

**FACILITATING AND MAKING INFORMED CHOICES DURING PREGNANCY:  
A STUDY OF MIDWIVES AND PREGNANT WOMEN**

**Valerie Anne Levy**

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**Department of Nursing**

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## INDEX

Acknowledgements	7
Summary	8
Introduction	10
<b>Part 1: Background and methodology</b>	<b>11</b>
Chapter 1: Introduction to the maternity services in England and rationale for the study	12
1.1 Introduction	12
1.2 Outline of present patterns of maternity care in England	13
1.3 Outline of the role of midwives and the status of midwifery in the United Kingdom	15
1.3.1 Midwifery and the role of midwives	15
1.3.2 An outline of the development of the midwifery profession in the United Kingdom	16
1.3.3 Midwifery in the 1990s	19
1.3.3.1 Changing Childbirth	21
1.3.4 Summary	27
1.4 Consumerism, patient participation and informed choice in maternity settings	27
1.4.1 The literature search	32
1.4.2 Role and power of the midwife	33
1.4.3 Availability of knowledge	36
1.4.4 Resources	39
1.4.5 Summary	40
1.5 Making informed choices in non-maternity health care settings	40
1.6 Summary and conclusions	42
 Chapter 2: The philosophical basis of the study	 44
2.1 Introduction	44
2.2 Paradigms	44
2.2.1 An overview of the development of the major research paradigms	45
2.3 The constructivist paradigm	48
2.3.1 Ontology	51
2.3.1.1 Symbolic interactionism	51
2.3.2 Epistemology	53
2.3.3 Methodology	55
2.3.3.1 Hermeneutics	55
2.3.3.2 Language	57



2.3.3.3 Reflexivity	58
2.4 Justification for the choice of the constructivist paradigm	59
2.5 Summary	62
 Chapter 3: The theoretical basis of the study	 63
3.1 Introduction	63
3.2 Theories, theoretical frameworks and concepts	63
3.3 Grounded theory	65
3.3.1 The development of grounded theory	66
3.4 Data collection, analysis and theory development	67
3.4.1 Concept formation: open coding	68
3.4.1.1 Memoing	69
3.4.1.2 Theoretical sampling	69
3.4.1.3 Theoretical sensitivity	71
3.4.1.4 The role of published literature in grounded theory studies	71
3.4.1.5 Hypothesising and categorising	72
3.4.2 Concept development: axial coding	73
3.4.3 Concept modification and integration	74
3.4.3.1 Closure	74
3.5 Trustworthiness of data and their analysis	75
3.5.1 Credibility	75
3.5.2 Transferability	76
3.5.3 Dependability	76
3.5.4 Confirmability	76
3.6 Summary: the application of the grounded theory approach	77
 Chapter 4: Method	 79
4.1 Introduction	79
4.2 Initial data collection	79
4.2.1 Initial recruitment strategies	80
4.2.2 Initial sampling strategies	81
4.2.3 Initial data collection and data management	82
4.2.4 Follow up interviews of midwives and women	84
4.3 Later stages of data collection	85
4.3.1 Subsequent recruitment and theoretical sampling	85
4.3.2 Ethical issues	88
4.4 Summary of data collection strategies	88
4.5 Data analysis	89
4.5.1 Concept formation: open coding	90
4.5.2 Memo writing	92
4.5.3 Concept development: axial coding	96
4.5.3.1 Theoretical sensitivity	98
4.5.4 Concept modification and integration	98
4.5.6 Identification of the core categories	104

4.6	Assessing trustworthiness	105
4.6.1	Assessing credibility	105
4.6.2	Assessing confirmability	106
4.6.3	Assessing transferability	107
4.7	Summary	108
<b>Part 2: Findings</b>		<b>109</b>
Chapter 5: The midwives: facilitating informed choice		110
5.1	Introduction	110
5.2	Protective Steering: 'Picking your line'	111
5.3	Orienting	115
5.3.1	Sensitising	115
5.3.1.1	Stereotyping	116
5.3.1.2	Perceiving	117
5.3.1.3	Exploring	118
5.3.2	Territory mapping	121
5.3.2.1	The hierarchy, policies and procedures	122
5.3.2.2	Midwives skills and knowledge	124
5.3.2.3	Ownership and 'stepping on toes'	125
5.4	Raising awareness	129
5.4.1	Setting the agenda	131
5.4.2	Elucidating	135
5.4.3	Offering choice	138
5.5	Protective gatekeeping	140
5.5.1	Protecting the woman	140
5.5.1.1	Protecting against physical harm	141
5.5.1.2	Protecting against emotional harm	147
5.5.2	Protecting self	153
5.6	Summary	155
Chapter 6: The women: Making informed choices		156
6.1	Introduction	156
6.2	Maintaining Equilibrium	156
6.3	Regulating information	159
6.3.1	Avoiding	161
6.3.2	Delaying	162
6.3.3	Pursuing	162
6.3.3.1	Strategies used to pursue information	167
6.3.3.2	Information in times of crisis	168
6.4	Contextualising information	176
6.4.1	Legitimizing	177
6.4.1.1	Checking information	177
6.4.1.2	Checking the individual	180

6.4.2	Personalising	181
6.5	Actioning	186
6.5.1	Asserting	186
6.5.2	Playing the game	189
6.5.3	Taking it as it comes	191
6.5.4	Handing over	191
6.6	Summary	194
<b>Part 3: Discussion</b>		<b>195</b>
Chapter 7: Discussion and summary of findings		196
7.1	Introduction	196
7.2	Conceptualisations of power	200
7.2.1	Power as a normalising influence: surveillance	202
7.2.2	Power as a positive force	210
7.2.3	Power, knowledge and truth	212
7.2.3.1	Hierarchy and oppression	214
7.2.3.2	Control of the agenda	215
7.2.3.3	Power and manipulation	217
7.2.3.4	Counterbalances	219
7.2.4	Empowerment	225
7.2.5	Summary	229
7.3	Trust	229
7.3.1	Trust by women of midwives	230
7.3.2	Trust by midwives of women	235
7.3.3	Trust by and of midwives of the working environment/ organisation	238
7.3.4	Summary	239
7.4	Summary of the main findings	239
7.5	Implications for midwifery practice	240
7.5.1	The relationship of this study to published midwifery and nursing theories	243
7.5.2	Summary and emergent hypotheses	244
Chapter 8: Reflections upon the study		248
8.1	Introduction	248
8.2	Planning the study	248
8.3	Organisation	251
8.3.1	Access	251
8.3.2	Rejection	252
8.3.3	Data collection	253
8.3.3.1	Observation	254
8.3.3.2	Interviewing	254
8.3.4	Analysis of data	257
8.4	Saturation	260



8.5	Conclusion	261
<b>Part 4: References and Appendices</b>		<b>262</b>
References		263
Appendix 1	The role and responsibilities of the midwife	283
Appendix 2	Characteristics of participants	285
Appendix 3	Consent forms for midwives	289
Appendix 4	Consent forms for women	293
Appendix 5	Transcript and preliminary analysis of data from Midwife C	297
Appendix 6	Transcript and preliminary analysis of data from Woman C	310
Appendix 7	Outline definitions of midwifery/obstetric terms	328
<b>List of Tables</b>		
Table 2.1	Comparison of some major paradigms	49
Table 3.1	Summary of the stages of data analysis	70
Table 4.1	Data collection strategies	89
Table 4.2	Transcript and related memo: Crisis	93
Table 4.3	Summary of strategies used to establish trustworthiness	105
Table 6.1	Matrix: Strategies for actioning	187
<b>List of Figures</b>		
Figure 4.1	Theoretical sensitivity	99
Figure 4.2	Preliminary framework: midwives	100
Figure 4.3	Interim framework: midwives	101
Figure 4.4	Preliminary framework: women	102
Figure 4.5	Interim framework: women	103
Figure 5.1	Midwives framework	112
Figure 5.2	Protective Steering	113
Figure 5.3	Raising awareness	133
Figure 5.4	Gatekeeping and assimilation of information	142
Figure 5.5	Midwives perceptions of outcome of women's assimilation of information	143
Figure 5.6	Factors influencing the provision of information	151
Figure 6.1	Women's framework	157
Figure 6.2	Maintaining equilibrium	158
Figure 6.3	Regulating information: Maintaining equilibrium	160
Figure 6.4	Levels of information required particularly in a crisis	175
Figure 6.5	Assessing truth and developing trust	178
Figure 7.1	Balancing: walking a tightrope	197
Figure 7.2	Outline of conditions and consequences of trust between individuals (and organisations)	233
Postscript		330

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Valerie Anne Levy

## Summary of thesis

Over the past several years various authors and Government reports have urged that women be enabled to make informed choices regarding their care during pregnancy and childbirth. The facilitation and making of these choices involves complex processes, however, which apparently have not yet been studied in depth; this is the purpose of this study.

A grounded theory approach to data collection and analysis has been used within a interpretive framework, influenced by symbolic interaction, to develop middle range, substantive theory.

Midwives and pregnant women were accessed from four maternity units. Data were collected by means of loosely structured interviews and observation. All 48 interviews were transcribed and provided the main source of data. Convenience sampling was supplemented later in the study by theoretical sampling.

Data were analysed and theoretical frameworks constructed according to grounded theory method. Several strategies were used to confirm the trustworthiness of the data and their analysis.

From the midwives data, the core category was identified as *Protective Steering*, whereby midwives tried to steer the women and themselves through various pitfalls and dilemmas. Substantive categories were Orienting, Raising Awareness and Protective Gatekeeping.

The core category emerging from the women's data was *Maintaining Equilibrium*, whereby the woman attempted to make decisions that would preserve the balance of her life, and that of her family. Substantive categories were Regulating, Contextualising and Actioning.



The category which linked the two sets of data and theoretical frameworks was named *Balancing: Walking a Tightrope*.

Two main over-arching issues emerged as power and trust. Issues of power related to the study are discussed mainly in terms of Foucault's and Lukes' interpretations of power. Trust is discussed in relation to existing theories and their application to this study.

Recommendations for midwifery practice are made, together with hypotheses for further exploration.

## **Introduction**

This thesis is organised into four parts. The first part, comprising Chapters 1 to 4, describes and discusses the background to the study, and its philosophical and methodological approaches.

The second part, consisting of Chapters 5 and 6, describes and discusses the findings of the study in terms of the midwives' and women's data respectively.

The third part, comprising Chapters 7 and 8, discusses the overarching issues pertaining to the midwives and the women's data, makes recommendations for practice and further research, and also reflects the role I played in the study, together with its development, conduct and limitations.

The fourth part contains references and appendices.

## **Part 1**

### **Background and methodology**

Chapter 1 provides a background to the study, focusing upon the maternity services, the role of the midwife in the United Kingdom, and consumerism in the health services.

Chapters 2 and 3 describe the philosophical and theoretical bases for the study, and Chapter 4 details the methodological approaches used.

## INTRODUCTION TO THE MATERNITY SERVICES IN ENGLAND AND RATIONALE FOR THE STUDY

### 1.1 Introduction

*The woman must be the focus of maternity care. She should be able to feel that she is in control of what is happening to her and able to make decisions about her care, based on her needs, having discussed matters fully with the professionals involved.'*

*(Department of Health (DoH 1993:9)*

The quotation above is extracted from the Changing Childbirth Report which advocated choice and control for women during childbirth, together with increased responsibility and autonomy for midwives. Over the past several years many authors, including midwives, have urged that women be enabled to make informed choices regarding their care during pregnancy and childbirth.

As a midwife recently engaged in trying to facilitate informed choice, and a user of the Health Service who has tried to make (and implement) my own choices, I am aware of some of the difficulties this poses in practice. After often quite long sessions trying to help women in pregnancy make choices I have sometimes asked myself questions such as *'Did I really put over the options fairly to her (the pregnant woman) or did my own feelings influence what I said?'* and *'Will she really do as she said she would? - I don't think she will - but why - what did she not tell me?'* As a patient trying to make choices I have been influenced by many factors, including my trust of the professional advising me, the extent of my information and my perception of the ability and willingness of the professional to inform me.

The concept of informed choice is generally advocated as highly desirable in empowering people to control their lives, but is, I believe, a complex process in need of deconstruction. As far as I am aware little work has been done in this area, particularly in relation to midwifery and childbirth. Consequently, the purpose of this study is to identify and explore the processes engaged in by midwives and the women in their care when facilitating or



making informed choices during pregnancy, and to construct theoretical frameworks to map these processes.

'Informed' is defined as '*knowing the facts, enlightened*' and 'choice' as '*deciding between alternatives*' (Fowler and Fowler, 1946). Little is known about the ways such facts and alternatives are presented by midwives to women, and the factors influencing, or the processes involved, when midwives facilitate, and women make, these choices.

A grounded theory approach to data collection and analysis will be used.

This Chapter will contextualise the study by outlining traditional and changing patterns of maternity care, the role of midwives and the development and status of the midwifery profession within the United Kingdom, especially with regard to the control of midwives and their practice. The provision of choice in relation to consumerism and power within health care settings will be discussed.

## **1.2 Outline of present patterns of maternity care in England**

Patterns of maternity care may differ throughout England, and continue to evolve as new initiatives in care are implemented (for example, DoH 1993, Currell 1996). The pattern of care which has been in operation for many years and is still frequently adopted is described as follows. Maternity care often starts when a woman attends her General Practitioner (GP) for confirmation of her pregnancy. At this point she is likely to meet her Community midwife who works with the GP, or who may be one of a small team of midwives working both in hospital and the community. Usually this happens within the first twelve weeks of pregnancy. The GP assesses the woman's medical and obstetric history, and a decision is made regarding where she will deliver the baby. If delivery under the care of a Consultant is chosen, the women will attend a 'booking' clinic at the hospital, where a full medical, obstetric and family history is taken by a midwife and the woman is examined by an obstetrician and offered various screening tests, mainly to investigate the normality of the fetus (these tests will be referred to in greater detail in subsequent Chapters). The woman will then normally return to her GP and community midwife for monthly antenatal checks

until the 28th week of gestation, then fortnightly until 36 weeks and weekly until delivered. Often, at 36 weeks, the woman will return to the Consultant Unit for examination by an obstetrician. If any serious problems arise during pregnancy, the GP will refer the woman to the Consultant Obstetrician.

