)

.....
.....
.....

If you have a partner/husband please state their current occupation. (if unemployed please state normal or previous occupation **as well**).....

.....
.....
.....

Have you any children living with you? YES/NO How many?.....
if **YES** what are their ages?.....

ABOUT THE WELL WOMAN CLINIC

1. a) How did you first hear about the clinic?.....

b) Why did you decide to come here rather than go to your own doctor?.....
.....
.....
Have you ever gone to your GP for the things that you came here for?
YES/NO **Would you ever go? YES/NO.**

2. What would you say was the **main** reason (or the most important one) for you coming to the well woman clinic?.....
.....

3. i) would you say that any of the following were also reasons for coming to the well woman clinic? **(tick as many as apply)**
a) I want to have a full check-up.....❐
b) I want to be examined by a woman.....❐
c) I want to have a cervical smear.....❐
d) I want to have my breasts examined.....❐
e) I want advice/help on contraceptives.....❐
f) I want advice/help on problems with periods/PMT.....❐
g) I want advice/help on vaginal discharges.....❐
h) I want advice on pregnancy and becoming pregnant.....❐
i) I want to talk to some-one about my health/worries.....❐

j) I felt **I** would be given **time** to talk about my health/worries.....❐

ii) have you any other reasons for coming to the well woman clinic?.....
.....

4. a) Do you feel that it will make a difference seeing a nurse rather than a doctor? **YES/ NO (please give a reason).....**

c) Would you prefer the well woman clinic to be run by a doctor or a nurse.
YES/NO/ I do not mind / Don't know.

5. a) Do you prefer to see a woman rather than a man? **YES/NO**
b) If YES to (a) would you say that seeing a woman rather than a man was one of the reasons you came to the well woman clinic? **YES/NO.**

C) How important is it for you that the clinic is mobile?
Very ❐
Fairly ❐
Not very ❐
Not at all ❐
Did you find it easy to get here to-day? (travel) **YES/NO.**

THANK-YOU FOR FILLING IN THIS SECTION .

❐❐❐❐

PART TWO

1. Do you feel that you got what you wanted from the well woman clinic? **YES/NO please give reasons**.....
.....
.....

b) Was the main reason for you coming dealt with? **(any problems if not)**.....
.....

2. Which of the following phrases or statements do you feel apply (if any) to the well woman clinic? **(ANSWER YES/NO)**
a) I got a complete check-up **YES/NO**
b) The nurse / person I saw had plenty of time for me **YES/NO**
c) I felt able to discuss everything that was worrying me. **YES/NO**
d) I was given helpful advice concerning my health **YES/NO**
e) I was given helpful advice concerning diet/exercise/relaxation. **YES/NO**
If NO to any of the above ask reasons
.....
.....
.....

3. Did you feel that you have been given new information or advice about health care that you did not have before? **YES/NO** if **YES** state what new infomation was given to you.
.....
.....

4. How do you feel about the advice given to you?
a) There was too much. ❐
It was about right ❐
I would have liked more information. ❐
on .....
b) I felt the advice would be easy to act on. ❐
I felt that the advice would be fairly easy to act on.❐
I felt that the advice would be difficult to act on.❐
I felt that the advice would be impossible to act on. ❐

c)Did you feel that you were being given unecessary infomation at all in any way/or information that you already knew **YES/NO..... what?**

d) Will the advice given to you change the way you do things? **YES/NO (please give reasons)**

.....
.....

5 a) Overall what do you like best about the well woman clinic, or the way you were treated?

.....
.....
.....

b) Overall what do you dislike most about the well woman clinic or the way you were treated?.....
.....
.....

6. Will you come to the well woman clinic again? **YES/NO (please give reasons).....**
.....

7. Having seen a nurse who would you prefer to run the clinic a doctor or a nurse? **DOCTOR/NURSE**

(The following questions relate to breast and cervical screening, areas in which the well woman clinic particularly wishes to respond to womens needs)

1. Do you know what a cervical smear is? **YES/NO/NOT SURE/I DONT KNOW.**

2. Did you have one here today? YES/NO/ Booking a future appointment.
Have you ever had a cervical smear test before today? **YES/NO/I MAY HAVE/I DONT KNOW./**
If **YES** do you have them regularly? **YES/NO frequency =**
If **NO** what is your main reason for not having one?
.....

3. What would you say it means to have a **positive result** after a smear test?.....
.....
.....

does it mean cancer? **YES/NO/DON'T KNOW**

4. What would you say that **inflamatory changes** means?.....

.....

.....

does it mean cancer? **YES/NO/DON'T KNOW**

5. Which of the following phrases or terms would you associate with the cervical smear test? **(tick as many as you feel apply)**

a) A preventitve health measure. ☐
b) A test which may save my life. ☐
c) A test to detect cancer. ☐
d) A test to prevent cancer. ☐
e) A painless test. ☐
f) An uncomfortable test. ☐
g) An embarrassing test. ☐

6. Do you feel that cervical cancer is curable? **(please tick one)**

YES ALWAYS. ☐
YES IN MOST CASES. ☐
YES BUT ONLY RARELY ☐

NO NEVER. ☐
DON'T KNOW. ☐

7 . What do you think are the main causes of cervical cancer?

.....

.....

8 a) Do you feel that the cause of cervcal cancer could be related to a womans occupation? **YES/NO.**

b) Do you feel that the cause of cervical cancer could be related to a womans husbands/partners occupation? **YES/NO.**

9. After having been to the well woman clinic do you feel less worried about the results of a smear test? **YES ALOT/ YES BUT ONLY SLIGHTLY/NO I FEEL SLIGHLTY MORE WORRIED/NO I FEEL ALOT MORE WORRIED/NO CHANGE.**

Why would that be?.....

.....
.....

10. a) Did you know how to examine your breasts before you went to the well woman clinic? **YES/NO/NOTSURE.**
b) Do you feel that you now know how to examine your breasts? **YES/NO/NOT SURE/KNEW BEFORE**

11. Do you feel it is useful for the nurse to examine your breasts? **YES/NO/I DON T KNOW.**
(please give a reason)
.....
.....
.....
.....

12.i) How frequently did you examine your breasts before today?.....
.....
.....

ii) Which of the following apply to you? **(tick one box only)**
a) I regularly examined by breasts and will do so in future ❐
a) I did not regularly examine my breasts but I will do so in the future. ❐
b) I would like to examine my breasts but I am unlikley to have the time.❐
c) I would like to examine my breasts but I do not know how to. ❐
d) I did not regularly examine my breasts and will not do so in the future.❐
e) I do not wish to examine my breasts and would prefer a nurse/doctor to examine them. ❐
f) I do not want my breasts examined by any-one. ❐

13. Would you say that you have any special needs that you would like the well woman clinic to respond to. **OR** That there was anything that wasn't covered by the clinic that you would have liked there to be.**YES/NO.**
If YES please explain in what way.....
.....
.....
.....

14. Please feel free to add any further comments you have concerning the well woman clinic

.....

.....

.....

.....

Thank-you for filling in this questionnaire. The results will be available for users of the well woman clinic.