Most women (especially if risk factors are present) deliver in Consultant Obstetric Units, which are usually maternity units attached to District General Hospital where all facilities for emergencies are readily available (such as anaesthesia, surgery, blood transfusion and neonatal intensive care). If no risk factors are present the woman may deliver in a peripheral GP unit, which has limited emergency facilities, or at home. These last two options are relatively rarely used mainly because of the closure of many GP Units on economic grounds and accusations that they provide an elitist service for the relatively small group of women able to access them (Campbell 1990). Concerns (probably unjustified) also have been voiced about the safety of GP Units (Campbell, MacFarlane and Cavenagh 1991), and many GPs are reluctant to provide medical cover for home deliveries (see 1.3.3). Some women with risk factors insist upon being delivered at home, however, and, according to the Midwives Rules (UKCC 1993) and Midwife's Code of Practice (UKCC 1994) it remains the midwife's duty to provide care for these women during labour even if medical cover is refused. Sited in some Consultant Units are GP or midwife-run delivery facilities, where women may be cared for in labour by their GP and/or midwife, only being transferred to the care of a Consultant if abnormalities arise.

A woman is likely to be cared for in labour, and delivered, by a midwife (further detail about the role of the midwife is provided in 1.3 and Appendix 1) unless abnormalities, such as slow progress in labour or fetal distress, occur when an obstetrician (together perhaps with an anaesthetist and paediatrician) will be called to provide medical assistance.

Patterns of postnatal care vary. Some women may return home (or to a GP Unit) between six and forty eight hours following delivery and the rest of their care will be provided by their community midwife and GP. If abnormalities are present (for example, hypertension, excessive blood loss, or problems with the baby) the woman's stay in the Consultant Unit may be longer. The midwife will provide postnatal care for the woman and her child, on



(usually) a daily basis until the tenth postnatal day, continuing her care as necessary until the twenty eighth day, when care is handed over to the health visitor. The woman will be asked to return to her GP approximately six weeks following delivery for a final postnatal examination.

A traditional pattern of care has been outlined, but as stated above, patterns of care are changing in response to the findings of research into the efficacy of antenatal visits at the intervals described above (for example, Hall, Chng and MacGillivray, 1980; Tucker, Florey, Howie, McIlwaine and Hall, 1994; Currell 1996). For example, in a few areas, midwives take additional responsibility for women in their care, bypassing GPs almost completely and having direct referral rights to a Consultant. Several innovative schemes have been set up to facilitate antenatal care and to make it less formal, such as 'walk in' clinics staffed by midwives and located in shopping centres (DoH 1993: 23). Additionally, 'booking' and other antenatal visits increasingly are carried out by midwives in women's homes. The use of computers to guide interactions between midwife and women and record the resulting data, is also becoming more widespread.

### **1.3 Outline of the role of midwives and the status of midwifery in the United Kingdom**

#### **1.3.1 Introduction: Midwifery and the role of midwives**

Midwives are trained and educated to provide care to women and their babies throughout pregnancy, labour and the postnatal periods. The mediaeval word 'midwyf' means 'with woman', and the midwife will attend the childbearing woman and her baby wherever and whenever they require care. The essence of the midwife's work is focused upon the needs of women and their babies. (An official definition of the midwife's role is provided in Appendix 1). The following section outlines the present role of the midwife and some aspects of the history of midwifery, focusing particularly upon the relationship between midwives and obstetricians, in order to demonstrate the controls historically imposed upon midwives and midwifery. Issues related to power, control and midwifery will be discussed further in subsequent Chapters, particularly in Chapters 5 onwards.

Since mediaeval times midwifery has been subject to governance by the Church or the State (Donnison 1977). Today the midwifery profession is regulated by an act of parliament and the resultant statutory body, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (the UKCC). The UKCC maintains professional registers, and oversees standards of education and training together with standards of professional competence. The National Boards are directly involved with improving standards of education, training and practice, together with advising on the supervision of midwifery practice (English National Board (ENB) 1996).

Amongst other requirements midwives

- have successfully completed a recognised programme of education leading to registration as a midwife with the UKCC,
- give complete care to the woman and her baby during normal pregnancy, labour and the postnatal period,
- provide emergency assistance in the absence of a medical practitioner,
- are required to be clinically competent and up-to-date,
- educate and advise women about pregnancy, childbirth, infant care and related issues,
- help women make informed choices about their care,
- liaise with other health professionals such as medical practitioners, health visitors and social workers.

Midwives may work in consultant maternity units, health centres, general practitioner surgeries and obstetric units, and in women's homes. Approximately 75% of deliveries in Great Britain are conducted solely by midwives (ENB 1994).

### 1.3.2 An outline of the development of the midwifery profession in the United Kingdom

Midwifery is traditionally credited with being the second oldest profession in the world, many ancient records (including the Bible) referring to women being with and caring for other women in labour. Standards of midwifery training and practice are reported to have fluctuated widely in England from mediaeval times to the present day. For example, during the 17<sup>th</sup> century London midwives were required to undergo several years of training, and,



licensed by the Bishop of London, appeared to have been generally highly regarded by the public (Hitchcock 1967).

The 17<sup>th</sup> century onwards saw the emergence of the 'male midwives', the precursors of today's obstetricians. It became fashionable in the more wealthy families to engage male midwives - armed with their newly invented obstetric forceps and interventionist strategies - for delivery (Aveling 1872). In 1872 the obstetrician's fee was reported as approximately 2 guineas (Forbes 1971). Poorer women could not afford these fees and so midwives, despite the growing numbers of male midwives, continued to deliver the majority of women.

During the Industrial Revolution standards of midwifery are reported to have fallen, and the reputation of midwifery and midwives became tarnished with accusations of incompetence, dirtiness and drunkenness, epitomised by Dicken's Sairey Gamp (Forbes, 1971). Whether, in fact, standards of midwifery care really did fall is unknown. Certainly, it was in the interests of the increasingly powerful group of 'male midwives' that standards amongst female midwives should be seen as unacceptably low. By denigrating the practice of (female) midwives, male midwives were enabled to continue to accrue professional power, and a near monopoly upon the potentially lucrative practice of obstetrics. Forbes (1971) points out however that according to a report by a contemporary statistician the maternal mortality rate in 1872 was 1 in 189 (about 5.3 per thousand); approximately one third of what it had been in the 1700s, and this reduction in mortality would appear to vindicate the standards of midwives who were still delivering most of the women. Indeed:

*'The Report (1872) went on to say that in the Royal Maternity Charity Hospital, an institution in which only trained midwives were employed, the maternal death rate in childbed was in general 1 in 400, and last year 1 in 900.'* (Forbes 1971:356)

It appears therefore that standards amongst trained midwives were as high, or higher, than ever and it seems that maternal mortality rates associated with trained midwifery practice were relatively low. Concerns were expressed, however, in particular by trained midwives and women's groups, about the low standards and ignorance of untrained midwives - both female and male; at this time anyone could practice as a midwife. A report of 1823 states:

*'One of them (a male midwife) had just taken up the practice of midwifery, and the only training he had received in the art was from an old midwife in the neighbourhood. At*



*one delivery he mistook the presenting head for the placenta. In attempting to cut through this structure, he scalped the baby. At about the same time another male midwife was indicted for the murder of a woman he had delivered ... he was about 75 years of age and not a regularly educated accoucher ... ' (Forbes 1971:356&7)*

Towards the end of the 19<sup>th</sup> century there was increasing concern expressed in parliament and elsewhere about high maternal and perinatal mortality rates. Trained midwives continued to be amongst the most vocal advocates for the proper training and licensing of midwives but encountered considerable opposition from the powerful medical lobby and this together with a lack of parliamentary interest delayed the passing of the first Midwives Act for many years (Donnison 1977). At last, however, it was recognised by parliament that midwifery and the training of midwives needed to be regulated for the safety of the public. Midwifery was legally recognised as a profession by the first Midwives Act of 1902, but only by conceding medical dominance of the Central Midwives Board, the body set up by the Act which assumed responsibility for the practice and examination of midwives (Robinson 1990).

As Robinson pointed out, the subsequent development of midwifery during the 20th century has been characterised by:

*'...changes in the structure and organisation of midwifery services, in particular, those which have affected provision of continuity of care by midwives, and women's access to midwives; the division of responsibility between midwives and medical staff .... and the extent to which midwives have been able to exert control over their own profession ....' (Robinson 1990:61&62)*

With the passing of several further Midwives Acts the midwifery profession continued in the struggle to improve standards of practice and to assert its right towards self regulation. Gradually the composition of the Central Midwives Board tended towards inclusion of more midwives, until eventually there was a majority of midwife members. For the first time in English history midwives possessed the balance of power to control the regulation of midwifery (Robinson 1990). This happy state of affairs lasted a mere 3 months, however (during which time the midwife dominated Board did not vote upon any issue), ending when the Nurses, Midwives and Health Visitors Acts of 1979 and 1992 were passed which set up the UKCC and the National Boards for Nursing, Midwifery and Health Visiting. With the passing of the 1979 Act, for the first time the professions of nursing and midwifery were



combined under a single legal framework, and midwives lost their recently acquired control of the regulation of midwifery to nursing.

### 1.3.3 Midwifery in the 1990s

Midwives continue to resist dominance by more powerful professions, such as medicine and nursing. Despite claims that midwives are practitioners in their own right (for example, Mander 1993a) with their own statutory regulations (Midwives Rules: UKCC 1993) and The Midwife's Code of Practice (UKCC 1994), midwifery practice has long been medically dominated. A prevailing view, which influenced the move towards hospital 'confinements' for all women, is that pregnancy is normal only in retrospect, and that medical complications needing urgent treatment are likely to arise at any time (Oakley 1984). Medically driven decisions have been imposed upon women in the belief that these are safer, and/or because they are more convenient for the medical establishment. For example, home deliveries have been discouraged to such an extent that if a woman, despite intense pressure from medical and sometimes midwifery practitioners, insists upon being delivered at home she runs the risk of being removed from the list of her GP:

*'... because they (GPs) do not want to provide medical support for home births, but nor are they willing to see midwives providing full maternity care for low-risk women with the medical back-up of obstetricians.'* (Newburn and Dodds 1995:66).

This is despite a lack of evidence that home births are any less safe for the mother or her child than hospital deliveries (for example, Tew 1990). Home births in England and Wales are, however, slowly increasing from an all time low of 0.9% in 1987 to 1.6% in 1993 (Macfarlane, Mugford, Johnson and Garcia, 1995).

Concern about the medicalisation of childbirth led to public inquiries and the publication of two particularly influential reports during the early 1990s. The first of these is The Second Report of the Health Committee of the House of Commons (DoH 1992) chaired by Nicholas Winterton MP. Universally known as the Winterton Report, this report on the maternity services discredited the pathological view of childbirth, reaffirming that childbirth is a normal physiological process for the majority of women, and asserting the right of women to make informed choices regarding their care during pregnancy, labour and the puerperium. Examples of these choices include whether or not to undergo certain tests for fetal



abnormality, where to attend for antenatal care, where and how labour is to take place, whether labour will be induced, whether invasive fetal monitoring techniques will be used, and whether the baby will be breast or bottle fed.

The Winterton Report gave rise to the Report of the Expert Maternity Group (DoH 1993) 'Changing Childbirth', chaired by Baroness Cumberledge. Both of these reports were informed by several midwifery initiatives as well as by individual midwives and midwifery and consumer organisations, and made far-ranging recommendations, most of which are of direct relevance to midwifery practice. Currell (1996) cautions however that many of these recommendations are based not upon evidence, but upon opinions voiced by relatively small groups that have specific interests and agendas to achieve, and may not represent the attitudes and wishes of all midwives and childbearing women. It may be cynical to point out that cost implications may have played a major part in the acceptance by the Government of the recommendations since midwives are probably cheaper to employ than doctors and 'natural' childbirths are probably cheaper in terms of facilities and equipment than 'technological' childbirths (Stolte, Myers and Owen 1994; Stone and Walker 1995), although it is difficult to state this with any certainty as few statistics related to comparative costs in the maternity services are available (Smith 1995). Ratcliffe, Ryan and Turner (1996) have shown, however, that community antenatal care by GPs and midwives costs significantly less than that provided by obstetrician-led shared care.

Nevertheless, both of these Reports have been widely regarded as a vindication and victory of 'natural childbirth' over 'technological childbirth', and of the practice of midwives as the primary providers of care in normal childbirth (Currell 1996). Some disquiet has been expressed regarding these views, however. For example, the notion of 'victory' of one group and model of childbirth over others has been criticised as unhelpful in provoking the continuation of old (and perhaps not so old) rivalries. Models of partnership (see 1:4) amongst professionals and women is advocated as the positive way forward (for example, Jackson 1993, Currell 1996). Some of the recommendations made by the Winterton and Changing Childbirth Reports imply radical changes to the way in which midwives practice, including the extent and way in which midwives facilitate informed choice. However, the extent to which these recommendations are being implemented is variable, although by



August 1994 Health Authorities were required to ensure that the maternity services they bought had strategies for implementing the recommended changes (Midwives Chronicle 1993). Some of the recommendations and strategies for their implementation are discussed below.

1.3.3.1. Changing Childbirth The 'Changing Childbirth' report (DoH 1993) made several recommendations for midwifery practice in England which are affecting the way that midwifery care is delivered. Emphasis is placed upon the importance of women being involved in making informed decisions about their care, for example:

*'Women should be fully involved when decisions are to be made about their care.'* (2:2);

*'Women should receive clear, unbiased advice and be able to choose where they would like their baby to be born. Their right to make that choice should be respected and every practical effort made to achieve the outcome that the woman believes is best for her baby and herself.'* (2:6);

*'Antenatal care should .... ensure that the woman and her partner feel supported and fully informed throughout the pregnancy, and are prepared for the birth and the care of their baby.'* (2:5);

*'Women should have the opportunity to discuss their plans for labour and birth ... every reasonable effort should be made to accommodate the wishes of the woman and her partner ...'* (2:8);

*'All women should have the opportunity to be fully involved in their care.'* (3:6).

There are several other major recommendations, one of which is:

*'A woman with an uncomplicated pregnancy should, if she wishes, be able to book with a midwife as the lead professional for the entire episode of care including delivery in a general hospital.'* (2:4)

Thus, a woman would be able to choose a midwife as the lead professional in her care throughout pregnancy, labour and the postnatal period. In the past, pregnant women have 'belonged' to obstetricians or GPs; this is no longer the case if a midwife is the lead professional. She or he takes responsibility for the care of the woman, referring her for medical intervention only if a specific need arises:



*'The knowledge and skill of the obstetrician should be used primarily to provide advice, support and expertise for those women who have complicated pregnancies.'* (2:12).

This is likely to result in better use of the obstetrician's skills. It should be noted however that a woman with a normal pregnancy in theory would be free to choose the obstetrician (or GP) as her lead professional. This would be likely to be prohibitively expensive and, particularly regarding the obstetrician, would constitute a misuse of her or his skills which would be more properly used in the care of high risk women (Currell 1996).

As the lead professional, the midwife has sole responsibility for helping the woman to make choices regarding her care, and has increased freedom of practice to carry through these choices. The full range of the midwife's skills is more likely to be utilised:

*'The part which the midwife plays in maternity care should make full use of all her skills and knowledge, and reflect the full role for which she has been trained.'* (2:11).

Midwives are trained and educated to provide care to women and their babies throughout normal pregnancy, labour and postnatal period. Their skills probably are cheaper than those of obstetricians and GPs, as long as they are properly targeted to the women who need them. For example, it would be wasteful of a midwife's time to spend long periods with a woman with a normal pregnancy and no social or other problems. Her time would be better spent supporting women experiencing problems (Warwick 1997). The full use of midwives' skills is economical for the NHS. Indeed, some NHS Trusts have contracted group practices of independent midwives to provide complete care for women in their catchment area (for example, Friend 1996). Several midwifery group practices have been set up outside the NHS, but possibly contracting to the NHS as mentioned above. Midwives in these independent practices may be employed directly by women to provide full care (often including home birth) for fees which are often variable, depending upon the ability of women to pay. These midwives have usually negotiated admitting rights to hospital maternity departments, with direct access to senior obstetricians.

Unfortunately, many of these entrepreneurial opportunities have failed, partly due to the refusal of insurance companies to provide affordable insurance for independent midwives (Independent Midwives Association (IMA) 1996). Midwives employed by Health Trusts are,



in effect, covered for malpractice/negligence claims by their Trust. Underwriting organisations offer midwives relatively cheap insurance, via professional organisations, knowing that negligence claims will probably be settled by the Trust and, more importantly, are unlikely to be brought against the midwife; the Trust itself or an obstetrician being a more likely target for claims. Midwives in independent practice are far more vulnerable to being sued directly, however, and are unlikely to be covered by a Health Trust as they are not employees of any Trust. Insurance companies are therefore unwilling to offer independent midwives affordable insurance; the high price of cover (over £12,000 per annum as opposed to approximately £100 per annum paid for the same cover by non-independent midwives) (Flint 1995) has resulted in many independent midwives giving up this form of practice, or practising uninsured (IMA 1996). Midwives are normally insured for claims up to approximately £2 million, which is a similar level to that of obstetricians. Midwives, however, earn considerably less than obstetricians and are consequently less able to afford insurance fees. Thus, by one relatively simple stroke, powerful organisations have removed from midwives the financial safety to practice independently. The Royal College of Midwives (to which most midwives belong as their professional organisation) have failed to resolve this issue (IMA 1996) so that although midwives are autonomous and accountable practitioners they are unable to practice safely as such without the cover of the powerful (and male, and often medically, dominated) Health Trusts.

The Changing Childbirth report advocated that each woman should know who 'her' midwife is, most having met the midwife caring for them during labour before labour starts:

*'Every woman should have the name of a midwife who works locally, is known to her and whom she can contact for advice ... Within 5 years, 75% of women should be cared for in labour by a midwife whom they have come to know during pregnancy.'* (2:3)

Many providers of maternity care have argued the need for continuity of care for several years, claiming that this leads (amongst other outcomes) to greater client satisfaction and less obstetric intervention (for example, Flint, Poulengeris and Grant 1989). Various initiatives such as the 'Know Your Midwife' scheme (Flint et al 1989) have been set up, comprising teams of midwives and involving women in their care. As Hodnett (1993) pointed out however the research evidence that continuity of care is effective and desirable is

scarce. Many schemes of 'team midwifery' have nevertheless been set up over the past several years (Wraight, Ball, Seccombe and Stock, 1993) designed to offer continuity of care to women, including having a midwife already known to the woman present at delivery. These schemes have not been without their problems, including poorly addressed logistical problems of small teams of midwives attempting to cope with heavy caseloads and the disruption 'on call' rotas cause to midwives' personal lives. Wraight et al (1993) found a quarter of team midwifery schemes set up in 1990 had been discontinued by 1991, and few schemes had been properly evaluated.

Initiatives to implement the recommendations of the Changing Childbirth report continue to be implemented. Innovative schemes were funded by the Department of Health (Jackson 1995), although Lewis (1995) pointed out that much of their success is at the expense of midwives in terms of their low salaries and their unrecompensed time and effort given to make such initiatives successful. The Changing Childbirth report set the following targets to be achieved within 5 years of the report:

- All women should be entitled to carry their own notes;
- Every woman should know one midwife who ensures continuity of her midwifery care - the named midwife;
- At least 30% of women should have the midwife as the lead professional;
- Every woman should know the lead professional who has a key role in the planning and provision of her care;
- At least 75% of women should know the person who cares for them during their delivery;
- Midwives should have direct access to some beds in all maternity units;
- At least 30% of women delivered in a maternity unit should be admitted under the management of a midwife;
- All women should have access to information about the services available in their locality.

(Adapted from the Changing Childbirth report: DoH 1993)



The ENB (1995) conducted a survey of midwifery practice in England to assess the progress being made towards achieving the targets outlined above. The survey revealed that, although there is still much to be done, in many areas patterns of care related to childbirth are indeed changing, and midwifery practice is developing, to become more woman centred and less medically dominated. The progress report noted:

- increased moves towards community based care, including more fetal assessment day care centres;
- a reduction in the average length of hospital stay;
- evidence that care is becoming more ‘woman centred’;
- the management of normal labour and the postnatal period is becoming increasingly the province of the midwife;
- more women are carrying their own case notes;
- more welcoming environments and facilities, especially in delivery suites;
- reorganisation of maternity services has often resulted in empowerment of midwives, and innovatory practice;
- more recognition of the need of midwives for continuing education;
- increased recognition of the importance of research;

However, the report revealed in some areas

- a lack of leadership and low staff morale;
- inadequate staffing levels preventing continuity of care;
- limited provision for continuing education of midwives;
- task oriented care, and little evidence of research based practice;
- inadequate or inappropriate record keeping;
- fragmentation of care, and care following rigid routines;
- medically oriented care;
- unwelcoming environments.

(Adapted from the ENB report 1995)

Recently an audit of maternity services has been conducted by the Audit Commission (1997) in order to describe and evaluate the nature and provision of maternity care, to investigate

the use of resources, and to obtain service users' views of the care they receive, especially in view of the recommendations of the Changing Childbirth report. Fitzsimmons (1997) reports some of the initial findings of a postal questionnaire survey the Audit Commission conducted to discover the views of a random sample of 2300 service users (detailed findings are not yet available). The survey results showed that, generally, women tended to rate highly the provision of care, over 80% indicating high levels of satisfaction, particularly regarding locally provided community services when women were highly likely to say they had been listened to, encouraged to ask questions and felt they had a more satisfactory, personal relationship with care providers. The survey also indicated, however, that women are not always receiving the necessary information to enable them to make choices regarding, for instance, where and from whom they receive antenatal care, and where they will give birth. Fitzsimmons reports:

*'There is also a limit to the extent to which women feel involved in key decisions about their care, particularly during labour. While in antenatal care over half of the women said they definitely had a say about whether to have certain screening tests or scans, but in labour the sense of involvement was less. Around 40% of the respondents felt they had a say in the decision about whether to induce or augment labour, but only one in five reported having a say in how the baby was monitored.'* (Fitzsimmons 1997: 390).

Only the findings of this audit specifically relating to choice have been summarised here but the scope of the audit is wide and there is little doubt that it will influence the development of national and local policies in the delivery of the type of care that has been advocated by the Changing Childbirth report. It appears that, although progress is being made towards delivering the type of maternity care women want, there is still some way to go before widespread achievement is apparent, particularly concerning the provision of information that can enable women to make informed choices about their care. There is evidence, however of individual and local group initiatives that focus upon enabling women to be in control of their pregnancies. For example, Page, Phillips and Drife (1997) described how the midwife (Page), the pregnant woman (Phillips) and the obstetrician (Drife) collaborated to their mutual benefit and satisfaction in assessing the risks (mainly of haemorrhage) of Ms Phillips, a grande multipara, delivering her baby at home. Ms Phillips was thereby helped to come to an informed choice regarding the place of birth in the light of research evidence.



Crichton (1997) reported the development of a 'Needs Assessment' model within her local Trust, which, although its evaluation is not yet complete, is designed to help women to make choices about their care.

#### 1.3.4 Summary

The purpose of this section has been to contextualise this study within today's changing midwifery scene. Women have been (and in many cases still are) cared for during pregnancy and childbirth by a medically dominated and paternalistic maternity service, within which many midwives continue to work. In response to consumer demands and supported by midwives and other health care professionals, recommendations have been made by government reports which maternity services are working towards implementing. These changes are aimed at enabling women to be involved in decisions regarding their care, presenting childbirth as an intrinsically normal process rather than a potentially pathological condition, and acknowledging the autonomy and accountability of midwives. Although these initiatives are generally welcomed by the midwifery profession, midwives currently are being asked to rethink and renegotiate their role and reorganise their practice. This process is occasionally painful as well as challenging. It is within this climate of change within the midwifery services that this study will be conducted.

#### **1.4 Consumerism, patient participation and informed choice in maternity settings**

In recent years the provision of health services has been influenced by consumerism. According to Richardson and Bray (1987) this trend was influenced by a desire by health service planners to engage with the increasing interest by the public in consumer issues (evidenced by the growth over the past several years in consumer oriented television programmes such as 'That's Life', 'Watchdog' and 'The Cook Report'). Consumerism, as Avis (1992:12) writes, involves getting to know consumers and their needs, and giving them what they want. Much of the evidence provided by consumer and other groups to the committees which produced the Winterton and Changing Childbirth reports emphasised the desire of women to make informed choices in childbirth and thus to gain some control over their care. Helping women to make informed decisions is constantly cited as an integral feature of midwifery care. For example:



*'One of the important principles upheld by the National Childbirth Trust is the right of women to make informed choices about their own and their baby's health care, specifically in relation to pregnancy and birth.'* (Taylor 1990:21)

Other government reports and charters have also advocated patients having choices, for example, 'Working for Patients' (Secretary of State for Health, 1989) and 'The Citizen's Charter' (The Government, 1991).

In a study of women's expectations and experiences of childbirth Green, Coupland and Kitzinger (1988) found that:

*'Most women wanted at least to have non-emergency decisions discussed with them and to be in control of what staff did to them ... The majority of women wanted to know as much as possible about what might happen in labour ... The great majority of women felt able to discuss their concerns with the staff. Working class and less educated women had more difficulties doing this ... A third of the sample felt dissatisfied with the amount of information they had been given so far during pregnancy ...'* (Green et al 1988a: Chapter summary 4).

*'Women with apparently identical experiences (of labour) draw totally different conclusions depending on the extent to which they see events as within their control ... wanting control and wishing to retain awareness of, and involvement in, the birth were important criteria to women assessing the pros and cons of different drugs ... the individual midwife's attitude was very important and could affect women's memories of the experience over and above the actual events of labour.'* (Green et al 1988b: Chapter summaries 1,4,8).

Brown, Lumley, Small and Astbury (1994) investigated women's perceptions of their experiences during childbirth and how the women thought these influenced their satisfaction with the birth and their wellbeing afterwards. Brown et al found that:

*'Not having an active say in decisions was associated with a six-fold increase in dissatisfaction among women having their first baby and a fifteen fold increase among women having a second or subsequent baby ... women who felt their views had been respected described how much they had valued this.'* (Brown et al 1994: 74 & 75)

In a factor analysis study of approximately 1800 newly delivered women in Canada Seguin, Therrien, Champagne and Larouche (1989) identified a major dimension of client satisfaction with care concerned receiving information and participating in making decisions.



Women require information to make decisions that enable them to feel in control of their care (King's Fund 1993). They may acquire information from a variety of sources including the media, consumer organisations such as the National Childbirth Trust, family and friends, and professionals, including midwives. Recently the Midwives Information and Resource Service (MIDIRS) has produced a series of leaflets aimed at providing midwives and women with up-to-date and user-friendly information regarding, for example, positions in labour and routine ultrasound (Rosser 1995). These leaflets have been evaluated to include their dissemination, acceptability to health professionals and pregnant women, and the design of the leaflets (Oliver, Rajan, Turner and Oakley, 1996). Implications of the findings from this evaluative study will be referred to at points throughout the subsequent text.

An editorial in the *Lancet* (1986) stated that the basic objectives of antenatal care are to meet the pregnant woman's need for information, advice and reassurance. As providers of antenatal care, and primary sources of information, midwives are in a strong position to influence the choices made by the mothers they attend. As Kirkham wrote:

*'Women want to be prepared for the experiences of the childbearing year. It should, therefore, be an important part of our work as midwives to help women and families gain the information and make the decisions which enable each individual to cope best.'*  
(Kirkham, 1993:14).

In a qualitative study of primigravidae who wished to be involved in planning their care, Munns and Galsworthy (1995) found that having a birth experience that matched their expectations was less important to the women than feeling they were in control of what happened to them. They all wanted information about what was happening, and the provision of such information contributed largely to their feelings of being in control. Walker, Hall and Thomas (1995) studied the experiences of 32 women cared for in a midwife-led unit and emphasised the importance placed by the women upon being given individual (as opposed to standardised) information regarding their progress in labour. Also of particular importance to these women was the provision of real choice regarding their place of delivery; they wanted a 'homely' and safe place in which to labour. Walker and her colleagues noted:



*'It appears that homeliness should not be judged solely by the physical environment but may more accurately reflect feelings of familiarity, reassurance and perceived support.'*  
(Walker et al 1995:126)

One of the women Walker et al studied in fact preferred to deliver in a Consultant Unit because the visibility of the facilities there made her feel safe, and 'at home'.

Leino-Kilpi, Iire, Suominen, Vuorenheimo and Valimaki (1993) note there are ideological and practical aspects of providing information that can lead to decision making. According to them, the ideological perspective highlights issues of patient autonomy, emancipation, reassurance, dignity and self respect together with the patient's right to know. The practical view suggests that well informed patients are more likely to comply with treatment. Patient participation has therefore been advocated as a positive step forward in meeting the needs of consumers as well as the aims of providers of health services. McCarthy supports the concept of patient participation as follows:

*'Positive health comes through participation and action, not through passive acceptance of "being a good patient".'* (McCarthy 1985:52)

Winkler describes the concept of partnership as arising from:

*'...the need to discard many of the distinctions between provider and consumer and to consider both as equal partners in the health care enterprise.'* (Winkler 1987:3)

McEwen, Martini and Wilkins (1983) suggest the advantages of participation (especially in self care) include increased client responsibility and commitment to health promoting behaviour, together with creating consumer demand for services and appropriate allocation of resources. Pritchard (1986) noted that patient participation may result in patients gaining a feeling of power and confidence within and contribution towards the health care system, and health care professionals may also gain from a feeling of improved communication between themselves and clients thus enhancing job satisfaction. Studies of midwives and the women within their care appear to support these claims (for example, McKay and Smith 1993, Munns and Galsworthy 1995).

A few studies of health service users other than childbearing women have found that some patients do not wish to make choices or participate in their care planning. In a study of elderly patients Waterworth and Luker (1990) noted that several preferred to remain as



passive consumers of health care, participating in decision making reluctantly only in order to 'toe the line' and avoid criticism from the nurses caring for them. A consensus statement produced by an independent panel considering Britain's maternity services (Kings Fund, 1993:5) pointed out that some women may not wish to make decisions regarding aspects of their care, but would prefer to hand over this responsibility to their attendants, and this wish should be respected. No empirical evidence of such a reluctance in childbearing women has been found in the literature, however, and there appears to be little doubt that on the whole women want information in order to make choices.

Various strategies to encourage partnership have been initiated; for instance that of the 'named nurse' (DoH 1989), and continuity of care, team midwifery, lead professional and named midwife schemes, all aimed towards achieving the objective of partnership in care. Following a randomised controlled trial in Glasgow to compare outcomes between midwife-managed care and shared care between midwives, hospital doctors and general practitioners, Turnbull, Holmes, Shields, Cheyne, Twaddle, Harper Gilmour, McGinley, Reid, Johnstone, Geer, McIlwaine and Burnett Lunan (1996) reported findings of significantly less interventions in the midwife managed unit, as well as more client satisfaction with care, particularly concerning choice, information, decision making and individualised care, together with increased job satisfaction for the midwives (Turnbull, Reid, McGinley and Shields 1995). Recently a midwife-led unit in Aberdeen which aimed to offer women choice, participation and control in their labour has been evaluated by means of a randomised controlled comparison with consultant led care to compare obstetric outcomes. The results indicated significantly less interventions in labour in the midwife-led unit (such as electronic fetal heart monitoring, epidural anaesthesia, and episiotomies), and no significant differences in mode of delivery or neonatal condition (Hundley, Cruickshank, Lang, Glazener, Milne, Turner, Blyth, Mollinson and Donaldson 1994). The authors pointed out however that antenatal criteria were unable to predict women who would require transfer to a Consultant Unit in labour and stressed that, in order to provide choice regarding place of delivery, the maternity services needed to supply a range of safe and acceptable options that would allow for transfer should this become necessary.



In an idealist sense, the partnership function of the midwife may be considered as a facilitating one, helping women to help themselves and providing the resources to enable them to make decisions, in accordance with the woman's own wishes and worldviews.

There is abundant evidence however that not all women are given information they perceive as adequate, for example, McKay and Smith (1993) and more recently the Audit Commission (1997), socially disadvantaged women appearing to experience particular difficulty in acquiring information (Jacoby 1988, Kirkham 1993). According to Kennedy (1981) as well as meeting customer's wishes, consumerism also implies providing a degree of protection for consumers. In situations other than health care consumers may usually withdraw from the transaction if the services or goods do not meet their requirements. This is more difficult in the health care setting. As Brierley (1990) pointed out:

*Patients are rarely equal partners in transactions and are often reluctant to press their case for information or alternative therapy, They may fear confrontation and being labelled as neurotic, a nuisance or unpopular ... in the case of nurses, patients are usually grateful for the care offered and tend to make allowances for shortcomings, which they attribute to the lack of physical amenities and to 'the system' in general.'* (Brierley 1990:90)

Green et al noted that:

*'Women who had considered but rejected using a birth plan were most likely to anticipate negative staff reactions ... the lack of clear, non-contradictory and sensitive staff support can cause major distress ...'* (Green et al 1988b: Ch 3 summary sheet)

Inability to withdraw from health care situations is likely to limit or affect in other ways the making and facilitation of informed choices. There are probably many other factors operating to affect these processes. The purpose of the following section is to outline, from the literature, what these factors may be.

#### 1.4.1 The literature search

A computer search was carried out of the English language nursing, midwifery, medical and psychological literature produced from 1983 to 1996. The following subject headings were amongst those used: Decision making, informed choice, power, empowerment, oppressed groups, satisfaction in childbirth/midwifery, control in childbirth/midwifery, birth plans, informed consent, expectations in midwifery, pregnancy and childbirth.



The conduct of further literature searches and reviews and the use of published literature in grounded theory studies will be discussed further in subsequent Chapters, particularly in 3.4.1.4.

#### 1.4.2 The role and power of the midwife

The role of the midwife potentially is a powerful one as she is the health professional most likely to have prolonged and frequent contact with her clients. She is therefore in a strong position to influence decisions being made. However, this concept of power is paradoxical, and the midwife may be disempowered by other health care professionals and the health care systems in which she is practising. Despite the progress made in implementing recommendations from the Changing Childbirth and other reports, childbirth remains medically dominated in many maternity care situations in the UK, as in the rest of the developed world. As discussed in 1.1, childbirth may be viewed as a '*normal physiological event and emotionally fulfilling experience*' (Beech 1992:153) or as a process, 'normal only in retrospect', from which women are perceived often to need rescuing by interventionist means. Many doctors and some midwives take the latter view (Beech 1992). Childbearing women may be seen to 'belong' to consultant obstetricians or general practitioners (Davies 1992). Midwives may find themselves guiding women towards decisions made not in the best interests of the woman (as perceived by the midwife and her client) but because they are aware that local obstetric protocols will be imposed regardless of the woman's wishes and feel themselves powerless to oppose them (Davies 1992). For example, some Consultant maternity units until recently (and perhaps currently) had policies requiring midwives to perform artificial rupture of the membranes when the labouring woman's cervix had dilated to 4 cm or more. There is little evidence to support this practice as beneficial for the woman or her fetus; indeed it may result in harm (Henderson 1990). Midwives who decide with the woman not to carry out this procedure may face the wrath of their medical and midwifery managerial colleagues, and even the threat of disciplinary action (Ralston 1994).

At present, medical attendants and hospital Trusts retain the power ultimately to decide upon the care women will receive, even when pregnancy is uncomplicated. In a discussion of



some of the ethical issues involved in facilitating informed choice Richards (1997) refers to the (in)famous waterbirth case that occurred in England in 1993. A woman was delivered in water at her home by two midwives. This woman had been sent a letter by the hospital Trust's chief executive informing her that, although she could labour in the birthing pool she had hired, she would have to get out of it for the actual birth of the baby. Although the woman initially agreed to this, in the event she refused to leave the birthing pool and delivered her baby in the pool (Anderson 1994). Although the delivery occurred in the woman's own home, and both mother and baby remained in excellent condition, the two attending midwives were disciplined for failing to adhere to Trust policy. Richards comments:

*'... it seems the midwives were disciplined for failing to adhere to Trust policy, even though elsewhere, waterbirth is incorporated into the midwives' scope of practice. The case highlights the incongruities in professional practice that exist as much between areas as between midwives themselves. Patient autonomy, it would seem, is affected by distinctions as ambiguous as geography. The case also illustrates how the autonomy of the practising midwife is likewise subject to restraints. Indeed, accountability to employer, public, profession and, above all, patients make uneasy bedfellows.'* (Richards 1997: 166)

Even though the woman and her child were safely delivered, in a way that the woman had chosen, because it was the policy of the local Trust not to 'allow' this particular way of delivering the midwives were held responsible for the woman's 'aberrant' actions and were disciplined. This case highlights the invidious, powerless positions in which midwives may find themselves, caught between Trust policy and the choices of the women in their care.

Davies wrote:

*'The midwife may be caught between the individual woman's needs and her loyalty to her professional colleagues, in which future employment prospects play a part'. ... In some units (midwives) do not have the authority to make decisions.'* (Davies 1992:145)

As Davies points out, above, midwives may experience dilemmas when the needs or wishes of the women in their care are not met by the actions of those more powerful, notably the medical staff, commenting:

*'Every midwife sometimes has to act as interpreter, explaining to a woman what a doctor has said, even though the midwife herself may not agree with the doctor ... Yet*



*some midwives accept this go-between role, thus losing accountability (Davies 1992:145)*

It is well known that midwives and nurses (and indeed, patients) are often reluctant to openly challenge medical staff. As long ago as 1978 Stein described 'doctor - nurse games' in which:

*'The cardinal rule ... is that open disagreement between the players must be avoided at all costs. Thus, the nurse can communicate her recommendations without appearing to be making a recommendation statement. The physician, in requesting a recommendation from a nurse, must do so without appearing to be asking for it.'* (Stein 1978:110)

These 'games' continue in many maternity care situations, played not only by doctors and nurses but also by patients. Kirkham (1987) observed women and their attendants during labour and described various strategies women used to obtain the information they needed concerning the progress of their labours. She also described apparent constraints experienced by midwives in providing such information, for example, the difficulties imposed by a hierarchical structure.

Many midwives, as educated and experienced practitioners, are likely to hold their own views on various issues which may or may not accord with those held by the mother. As Brain commented:

*'Midwifery is an almost exclusively female profession caring for an exclusively female group of service users. They therefore have a legitimate interest in a range of women's issues ...'* (Brain 1990:67)

Midwives' own wishes may be imposed (intentionally or unintentionally) upon clients. Jackson (1993) pointed out that it is often difficult to avoid presenting biased opinions, especially when women wish to know the midwife's views on certain issues. Ralston (1994) noted that deliberate misinformation may be given to scare a woman into compliance. For example, when performing an artificial rupture of the membranes the reason given may be to check that the baby is not hypoxic whereas the real reason may be to comply with medical policies.

Health promotion and health education are important aspects of the midwife's role, apparently aimed at enabling women to participate in decision making processes (for example, Royal College of Nursing (RCN) 1993). The rationale of many (if not all) parentcraft programmes run by midwives is to educate participants so they may make informed choices, but Levin (1978) suggests that far from being an enabling process, patient education may serve to bend patient behaviour to accommodate the needs of the system.

Grace, writing of the New Zealand experience noted:

*'On the one hand 'we' provide according to 'their' needs, yet on the other hand 'we' tell them 'their' needs.'* (Grace 1991:339)

A midwife may not believe it necessary to inform the woman, or to offer her a choice. In a study of labouring women and their midwives Henderson (1990) found that half the sample of midwives did not discuss the procedure of rupturing membranes with the woman before carrying it out, assuming the woman did not wish to be consulted or that she already knew about the procedure. Some professionals may believe that:

*'... they have the knowledge and therefore the authority to make decisions and clients should comply.'* (Marsh 1996:83)

#### 1.4.3 Availability of knowledge

Although individual midwives may be knowledgeable regarding aspects of maternity care, others may be less informed and so may feel unable to provide information. For example, some midwives may be skilled in the use of complementary therapies (for example, aromatherapy or hypnotherapy) and will be in a position to offer advice regarding these, but (although figures are not available) most midwives will be unlikely to be in possession of this knowledge and experience. Alternatively, a midwife may wrongly perceive herself to be knowledgeable and may inadvertently give inaccurate information. For example, a newly appointed midwife may not be familiar with the policies and procedures of the local maternity unit and may inadvertently give wrong information regarding for example, transfer home policies.

Dyson, Fielder and Kirkham (1996) studied midwives knowledge regarding haemoglobinopathies. They found that the majority of the sample of 850 failed to answer correctly simple questions on the ethnic groups affected by these disorders, and the genetic



issues concerned. Dyson et al concluded that this lack of knowledge limited the provision of an equitable service to women at risk of haemoglobinopathies, preventing them from accessing information which would enable them to be involved in making choices regarding their care.

Although midwifery is moving towards becoming a research based profession (Hicks 1992), many aspects of practice are not informed by research. A Kings Fund document pointed out:

*'... women's choice can be constrained by the fact that professionals often do not have, and probably never will have, definitive answers on the implications of pursuing a particular course.'* (Kings Fund 1993:7),

and Ralston (1994) wrote:

*'Choices are only as good as the information upon which they are based, which in turn is only as good as the research on which that is based.'* (Ralston 1994:454)

Decisions are often required to be made when the available information is lacking and the likely outcome of the decision uncertain. Midwives are frequently in the position of helping women in their care to make decisions that may have far-reaching effects on their lives, as well as upon their babies and families, when the outcome of that decision is uncertain. Eddy suggested:

*'...the uncertainty could be managed if it were possible to conduct enough experiments under enough conditions and observe the outcomes.'* (Eddy 1988:50)

He went on to write that this is of course impossible, and professionals and clients have to do the best they can in using the available information, balancing various factors, weighing up probabilities and attempting to predict the outcome, in order to make the right decision. Professionals are often viewed by clients as possessing special knowledge, and skills in analytic decision-making, that will help in reaching the correct decision (Moline 1986) and women often turn to midwives for help and advice in making difficult decisions. Midwives may or may not possess the skills to present information in such a way that choices may be made. As pointed out:

*'...professionals need the confidence and the communication skills to help users to make decisions in the face of uncertainty.'* (King's Fund 1993:7)

Whether or not the midwife possesses the communication skills to facilitate choice, she may perceive herself as not having the time or facilities to convey that knowledge, especially during a busy, crowded, noisy antenatal clinic.

Decision making may be stressful. Any decision is right or wrong only prospectively and not retrospectively (Lilford and Thornton 1992). The decision therefore may have been correct, but the outcome disastrous. In this case the decision maker may face material and social loss including loss of self esteem and reputation (Evans 1990). Decision making in situations of uncertainty thus is often stressful, the stress increasing with the importance of the decision. During pregnancy women may make very difficult decisions, assisted by midwives, and this process may be stressful and painful for both, particularly if the outcome is not good. Evans (1990) has described various strategies used by nurses working in intensive care units to try to avoid or reduce this stress, and it is possible that midwives, if experiencing or anticipating stress may use similar - or different - strategies. Women during pregnancy may also employ various strategies in this respect and it will be a purpose of the study to identify such strategies. These issues will be discussed further in Chapters 5,6 and 7.

Childbearing is rich in myth. The myths may or may not be founded in truth, but may strongly influence women when making choices - or midwives when providing information to facilitate choices (Chamberlain 1981). Initial scepticism on the part of the woman or the midwife regarding the truth of the myth may be tempered by a personal experience which may lend it credibility. When trying to attribute cause, or seeking meaning when the outcome of childbirth is not as expected, women may search for an explanation which often involves self-blame (Farrant 1980, Rothman, 1994). For example, Oakley (1992:201) vividly describes the emotional distress of a woman who had given birth to a preterm, poorly nourished baby who died soon after birth. This woman cast around for an explanation for his death, apportioning blame to herself for shifting furniture during pregnancy and perceiving herself as generally unfit for motherhood. Following the birth of a baby with abnormalities women may search desperately for explanation and blame certain actions they undertook in pregnancy, such as imbibing a glass of beer or travelling abroad for a holiday (Rothman 1994:226).



Myths are often dismissed under the derogatory label of 'Old Wives Tales' implying the information is untrue and put about by ignorant and misguided women; 'Professional's Tales' may be a more appropriate label. It should be noted that the example (above) of a woman's perception of the effects upon her baby of drinking a small amount of alcohol provides an example of a myth popularised by the 'scientific' press. Drinking a glass of wine (or its alcohol equivalent) each day during pregnancy has not been shown to have any effect upon the birthweight or normality of the baby (for example, Plant 1990) despite much publicity (particularly during the 1980s) regarding the fetal alcohol syndrome and warnings against drinking any alcohol whatsoever during pregnancy. This may be cited as an example of a modern day myth; by no means all of the myths of childbirth originate from 'Old Wives'. Modern day myths and the discrediting and suppression of the knowledge of less powerful groups by the more powerful is discussed in Chapters 5 and 7 and will not be further pursued here.

To conclude this section, Avis' (1992) comment is noted that health care professionals are in positions of power in view of their (sometimes wrongly) assumed knowledge and expertise which, unless the professional chooses to share it, the client is unlikely to possess. Avis commented:

*'It is simplistic to imagine that patients can participate as equal partners or challenge the nurse's authority ... partnership can just as easily become a rallying cry for a professionalising ideology (rather than) a genuine commitment to patient choice.'* (Avis 1992:14)

#### 1.4.4 Resources

Even if the knowledge exists, the facilities may not. For example, Dimond (1993) pointed out that a woman may wish to have a water birth, but if the facilities for this are not available then this choice will be denied her, and as previously mentioned, a woman with a normal pregnancy who chooses an obstetrician as her lead professional may be refused this choice as not being cost effective and wasteful of the obstetrician's skills.

#### 1.4.5. Summary

As Leavy, Wilkin and Metcalfe (1989) point out, consumer choice implies that consumers are offered information about a range of alternatives, and enabled to make choices that can be actually implemented. Many factors, mostly related to power, knowledge and resources, may however intrude to affect the facilitation of true consumer choice.

### 1.5 Making informed choices in non-maternity health care settings

An extensive search of the English language midwifery, medical and psychology literature published within the past 10 years has revealed no study exploring the processes, realities and implications of facilitating decision making and informed choice in the context of childbirth and midwifery care. Some authors have suggested recently that such a study needs to be conducted, for example, Hope (1996) who advocated ‘evidence-based patient choice’. Oliver et al (1996) have recently conducted a pilot study to evaluate (amongst other outcomes) the impact of MIDIRS leaflets which are aimed to facilitate informed choices regarding positions in labour, and routine ultrasound. One of their conclusions was that:

*‘... there is no such simple thing as informed choice in maternity care - there are many processes and forms of it’ (p 59) ... ‘A qualitative study of just how different groups of users and professionals define and operationalise informed choice (is needed). The data collected in the pilot has shown how complex some of the issues here are, and we need to know more about the context of attitudes and expectations into which interventions such as informed choices leaflets are introduced.’ (Oliver et al 1996:62)*

Several studies have investigated these issues in relation to other areas of health care and some of these are outlined below. The findings may not be transferable to the domain of maternity care, however, since consumers of the maternity services are almost always well, and undergoing the normal physiological process of childbirth. Consumers of other areas of health care are usually unwell, experiencing pathological signs and symptoms. Different paradigms of wellness and sickness are therefore operating which may affect decision-making processes. Additionally, women in pregnancy are making decisions that will affect not only themselves, but also their unborn babies, and their families.



Sutherland, Llewellyn-Thomas, Lockwood, Tritchler and Till (1989) summarised reasons why consumers of health care should be enabled to play an active role in making choices about their care, as follows:-

ethically, *'where there has been a change from a paternalistic philosophy of care to one in which autonomy and patient self-determination are promoted...'*;

legally, particularly in the area of need for informed consent; and

socially, with the *'growing movement advocating the view that the patient is a health care consumer with rights to information ... interaction .. and participation.'* (Sutherland et al 1989:260).

Sayner (1982) used a grounded theory approach to study the processes of decision making in patients undergoing surgery for stroke prevention. She developed a conceptual model identifying 5 stages to account for the process. These were (perception of) Threat, (development of) Trust (in physician), Holding (when further information was sought), Contemplation (of risks and benefits), and Compliance. Each of these stages was mediated by present brain symptomology; the timetable (the degree of risk of stroke and urgency of surgery); and support from and trust in the physician and the family.

Biley (1992) also used grounded theory to discover how patients who had undergone surgery recently felt about participating in decision making about nursing care. The study was small in that only 8 informants were interviewed (once) and category saturation was not achieved. Tentative suggestions only could be made. Three second order categories were identified as follows:

1. 'If I am well enough' which described the state of being too ill to be involved in decision making, or being well which allowed more participation.
2. 'If I know enough' which described situations requiring technical knowledge or where the patient preferred to remain passive.

3. 'If I can' which related to the organisational constraints or freedom that constrained or facilitated choice.

Davison, Degner and Morgan (1995) surveyed the opinions of men with prostate cancer regarding their preferred role in treatment decision making. They found that, although the majority of respondents preferred their physicians to make the final decisions regarding treatment, they, the men, wanted information and for their views to be taken into account.

### **1.6 Summary and conclusions**

This introduction has argued that enabling informed choice is seen as a desirable feature of maternity care. Midwives are in a strong position to provide information which will enable choices to be made. It is noted, however, that an aspect of freedom to make choices is that of electing not to make a choice. The overwhelming evidence from research studies is however that women want information in order to make informed choices and thus retain control of what is happening to them in pregnancy and childbirth.

Rarely can a single choice be made from a 'shopping list' of alternatives. When a woman chooses a course of action in her pregnancy this almost invariably leads to making further choices. A cascade of choices may need to be made. For example if a woman decides to undergo a blood test for fetal normality screening tests and a high risk of Down's syndrome is identified she will then need to decide whether to proceed to amniocentesis. If the amniocentesis indicates the fetus has Down's syndrome she will then need to decide if she wishes to continue with the pregnancy or to have the pregnancy terminated. Each of these major choices contains several decisions within them, and each major choice will lead to more decisions to be made - and so the cascade of choice gathers force. It is the midwife's role to guide the woman through making these decisions, informing and advising her of their implications.

The role of the midwife, together with the development and current climate of the midwifery profession in the UK, has been outlined in order to provide a context for this study.

Government and other reports urge midwives to help women make informed choices during childbirth. There is little acknowledgement, however, that this may involve complicated



processes influenced by many issues. These issues need to be identified in order to clarify and inform this aspect of midwifery practice. Some factors, identified from the literature and likely to influence midwives and their clients when engaged in decision making, have been described. Other, as yet unidentified, issues also may operate to produce accords or tensions when midwives are engaged in facilitating decision making. This study will attempt to illuminate these issues.

Studies of facilitating informed choice have been conducted in various health (or, rather, sickness) care settings. These studies have tended to focus upon outcomes such as patient satisfaction. Few studies have investigated the processes involved in facilitating choices, and no study has been found which seeks to clarify how women are enabled to make informed choices in the context of midwifery care. This is the purpose of this study.

## CHAPTER 2

### THE PHILOSOPHICAL BASIS OF THE STUDY

#### 2.1 Introduction

The aim of this study is to generate substantive theory to describe the processes involved when pregnant women make, and midwives help them to make, informed choices during their pregnancy.

The study is conducted within the constructivist paradigm (Lincoln 1990) using grounded theory (Glaser and Strauss 1967) to guide the collection and analysis of qualitative data.

This Chapter will discuss the philosophical basis of the study. Reference will be made to the basic assumptions and tenets of different research paradigms with emphasis upon the constructivist paradigm, hermeneutics, and reflexivity. The relationship between the constructivist paradigm and this research study will be discussed in section 2.4. Grounded theory will be discussed in Chapter 3.

#### 2.2 Paradigms

The constructivist (sometimes termed the interpretivist: Greene 1990:233) paradigm was chosen as the philosophical base for this study. This section outlines the development and describes the assumptions and characteristics of the constructivist paradigm, and justifies its choice. Patton describes a paradigm as:

*'... a world view, a general perspective, a way of breaking down the complexity of the real world. As such, paradigms are deeply embedded in the socialisation of adherents and practitioners: paradigms tell them what is important, legitimate, and reasonable.'* (Patton 1986:181)

and Guba and Lincoln define a paradigm, when used to guide research, as:

*'...the basic belief system or worldview that guides the investigator, not only in choices of method but in ontologically and epistemologically fundamental ways.'* (Guba and Lincoln 1994:105)



A paradigm is thus a worldview, or a set of assumptions that may be used to guide research, within which the inquirer works and uses to guide the choice of research question and approaches to gathering and analysing data. Patton warns against uncritical adherence to paradigm sets, however:

*'Paradigms are ... normative, telling the practitioner what to do without the necessity of long existential or epistemological consideration. But it is this aspect of paradigms that constitutes both their strength and their weakness - their strength in that it makes action possible, their weakness in that the very reason for action is hidden in the unquestioned assumptions of the paradigm.'* (Patton 1986:182)

Atkinson pointed out that qualitative researchers often go to some lengths to differentiate between the assumptions of their selected paradigm and others in an effort to demonstrate purity of research approach, and have deprecated the practice of blurring the boundaries between paradigms. Atkinson questions the mutual exclusivity of paradigms, commenting:

*'In practice it is rare for researchers to confine themselves to narrowly defined methods, while eschewing all interest and influence from other quarters. The realities of social research are not properly served by attempts to fit the social world to the Procrustean bed of so-called paradigms ... nor should we use the rhetoric of paradigms to erect a technician view of qualitative research that fetishes method.'* (Atkinson 1995: 121)

The interpretation and use of the constructivist paradigm in this study will be discussed in this and subsequent Chapters (particularly Chapters 4 and 8). The following section of this Chapter will trace the philosophical movements influencing the development of some of the major research paradigms, with emphasis upon qualitative approaches and grounded theory.

### 2.2.1 An overview of the development of the major research paradigms

Denzin and Lincoln (1994:2) provide a summary of the key stages in the development of the major research approaches and paradigms, as follows:

1. The traditional age (1900 - 1950), associated with the positivist paradigm. Positivists sought facts that could lead to the discovery of laws of nature, and regarded any proposition that could not be reduced to a statement as meaningless. (see Table 2.1) The methodology of the randomised controlled trial was developed and used in medical research (Poole and Jones 1996). During this period, however, alternative views of truth and method



were considered. For example, Mead (1934) cited by Blumer (1969) developed the philosophy of symbolic interaction (see 2.3.1.1).

2. The modernist age (1950 - 1970), associated with postpositivist paradigms during which the limitations of human objectivity when studying phenomena was acknowledged. Kegley (1995) pointed out that, from time to time, fundamental problems are recognised by inquirers when using current paradigms. A revolutionary period then ensues when new paradigms are developed. Kuhn (1962) provoked such a 'revolution' when he challenged the positivist view of science. He saw inquiry as guided by a dominant paradigm which remains stable for some time and is then challenged and replaced by a new paradigm during a 'scientific revolution', as people's views of the world and science change. Inquiry had been and continued to be dominated by the positivist paradigm, but from the 1950s onwards other paradigms were developed, influenced by postpositivist and postmodern movements. Quantitative approaches continued to develop and the randomised controlled trial grew in popularity, particularly in medical science. Nursing research, then in its infancy, comprised mainly quantitative studies (Poole and Jones 1996), although qualitative methods were developed and formalised. For example, Glaser and Strauss (1967) described how qualitative data could be used to construct theories grounded within the data.

3. The blurred genre age (1970 - 1986), during which post-positivist paradigms flourished, and qualitative approaches became more widely accepted and increasingly used in nursing research. A plethora of strategies were developed to collect and analyse qualitative data, and Geertz (1973 & 1983) argued for the demise of positivist approaches in favour of the new interpretive paradigms. Glaser (1978) developed constructivist approaches to constructing grounded theories whilst Strauss continued to follow more rigid, structured pathways. Nurse researchers increasingly used grounded theory and other interpretive approaches, although the randomised controlled trial remained the 'gold standard' of medical (and nursing) research. Critical, constructivist paradigms, such as hermeneutics, semiotics, phenomenology and feminism were introduced for the study of the humanities. Concerns were expressed regarding the politics, reliability, validity and ethics of qualitative research, however, which led to:



4. The crisis of representation age (1986 - 1990) where researchers struggled to apply and justify their use of the approaches introduced in the 'blurred genre age'. Although there was a move away from the notion that the reliability and validity of constructivist research could be assessed in the same way as in positivist research, and attention was given to further explicating the values and intentions of constructivist paradigms (for example, Lincoln and Guba 1985), doubt was still expressed that constructivist research can ever be legitimated in terms of reliability, validity and generalisability. Furthermore, questions remain that researchers can ever capture other individuals' lived experiences because researchers are themselves influenced by their culture, gender and other factors: thus the expression 'crisis of representation' (Denzin and Lincoln 1994:2).

5. The postmodern age (1990 - present) the core of which is the doubt that any approach or paradigm is always the 'right' one to use, and the suspicion that all investigation is influenced by political, local and cultural interests and the limitations of the 'knower', or the investigator (Richardson 1994:517). Positivist and constructivist approaches are recognised as legitimate research paradigms; for example randomised controlled trials, surveys, ethnography, discourse analysis or phenomenology (amongst other approaches) may be used to address similar research problems depending upon how the research question is conceptualised. Each approach is recognised as having its own particular strengths and limitations and its own contribution to make to the acquisition of knowledge.

Currently, the importance of evidence based practice within medicine and other health care disciplines is stressed (eg DoH 1996), the concept of practice based upon 'evidence' rather than 'research' indicating an acknowledgement that appropriate evidence may be gathered from a wider variety of sources than that circumscribed by the term 'research'. Despite the growing use and acceptance of constructivist approaches, however, there exists still a strong hierarchy of research methods upon which the quality of 'evidence' is based, headed by meta-analysis and randomised controlled trials, with '*other robust experimental or observational studies*', and expert opinion, following in second and third place respectively (DoH 1996:16).

Hope (1996:1) noted that, by bringing together the concepts of evidence based practice and patient centered practice, evolution in medical practice is thereby made possible from that based upon the authority of the doctor to that based upon the evaluation of clinical effectiveness. The genuine involvement of the patient or client in decisions about her or his treatment is thus facilitated, by this access to evaluated evidence. Data bases are currently being developed and are widely available to doctors, midwives and other health professionals (and potentially to the women in their care, providing they know about them and where to obtain them) such as the Cochrane database (Enkin, Kierse, Renfrew and Neilson 1995), a data base on compact disc comprising meta-analyses of randomised controlled trials pertinent to obstetrics and midwifery. As yet, however, there are few, if any, examples of evidence gathered from studies carried out within paradigms other than the positivist contributing to these databases. It is possible that this situation will change over the following years if the contribution constructivist research can make towards evidence based practice continues to gain recognition. It is certainly hoped that the findings of this present constructivist study will help to guide and inform midwifery practice.

### **2.3 The constructivist paradigm**

Guba (1990:18) maintains that characteristics of paradigms can be determined by '*the way their proponents respond to 3 questions*':

- Ontological: what is the nature of reality, and the nature of the 'knowable'?
- Epistemological: what is the relationship between the inquirer and the inquired-into?  
What is the nature and grounds of knowledge?
- Methodological: how should the inquirer find out knowledge?

These questions serve as a model for the following section which describes the assumptions of the constructivist paradigm (See Table 2.1 for a summary of the major research paradigms).



**Table 2:1 Comparison of some major paradigms**

Adapted from Guba and Lincoln (1994: 109-116)

Paradigm	Ontology	Epistemology	Methodology
<b>Positivist</b>	<p>The positivist paradigm takes a 'realist', reductionist view of reality; in other words there is a real world 'out there', driven by immutable laws which can be studied and understood, independently of time and context. Phenomena may be broken down into their component parts which can be studied independently. If necessary they can then be reconstructed, producing a valid representation of reality; the whole is merely the sum of its parts. Nomothetic statements (which will not change over context or time) may be made, and these may be generalised to a wider, albeit to varying extents similar, populations or situations. Positivists are primarily concerned with explaining causal relationships in order to predict, and therefore control, outcomes.</p>	<p>Positivists believe that separation or 'dualism' is both possible and necessary in order that the researcher will not contaminate the object of inquiry by his or her presence or bias, or will not be contaminated by it. To demonstrate lack of bias assurance is sought that dualism has been achieved. Rigour in following prescribed procedures and assurance of internal and external validity, reliability and objectivity are instrumental in demonstrating that dualism has been achieved and bias thereby excluded. Findings may be replicated and then considered as 'true'. (Guba and Lincoln 1994:110).</p>	<p>Control is an essential element of positivist approaches. Possible confounding variables which could introduce bias are manipulated so that they will not influence the outcomes of the study. Hypotheses may be formulated and tested in order to verify them. Quantitative methods are predominant although qualitative approaches may be used. Experimental or survey designs are used.</p>
<b>Postpositivist</b>	<p>Postpositivists argue although there is a real world and laws that may be studied, because of human limitations and the difficulties of studying phenomena it can only be imperfectly understood. This (imperfect) understanding should be maximised by subjecting it to the widest possible critical examination. The ontological stance of postpositivism is labelled <i>critical realism</i>. As with positivism, prediction, control and generalisability are the aims, although it is acknowledged that absolute certainty regarding causal relationships is unlikely.</p>	<p>The postpositivist tradition maintains that dualism is not entirely possible, but should be strived for. Findings are scrutinised for 'fit' with preexisting knowledge, and are subjected to peer and expert critical review. Replication and other studies should attempt to falsify findings/hypotheses instead of trying to support them.</p>	<p>Postpositivists tend to use qualitative approaches more than positivists, in order to utilise natural, less controlled settings and to introduce more of a discovery element to the inquiry (Guba and Lincoln 1994:110). By using qualitative as well as quantitative approaches in a form of 'critical multiplism' of methods, attempts are made to falsify rather than verify hypotheses.</p>



Table 2.1 (cont)

Paradigm	Ontology	Epistemology	Methodology
<p><b>Critical Theorist</b></p>	<p>Critical theorists take a position of historical realism, in which it is believed that realities are shaped into structures by cultural, economic, political, ethnic, social and gender issues. These structures are then regarded as 'real' for all practical purposes and may be studied and understood.</p>	<p>Critical theorists argue that research is always value-bound, the findings are therefore influenced by the values of the researcher who is interactively linked with the participant. Findings are thereby said to be value-mediated (Guba and Lincoln 1994:110), and the epistemological approach transactional and subjectivist. The division between ontological and epistemological considerations consequently is removed. As Guba and Lincoln point out, '<i>...what can be known is inextricably linked with the interaction between a particular investigator and a particular object or group</i>'. A Foucaultian view of knowledge as power is central to this paradigm. (eg Foucault 1980). Knowledge is developed and shared between inquirer and participant in order that emancipation from coercion and domination may occur. Knowledge is seen always to be influenced by political and power issues.</p>	<p>Critical theorists use dialogic approaches as a result of the transactional nature of their interaction with people they are studying. Kim and Holter (1995:208) cite Habermas (1972) who classifies knowledge in terms of its use, that is, technical (used for prediction and control), practical (used for interpretive understanding and reflective judgment) and emancipatory (used to free individuals from constraints and domination). Critical theory is essentially emancipatory and transformative in nature, aiming to raise awareness and emancipate those studied. Consequently, the approaches are also dialectic in order to inform, raise awareness and empower to action by means of the interaction between the critical theorist and people studied (Guba and Lincoln 1994:110).</p>
<p><b>Constructivist</b></p>	<p>The constructivist paradigm assumes a relativist view of reality. There are many realities, or truths, depending upon the interpretations and constructions of the people who experience them, although there may be common elements shared between individuals, and occasionally cultures (Guba and Lincoln 1994:110). Reality changes according to context and time, and there are no absolute 'truths'; constructions of the 'truth' are seen only as being more or less informed, and more or less likely to approximate reality. Thus, multiple context- and time-bound realities may be perceived according to individual interpretations. Because situations are continually changing it is usually impossible (and undesirable) to separate cause from effect, and thus notions of 'cause and effect' are regarded as overly simplistic. Claims regarding generalisability need to be made with caution, if at all.</p>	<p>Constructivists take a transactional and subjectivist stance, regarding findings as the creation between the inquirer and the inquired-into, and believing that knowledge is constructed, rather than discovered. Knowledge is thus seen as invented and error-prone (<i>'epistemological fallibility'</i>). It is assumed that the inquirer and the inquired-into interact and are inseparable. Constructivist researchers assume that research is always value-bound, by the way the researcher designs the study, in the choice of research question or hypotheses, the research paradigm, the theoretical basis of the study, and the approach to data collection and analysis - these will all be influenced by the beliefs held by the researcher, and also by the values inherent within the context of the study. Thus, the researcher is seen as bringing his or her experience, knowledge and personality to the inquiry, and it is viewed as inevitable that the data will be influenced as they are collected and analysed.</p>	<p>Constructivists use a hermeneutic, dialectic approach. Interpretations are compared and contrasted dialectically to generate constructions about which there is substantial agreement by, for example, participants and researchers. Constructivists view knowledge as a means towards understanding, requiring hermeneutic or interpretive approaches towards its construction. Guba and Lincoln (1989:84) describe inquiry in the constructivist paradigm as '<i>beginning with issues and/or concerns of participants and unfolds through a 'dialectic' of iteration, analysis, critique, reiteration, reanalysis, and so on that leads eventually to a joint (among inquirer and respondents) construction of a case (ie findings or outcomes)</i>'. A hermeneutical approach is central to the constructivist paradigm.</p>



### 2.3.1. Ontology

The constructivist paradigm assumes a relativist view of reality, that is, there are believed to be many realities, or truths, depending upon the interpretations and constructions of the people who experience them, although there may be common elements shared between individuals, and occasionally cultures (Guba and Lincoln 1994:110). The researcher is required to enter into the participants' world in order to gain an emic perspective of meaning, and to gain understanding of the situation or reality as they see it (Blumer 1969:56). Reality changes according to context and time, however, and there are no absolute 'truths'. Constructions of the 'truth' are seen only as being more or less correct, and perceived according to individual interpretations. Mies (1993) quotes Mao Tse-Tung who pointed out that, merely by studying a phenomenon, one may in the process change it:

*'If you want to know the taste of a pear, you must change it, that is, you must chew it in your mouth.'* (Mao Tse-Tung 1968).

People are seen as autonomous, intentional and goal directed social beings who cannot be separated from their environment, work, families and culture, and who interact continually with others through language and behaviour, which is often symbolic and requires interpretation. Sullivan maintains that:

*'...human action or conduct presupposes that the human act could be understood by reference to the ends or intentions an actor is pursuing and also the context or conditions under which action pursues its ends. The important assumption is that human actions ... are meaningful and are, therefore, not arbitrary. ... Making an act intelligible is, in essence, interpretation. ... An interpretative explanation ... explains by showing that an act makes sense against a background of a social code of rules, practices, or belief.'* (Sullivan 1990:112)

These insights arise from the philosophy of symbolic interaction, which is described below.

2.3.1.1 Symbolic interactionism The aim of grounded theory is to develop theory that explains interactions in areas of common social life. The methodology of grounded theory was based upon Mead's (1934) conceptual framework of symbolic interactionism whose principal tenets were developed and described by Blumer (1969) as follows:

- An individual will act towards other human beings, animals, or inanimate objects in terms of the meaning they have for that individual. Meanings are central to the understanding of behaviour, and cannot be ignored.
- These meanings arise from the interaction the individual has with other people. Meanings are seen:

*'...as social products, as creations that are formed in and through the defining activities of people as they interact.'* (Blumer, 1969:5).

A symbolic interactionist approach sees meaning as derived by individuals from their social interactions, during which symbolic actions and language are perceived.

- The use of meaning involves interpretation: an interaction with self to handle meaning. This hermeneutical process involves two stages; firstly, perception by the individual that something (an object, communication or an action), has meaning, and secondly an internalised process of organising and making sense of that meaning in order to decide upon ensuing action.

As Annells (1996) wrote, symbolic interactionism:

*'...tackles the question of the individual in society and the relationships between individual perceptions, collective action, and society.'* (Annells 1996:381)

Traditional approaches of symbolic interactionism perceive individuals' interpretations of meaning, and consequently their actions, to be created by social processes, and therefore able to be understood only within a social context. Traditional interactionists focus upon individuals and their interpretations of meanings in everyday life. Chenitz (1986:4) pointed out that symbolic interactionism consequently contains a strong phenomenological element. Porter (1991) interprets symbolic interactionism as indicating that reality is not static, but continually changes as the actions and interactions of people change.

Blumer/Mead's conception of symbolic interactionism focuses exclusively upon the individual in society (Annells 1996:381). Denzin (1989) argues for a critical theorist approach to symbolic interactionism, by increasing the influence of cultural and feminist insights upon the interpretation of meaning. Thus, modern interpretations of symbolic interactionism involve the consideration of how issues such as power, gender, race and class



may shape society, as well as studying the individual's behaviour and role within that society.

To summarise, in an explanation of symbolic interactionism, Blumer wrote:

*'Whatever the action in which he is engaged, the human individual proceeds by pointing out to himself (sic) the divergent things which have to be taken into account in the course of his actions. He has to note what he wants to do and how he is to do it: ... he has to take account of the demands, the expectations, the prohibitions and the threats as they may arise in the situation in which he is acting. His action is built up step-by-step through a process of such self-indication. The human individual pieces together and guides his action by taking account of different things and interpreting their significance for his prospective action.'* (Blumer 1969:81)

Midwives and the women they attend need to take many 'things' into consideration when facilitating or making decisions. For example when providing information or making decisions they have to take account of 'demands, expectations, prohibitions and threats', piecing them together and assessing their significance. Midwives and their clients interact within a social context guided by their interpretation of sets of rules and norms of behaviour, influenced on the part of midwives, for example, by their professional and personal codes of conduct, and on the part of pregnant women by cultural and other influences. Issues related to power and gender permeate the maternity care services and are likely to influence interactions between midwives and pregnant women. As *'both a theory about human behaviour and an approach to inquiring about human conduct and group behaviour'* (Anells 1996:380), symbolic interactionism will provide an appropriate methodological conceptual framework upon which to base this study, and supports the choice of a grounded theory approach.

### 2.3.2 Epistemology

Constructivists believe that knowledge is constructed, rather than discovered, in that models and schemes that explain human experiences are made and modified by elucidating, clarifying and constructing meanings within the language and actions of people (Schwandt 1994:118 and 126). Instead of explanation in terms of cause and effect, the goal is understanding of meaning.

Constructivists take a transactional and subjectivist stance, regarding findings as the creation between the inquirer and the people studied. In accordance with the transactional view, it is assumed that the researcher and the researched-into interact and are inseparable. People are acknowledged as the experts upon their own lives and have experiences that are interesting and worth inquiry. The researcher is a gatherer of information about these experiences, and is an interpreter of meaning.

Constructivist researchers assume that research is always value-bound, in several ways, for example, by the way the researcher designs the study in that the choice of research question or hypotheses, the research paradigm, the theoretical basis of the study, and the approach to data collection and analysis will all be influenced by the beliefs held by the researcher, and also by the values inherent within the context of the study. The researcher is personally involved with the topic and is seen as bringing her or his experience, knowledge and personality to the inquiry. It is therefore viewed as inevitable that the data will be influenced as they are collected and analysed. Arguing that the knowledge and attitudes of the observer have a major influence on his or her perception and interpretation of what is observed, Hanson wrote *'there is more to seeing than meets the eyeball'* (Hanson 1965:7) and Phillips stated:

*'...there is no such thing as objective truth, for what observers take to be true depends upon the framework of knowledge and assumptions they bring with them.'* (Phillips 1990:34)

Campbell and Bunting wrote:

*'Knowledge is relational and contextual ... The questions and the interpretation of the 'answers' are very much influenced by the point of view of the person asking the questions.'* (Campbell and Bunting 1991:7/8)

Dewey (1966) suggested the term 'warranted assertibility' as preferable to 'truth', to which Phillips responded:

*'...this change of language highlighted the fact that a warrant is not forever; today's warrant can be rescinded tomorrow, following further inquiry.'* (Phillips 1990:32)



There can be no guarantee that findings will remain constant over time and situations, and claims to generalisability need to be made with caution, if at all. Because situations are continually changing it is usually impossible (and undesirable) to separate cause from effect, and so notions of 'cause and effect' are regarded as overly simplistic.

### 2.3.3 Methodology

Constructivists use a hermeneutic, dialectic approach (see 2.3.3.1). The researcher is unlikely to represent her/himself to participants as an expert, but rather as a naive inquirer who is genuinely interested in their experiences of the topic. Interpretations are compared and contrasted dialectically to generate constructions about which there is substantial agreement by participants and the researcher. Constructivists view knowledge as a means towards understanding, requiring hermeneutic or interpretive approaches towards its construction, and initial naivety is likely to progress to knowledgability during the course of the study. Guba and Lincoln described inquiry in the constructivist paradigm as:

*'...beginning with issues and/or concerns of participants and unfolds through a 'dialectic' of iteration, analysis, critique, reiteration, reanalysis, and so on that leads eventually to a joint (among inquirer and respondents) construction of a case (i.e. findings or outcomes).'* (Guba and Lincoln 1989:84)

People studied are termed participants because of the co-operative nature of the inquiry (Heron 1981: 19), the extent of participants involvement varying considerably from that of full co-researcher to negotiating agreement about the findings.

To summarise, the assumptions of symbolic interactionism and the constructivist paradigm provide the guiding influences for this study. A hermeneutical approach is central to the constructivist paradigm (Schwandt 1994:118) and merits further explanation.

2.3.3.1 Hermeneutics Towards the end of the last century Dilthey proposed that whereas study of the natural sciences sought explanation, study of human experience required interpretation of meaning (Steedman 1991). Dilthey considered understanding to be a process of psychological reconstruction of the original intentions of the author, the interpreter needing to align him/herself with the author's 'horizon' in order to understand. Understanding was also arrived at from the perspective of the interpreter's own experience

(Steeves and Kahn 1995:177). Hermeneutics, a term originally used to describe specifically the interpretation of theological texts, was the name given to this more general philosophy of interpretation and understanding. Hermeneutics is both a philosophy of how humans understand experience (Steeves and Kahn 1995:177), implying a reflective interpretation of an individual's words or actions, as well as an approach to research which focuses upon meaning and understanding within the context of the study. Thompson pointed out that symbolic interactionism and grounded theory have long been influenced by hermeneutical approaches. She observed that:

*'... hermeneutic philosophy describes understanding as a cognitive, affective and practical process that is based on a sphere of shared meanings and shared experiences within a common linguistic community.'* (Thompson 1990:240)

Steeves and Kahn (1995:188) explained that the dialogic action of shared meanings and experiences underpins the 'hermeneutic circle', a metaphor used to describe the process by which issues are interpreted in order to gain understanding. At first, regarding the whole topic studied, only a broad, tentative understanding is possible. As the component parts of the issues are considered, understanding is increased. This new understanding of the parts facilitates a greater understanding of the whole, which in turn helps understanding of other relevant parts. Thus the hermeneutic circle represents a dialectic between the whole and the parts of a topic. Palmer noted that:

*'By dialectic interaction between the whole and the part, each gives the other meaning: understanding is circular, then. Because within the "circle" the meaning comes to stand, we call this the "hermeneutic circle".'* (Palmer 1969:87)

And Gadamer asserted:

*'... the meaning of the part is always discovered only from the context, i.e. ultimately from the whole.'* (Gadamer 1975:167)

Kockelmans insisted, however, that interpretive (that is, theoretical) schemes should not be imposed upon the object of study:

*'The source and criterion of the articulated meaning is and remains the phenomena ...'* (Kockelmans 1975:84)



Steeves and Kahn (1995:189) pointed out that, although the imposition of interpretive schemes is to be avoided, theoretical issues are nevertheless of concern. In order to include theoretical concerns without imposing them, they advocate the use of the hermeneutic circle at a different, higher level, in the form of a dialectic between the issues studied and relevant theoretical material.

Gadamer (1975:267-74) used another metaphor to argue that the hermeneutic circle (or as Sullivan (1990) preferred to call it, the 'interpretive spiral') is bounded by the 'horizon' of the interpreter. In other words, any interpretation must be limited by the interpreter's experience of her or his personal world. The aim of understanding is the fusion of horizons: that of the interpreter and her or his world, and the larger, global issues revealed by the inquiry. Geertz argued that the quality of the research process depends upon:

*'...a continuous dialectical tracking between the most local of local detail and the most global structure in such a way as to bring them into simultaneous view.'* (Geertz 1983:69)

2.3.3.2 Language The use of language is central to hermeneutics. Language is a powerful agent in the transmission of shades of meaning (Cicourel 1973). Hanson wrote:

*'It is not language with which we are concerned. It is the concepts underlying this language.'* (Hanson 1965:50)

Malterud (1993) pointed out that the use of language and voice is not merely a question of pitch and volume, but may also reveal how knowledge is constructed, from whose reality it is interpreted, and whose viewpoints are regarded as relevant in encounters between individuals. People use language to construct meanings of their social world. Habermas (1971: 176) wrote that the researcher must penetrate the language and social context of the individuals or cultures, in order to know and understand what is being studied. Thompson pointed out that:

*'It is a reiteration of the existentialist insight that language and cultural practices (or language and being) are inextricably linked, and that we only have a world through language.'* (Thompson 1990:240)

and, in a discussion of Gadamer's account of the importance of language, Hekman stated that:

*'We become acquainted with the world and even ourselves through language because language is the universal mode of being and knowledge ... it is more correct to say that language speaks us rather than we speak it.'* (Hekman 1986:110)

Individuals usually account for and describe the same event in many different ways and many factors (cultural, interpersonal and situational), may explain these differences. Versions of events are built from and communicated by language; active selections need to be made of words to include or omit. Accounts construct and reflect reality. For example, some accounts may speak of "terrorists" whereas others speak of "freedom fighters". Some cultures have words for concepts others do not, and cultural practices and beliefs are thereby revealed. For example, Timbukhtutians have no word for "ivory" as they do not hunt elephant for tusks; Inuits have many words meaning "snow"; in English there is no word for a woman cared for by midwives during pregnancy and childbirth ("patient", "woman", "client", "mother" have all been used but none is completely satisfactory).

2.3.3.3 Reflexivity Central to the hermeneutic approach is the notion of reflexivity, defined by Lamb and Huttlinger as:

*'...a self awareness and an awareness of the relationship between the investigator and the research environment.'* (Lamb and Huttlinger 1989:766)

and by Appignanesi and Garratt as:

*'...an immediate critical consciousness of what one is doing, thinking or writing.'* (Appignanesi and Garratt 1995:73)

Appignanesi and Garratt emphasise the immediate nature of reflexivity, explaining that it is more than reflecting upon one's actions, thoughts or writing which may be done some considerable time after the event. Hammersley and Atkinson (1983:14) point out that social research is reflexive by nature, as the researcher is part of the social world she or he studies. Esterson defines reflexivity as:

*'... the study of the reciprocities of persons and groups of persons in contrast to the study of natural events.'* (Esterson 1972: 213)

Esterson (1972:224) proceeds to describe the process of reflexivity in terms of a circle, as follows:



### The inquirer

- acknowledges reciprocity between herself and the social world studied but has an imperfect understanding of the nature of that reciprocity as she is caught up by it;
- temporarily withdraws from active participation in order to reflect in a discriminatory fashion on herself and her experiences of and in the social world studied. Achieves self realisation, by a change in the inquirer's perception of herself;
- returns to reciprocity.

This cycle is repeated, producing increased self realisation, and increased ability to:

*'...cope with changes in the situation - with the unexpected, with events which contradict one's expectations ... This is a process often referred to as personal growth ... a creative and dialectical process ...'* (Rowan 1981:168)

Rowan noted that the reflexive circle consequently represents a process of self discovery, as well as discovery of the social world studied.

### **2.4 Justification for the choice of paradigm**

This study is concerned with explicating the processes of facilitating and making informed choices in pregnancy. The constructivist paradigm has been chosen to guide the design of the study, and within this paradigm, a grounded theory approach (influenced by symbolic interactionism - see 2.3.1) is used to determine specific methods of data collection and analysis. The grounded theory approach, especially that advocated by Glaser (see Chapter 3) and which is used in this study, is hermeneutical in nature and consistent with the constructivist paradigm (Annells 1996).

As described in section 2.3 the constructivist approach is based upon several assumptions; those most relevant to this study are discussed as follows. Firstly there is the assumption that there are many realities or truths depending upon the interpretations of the people who experience them, although there may be common elements shared between individuals. My intention in this study is to explore the realities of facilitating and making informed choices as experienced and interpreted by individual midwives and pregnant women, and, by using grounded theory techniques, to weave all of these individual realities into theoretical frameworks that will explicate the common elements related to choice in pregnancy.

Constructivist research uses qualitative data; this is appropriate in this study as qualitative data are more likely than quantitative data to reflect the existence of the multiple realities experienced by midwives and pregnant women.

Secondly, there is the assumption that findings are the creation of the inquirer and the inquired-into; knowledge is thereby created rather than discovered. Constructivists regard individuals supplying data as participants in the study rather than subjects to be studied. This participation may extend to individuals assessing the truth of the theoretical frameworks in terms of their own realities, and this strategy will be used in this study (see 4.6.2). Thus, the resulting knowledge (that is, the frameworks) is a construction between the inquirer and inquired-into, which seems appropriate in a study of this nature which is attempting to construct theory from several different perspectives of reality.

Thirdly, this created knowledge is assumed to be bound by context and time. This study will investigate how choices are facilitated and made within the context of today's maternity services. As outlined in Chapter 1, the maternity services scene is changing; patterns and standards of care will continue to evolve. The constructivist approach acknowledges that research takes place in this changing world and the findings should be interpreted accordingly. This assumption that inquiry is context and time-bound is also integral to the grounded theory approach (Glaser and Strauss, 1967:22; as discussed in more detail in Chapters 3 and 4) wherein theoretical frameworks may be added to and refined as circumstances change. Thus, the theoretical frameworks constructed in this study are offered, not as static statements that will remain true in all contexts for all time, but rather as robust representations of how a group of midwives and pregnant women facilitate and make informed choices today.

Fourthly, the influence of the inquirer is also acknowledged in that I, as an experienced midwife and occasional user of the health services, experience my own reality and interact with other people in many different ways. For example, when interviewing midwives about facilitating informed choice it would be impossible for me to approach them as a completely naïve inquirer as I have been engaged in similar activities for many years, and I bring my own experiences and views to the collection and interpretation of data. The constructivist



approach, in acknowledging this, demands that I reflect upon such experiences and views and this helps make transparent both my role as inquirer and my effect upon the data.

My own interests, beliefs and value systems developed throughout my personal and professional life have formed the basis for this study. I come to this study having practised and taught midwifery for 25 years, although I have never personally used the midwifery services. I am passionately committed to midwifery as a means for improving the lot of childbearing women and their families, believing that midwives have enormous power to influence the wellbeing of the women and families in their care. How this power is used is one of the issues addressed in this study.

At the beginning of the study I took a critical theory, feminist stance, more liberal than radical, with the belief that what should be aimed for is a gradual change in the social, political and economic structures that would remove gender discrimination and enable women to reach their full potential (Haralambos and Holborn 1991:536), not bound by constraints imposed a society largely defined and controlled by male patriarchy. An additional belief I held (and still do) that all women have the right to live their lives, exercising autonomy and fulfilling themselves whilst according others the same rights (Tong 1989: 11). The exercise of autonomy and self-fulfilment are obviously closely intertwined with the ability to make and operationalise informed choices in pregnancy. I strongly suspected, however, that the findings would indicate that the women in this study (that is, midwives and pregnant women) are prevented from exercising autonomy and self-fulfilment because of the male dominated, patriarchal nature of the maternity services (as discussed in Chapter 1, and later in Chapter 7).

Reflecting upon these personal attitudes and beliefs, I came to the view that to gather and interpret data under their influence would serve more to cloud issues than to clarify them. I wanted to 'see' emerging issues (such as power and control) in as uncluttered a fashion as possible. I thought that by using a critical theory, feminist paradigm I would risk being directed towards taking a preordained, polemic stance and I wanted to avoid this. I therefore tried to assume a neutral stance that would allow me, by using a grounded theory approach, to let the data speak for themselves, instead of subjecting the data to the risk of

my 'forcing' categories from them (Stern 1994). I believe this decision was the right one in that I was free to consider issues from many angles. This was particularly important when interpreting data. Later in the study, when considering issues of power, I adopted critical theory and feminist stances when I thought it appropriate to do so. Issues arising from this will be considered further in Chapter 8, when I will reflect upon my perception of how I influenced the study, and how it influenced me, particularly regarding my conception of feminism.

## **2.5 Summary**

To summarise, the constructivist paradigm influencing this study acknowledges that each participant, and the researcher, experiences her/his own reality and interacts with other people in many ways. Language and actions are imbued with symbol and require interpretation to reach understanding of meaning. Each person involved in the study is an expert upon her (or his) own life and experiences. My realities and perspectives will be identified and used to interpret data to construct and link the categories forming theoretical frameworks. These assumptions accord with those of the constructivist paradigm. I have taken a qualitative approach to data collection, qualitative data being more likely to reflect the existence of multiple realities within an holistic context.

Based upon symbolic interactionism, the constructivist paradigm espouses a relativist view of reality, and an interpretive approach to the construction of knowledge. Although consensus is aimed for, such constructs are open to new interpretations and may change over time and context. A hermeneutic/dialectic reflexive approach is used to interpret data. A grounded theory approach will facilitate the operationalisation of these constructs, and this approach is described in the following Chapter.



## CHAPTER 3

### THE THEORETICAL BASIS OF THE STUDY

#### 3.1 Introduction

The aim of this Chapter is to explain the characteristics of a grounded theory approach, and to justify its choice in this study. Grounded theory is based upon a model of theory generation, where theory is discovered from, and therefore grounded within, data (Glaser and Strauss 1967:1). The purpose of grounded theory is to explain phenomena experienced in the everyday, social world, and the social processes underlying these phenomena by which reality is constructed and maintained (Artinian 1986:16).

Grounded theory is not based upon any a priori theories, because its function is to construct theories. It is instead based upon the conceptual framework of symbolic interaction, and consequently contains a major interpretative element. Grounded theory provides a means to guide the collection and interpretation of (usually) qualitative data, and to discover categories and concepts that can be linked to describe processes, and build theoretical frameworks. These frameworks are thereby grounded in the data.

#### 3.2 Theories, theoretical frameworks and concepts

The purpose of grounded theory is to generate theories and theoretical frameworks. At its simplest, a theory may be seen as:

*'...a statement that purports to account for or characterise some phenomenon.'* (Stevens, 1984:1)

This is perhaps the least restrictive definition amongst numerous alternatives, many of which require that the concepts manifest within a theory should be defined and their interrelationships explicated. Moody defines a theory as:

*'...a set of concepts or interrelated statements that may be tested empirically and serve to explain, describe, or predict phenomena of interest to the discipline.'* (Moody 1990:57)

and proceeds to define a theoretical framework as:

*'...a collection of theories that are interrelated with common phenomena of study in a research project ...'*

Concepts have been described as the 'building block of theories' (Moody 1990: 52) and are abstract representations of reality, or labels to attach to mental images; (such as, for example, 'safety', 'woman-centred', 'empowerment', 'mentor', 'normal involution of the uterus'). (Bryar 1995: 26). Concepts may be linked together to form a theory that outlines and explains a situation. Walker and Avant (1995:38) see concept development as a crucial approach to the development of theory, emphasising that the basis of any theory depends on the identification and explication of the concepts to be considered in it. Some concepts are easier to define/agree than others. For example 'preterm' can be fairly easily defined in terms of various indicators, whereas 'empowerment' may contain far more complex and abstract ideas/indicators (Bryar 1995:27). The grounded theory approach facilitates the identification, development and clarification of the concepts utilised in a theoretical framework.

Theories are often described according to their scope, at 4 levels (Moody 1990:55):

- Metatheories, which theorise about theory.
- Grand theories, which in themselves are not testable, but serve to generate further theory, and hypotheses which can be tested. Grand theories consist of global conceptual frameworks or models defining broad perspectives to guide, for example, practice and curriculum design. In contrast with nursing there has been little development of grand theory in midwifery, although Bryar (1995:104) wrote that individual midwives do have a framework that guides their practice which lies on a continuum between 2 main models:

Medical/Obstetric: Pregnancy as a pathological condition requiring medical intervention

Normal life event: Pregnancy as a natural process

- Middle range theories, which account for a significant area of practice and are less abstract than grand theories. They attempt to describe, explain and predict situations. Middle range theories are limited both in the number of variables they contain and in



scope, and are thus particularly useful in practice and research (for example, theories of attachment, burnout, grieving et cetera.).

- Practice theories, which are used in everyday life. They attempt to prescribe care, by identifying actions that need to be taken to achieve certain outcomes.

Glaser and Strauss further differentiate theory depending upon whether it is substantive or formal. They describe substantive theory as:

*'...that developed for a substantive, or empirical, area of sociological inquiry, such as patient care, race relations, professional education, delinquency, or research organisations.'* (Glaser and Strauss, 1967:32)

as opposed to formal theory which is:

*'...that developed for a formal or conceptual area of sociological inquiry, such as stigma, deviant behaviour, formal organisation, socialisation, status congruency, authority and power, reward systems or social mobility.'* (Glaser and Strauss, 1967:32)

Glaser and Strauss classify both substantive and formal theory as 'middle range':

*'...(falling) between the minor working hypotheses of everyday life and the all-inclusive grand theories.'* (Glaser and Strauss, 1967:33).

This study aims to generate substantive, middle range theory concerning aspects of midwifery care.

### **3.3 Grounded theory**

The purpose of grounded theory research is to understand how a group of people define, via social interaction, their reality (Stern, Allen and Moxley, 1982). A grounded theory is constructed inductively and deductively from data, its construction involving the discovery, development and verification of theory. As Glaser and Strauss (1967:237-249) note, grounded theories should

- fit the substantive area by faithfully representing the data.
- make sense to the participants, and to practitioners within the area studied.
- be applicable to that area and useful in a variety of situations, by using comprehensive data gathered from a wide base and interpreting them broadly and conceptually. The theory needs to be sufficiently abstract to allow this, but not so abstract as not to be

useful in daily situations. The applicability of the theory may be restricted to the area studied but Strauss and Corbin (1990:24) point out that theories may be accumulated within a discipline to result in a wider application.

- enable control (or partial control) of those situations as they change over time. The theory must be sufficiently developed and rich to allow the user to analyse, predict and to some extent control situations, and to move flexibly within it as changes occur.

Stern (1980) noted that grounded theory differs from other research approaches as follows:

- 1. Theory is induced directly from the data, and not from previous studies (although these may be used in the later stages of the study to enrich the categories).
- 2. Processes are described rather than static conditions.
- 3. In the process of ‘constant comparative analysis’ each section of data is compared with every other section.
- 4. The questions asked of the data, and the directions of sampling (theoretical sampling) are influenced by the developing theory.
- 5. Data collection and analysis run concurrently.

### 3.3.1. The development of grounded theory

During the 1950’s and 60’s research based upon the framework of symbolic interactionism became popular within the social sciences. Unfortunately, although theoretical explanations of the phenomenon studied were produced, little was written about the analytical processes used to arrive at the theory, and this gave rise to considerable criticism by scientists and others (Robrecht 1995). Two sociologists, Barney Glaser and Anselm Strauss collaborated to explicate these processes, and this resulted in the publication of their grounded theory method in 1967.

Heavily influenced by Mead’s symbolic interactionism and its focus upon the interrelationships of conditions, meaning and action, Strauss emphasised the importance of recognising the contextual, changing, complex nature of reality, together with the active role people take in shaping the world they live in. He advocated that researchers should facilitate their understanding of what was studied by being ‘in the field’. Glaser came from a



background of quantitative research. When he became involved in a qualitative study, although impressed by the richness of the data, Glaser nevertheless saw the need for a properly thought out approach to data collection, analysis and theory generation (Strauss and Corbin 1990:25).

Glaser and Strauss collaborated for several years. When they parted, Strauss continued to develop grounded theory and, in an effort to answer remaining criticisms of the approach, together with Corbin (1990) produced firm guidelines and rules for the analysis of data.

Stern suggested that:

*'The need to respond to critics, I think, led Strauss ... to modify (his) description of grounded theory from its original concept of emergence to a densely codified structured operation.'* (Stern, 1994:220)

Glaser favours an alternative, interpretive approach, allowing theory to emerge from the data. For example, Stern wrote that the Straussian approach asks 'what if' of the data at every opportunity:

*'... bring(ing) to bear every possible contingency that could relate to the data, whether it appears in the data or not. Glaser focuses his attention on the data to allow the data to tell their own story.'* (Stern, 1994:220)

Glaser (1992 cited by Melia 1996) commented that the densely codified Straussian method should be called 'conceptual description' reserving the term 'grounded theory' for the Glaserian approach. The Glaserian approach is more in accord than the Strausserian with the constructivist paradigm and therefore will be adopted in this study in that broader interpretative approaches will be favoured rather than rigid adherence to set protocols. Strategies for data collection and analysis suggested by Strauss and Corbin will, however, be used and adapted where necessary to guide analysis.

### **3.4 Data collection, analysis and theory development**

Data collection, analysis and theory development occur in a reciprocal fashion (Strauss and Corbin 1990:23). The process is not linear, but cyclical or spiral, and is influenced at all stages by the emerging theory (Glaser 1978:2).

Since emergent theories are grounded in the data, data needs to be gleaned from a sufficiently wide source to enable the development of theory which is wide in scope, has fit and relevance, and works in practice (Glaser 1978: 4). Qualitative data are obtained, usually by interviews and/or observation, which can be recorded and stored in the form of transcripts. Qualitative data comprise 'soft data'; words, as opposed to the numerical 'hard data' of quantitative research. As Hockey (1991) pointed out, qualitative research is concerned with individual situations and explores how people feel and behave in those situations.

Since data analysis and theory construction has a hermeneutic basis, comprehension of the data by the analyst is essential. Morse (1994:27) pointed out that in order to comprehend, the inquirer needs to enter the field with as open mind as possible, and as a 'stranger' who tries to take nothing for granted, but who hears and sees everything that is relevant without being judgemental. Participants need to trust the inquirer and provide information. Active inquiry aids comprehension, by the researcher probing the information provided by the participants, asking questions at every opportunity, and noting the responses together with the ideas these generate. The researcher/interpreter needs to understand the data, from the participant's point of view, or 'horizon'(Steeves and Kahn 1995).

Comprehension, noted Morse, is further developed during data analysis, when underlying meanings, values and links to other sections of the data may emerge. Data analysis falls into three broad stages, concept formation, concept development and concept modification and integration (Table 3:1).

#### 3.4.1 Concept formation: Open coding

Coding starts as soon as the first data have been collected, and continues throughout the study, often until the writing of the final report (Strauss and Corbin 1990). Open coding breaks down and then restructures the data. Transcripts are scrutinised to identify phenomena within the data, which are then labelled with provisional code names. Stern (1985) suggests that at least some of these codes take the form of gerunds, that is, words indicating action/process and ending in 'ing'. 'In vivo' codes (that is, terms used by respondents) may be used, as well as codes constructed by the researcher.



3.4.1.1. Memoing As soon as coding starts memos are written, in which questions about words, phrases, actions et cetera. are asked and possible lines of inquiry noted, in text or diagrammatic form. Memos are frequently written or drawn, and tend to become more detailed as the study progresses. They are used to develop and dimensionalise categories, and to provide ideas for investigation and directions of theoretical sampling. They are the '*...analyst's written records of the analytic process*' (Corbin, 1986: 108). Glaser considers memoing to be:

*'The core stage in the process of generating theory, the bedrock of theory generation ...'*  
(Glaser, 1978:83)

Memos may be operational, consisting of notes from the inquirer to remind her where to collect more data, or analytic. Analytic memos focus, for example, upon ideas for coding or emerging categories, or for links between categories or the identification of core categories (Glaser 1978:84). The type and form of the memo will reflect the stage of the study, and the personal style of the researcher (Strauss 1987:109).

3.4.1.2 Theoretical sampling In order to facilitate dimensionalisation of categories, especially core categories (Glaser and Strauss 1967: 69) theoretical sampling is employed so that sampling is purposively directed towards participants and situations thought likely to provide relevant data, and questions asked during interviews may become progressively focused. In the early stages of the study, sampling needs to be as open as possible in order to allow a range of phenomena to be identified and categorised, along with their properties and dimensions. The researcher needs patience to wait for things to happen, or for something interesting to be said, and:

*'...to allow sufficient space for ... potentially relevant concepts to emerge'* (Strauss and Corbin, 1990:181).

It is unknown at the outset of the study (and indeed until the study is almost complete) how many participants or incidents need to be sampled; sampling continues until, according to Stern:

*'...she or he is satisfied that a conceptual framework is developed that is integrated, testable, and explains the problem - in other words, the truth.'* (Stern, 1985:153)

**Table 3:1****Summary of the stages of data analysis****A. Concept formation: Open coding**

→ Preliminary coding to break down the data

→ Developing substantive codes

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*Aided by:*

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**B. Concept development: Axial coding**

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*Constant comparative analysis*

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→ Testing hypothesised links between substantive codes, forming categories

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*Memo writing*

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→ Linking categories into larger, more abstract, substantive categories

.

*Theoretical sampling*

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*Theoretical sensitivity*

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**C. Concept modification and integration**

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.

→ Linking the substantive categories to form a theoretical framework

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→ Identifying one or more categories

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3.4.1.3. Theoretical sensitivity According to Strauss and Corbin (1990:41) theoretical sensitivity refers to the personal qualities of the researcher and her awareness of the subtleties of meaning contained within data, her insights into and comprehension of the data, and her ability to extract from it relevant material. Since the collection and analysis of data is hermeneutical and intuitive, theoretical sensitivity is an important attribute of the researcher. Theoretical sensitivity may be acquired from professional and personal experience, and from the literature on the topic studied. During the study, theoretical sensitivity is likely to sharpen with the collection and analysis of data. Theoretical sensitivity is discussed further in section 4.5.3.1.

3.4.1.4 The role of published literature in grounded theory studies Chenitz (1986) states that there is confusion regarding the role of literature reviews in grounded theory studies, this confusion resulting from a lack of differentiation between studies designed to generate theory, and those to verify theory. In the latter, the researcher searches the literature to assist in the operationalisation of the theory into variables and hypotheses that can be tested. Chenitz wrote that the grounded theorist will approach the literature as a source for data as the study progresses, using it to further dimensionalise categories and test the relationships between them. She advocates restraint in the early part of a study:

*'...the grounded theorist maintains a cautious and sceptical attitude about the literature. This is particularly important during the early stages of a project since at this point the researcher can unconsciously fall into accepting what is written.'* (Chenitz, 1986:44)

Chenitz believes this becomes progressively less dangerous as data are collected and analysed, and concepts and categories are identified enabling critical comparison with the literature. She pointed out however that a review of the literature is often necessary in the research proposal to gain approval, for example, for funding. Strauss and Corbin (1990:48) recognised that the researcher is likely to come to the study with considerable knowledge of the relevant literature, but, like Chenitz, warned against using it to presuppose categories, which must develop from the data and not from the literature. They advocated using the literature in the following ways:

- To stimulate theoretical sensitivity to certain recurring and apparently important themes and concepts that may be looked for in the data



- Using knowledge of existing theories to approach and interpret data
- As a secondary source of data, for example quotes may be re-used
- To stimulate interview, or observation, questions
- To provide ideas for directing theoretical sampling
- To help validate the theory.

The general view of the use of the literature is that, although it must be used with caution so as not to unduly influence the progress of the study, it may be used consciously and carefully to achieve specific objectives as suggested above. There is, however, a dilemma in that researchers are unlikely to enter into a study blind to at least some of the literature concerning the topic; much of which will have been absorbed over time into the researcher's personal body of knowledge. Indeed, knowledge gleaned from the literature and the attitudes and ways of practising that have developed from it may be so well integrated into the researcher's persona that it is difficult for her or him to identify particular, discrete aspects that require scrutiny. This is also true, of course, of knowledge, attitudes and practice that are culturally determined. 'Bracketing' of material (Bergum 1991) is a difficult and often impossible process but some attempt is nevertheless desirable in order to assist reflexivity, especially when considering the influence of the researcher upon the data and their analysis. These issues as they related specifically to this study are considered further in Chapter 8.

3.4.1.5 Hypothesising and categorising Provisional codes are tentatively clustered and organised to form categories. This is both a hermeneutical and intuitive process. Hypotheses are suggested regarding the allocation of pieces of data to certain categories, and these hypotheses are tested by collecting and analysing more data. Hypotheses may be accepted or rejected; in the former case the category will be strengthened and dimensionalised, in the latter the data may need allocation to a different category. During this process at least some of the categories are likely to be rejected and/or reorganised and recoded (Chenitz and Swanson, 1986:8); indeed the whole provisional scheme of categories may require several revisions. Thus categories are formulated and reformulated by constant comparative analysis, which is a fundamental attribute of the grounded theory approach. Within the data are sought consistencies and contradictions as well as similar and negative cases in order to



test and dimensionalise the emerging substantive categories. Stern (1980) pointed out that there is a similarity between constant comparative analysis and computer factor analysis in that in both approaches each piece of data is compared to every other piece. The difference, she wrote, is that in constant comparative analysis the researcher's brain takes the place of the computer.

Studies of this nature often collect more data than can be utilised, and it may be necessary to focus upon specific categories, putting aside others.

#### 3.4.2 Concept development: axial coding

Data collection, memoing and constant comparative analysis continue. Theoretical sampling becomes focused upon choosing participants or situations that will further dimensionalise, or substantiate relationships between, categories (Strauss and Corbin 1990:185). Categories are combined into larger, more abstract 'substantive' categories. Each substantive category becomes richer in detail, that is, it becomes dimensionalised and densified by full descriptions of its properties, the conditions under which the category occurs, any strategies involved, and the consequences of the actions or outcomes contained for all involved (Strauss 1987). Strauss and Corbin (1990:99) offer a 'coding paradigm' to remind the inquirer to code the data in terms of:

- cause of a phenomenon
- context: the setting in which the phenomenon is seen, and the meaning it has for individuals
- intervening conditions (often revealed by phrases such as 'because', 'since', 'on account of'.
- strategies and interaction among individuals
- consequences (revealed by for example, 'as a result', 'because of that', 'the result was').

At this point the literature may be examined for descriptions of the identified substantive categories, and this is used as data to enrich the categories, guided by theoretical sensitivity. New data are collected, and the process described above continues until the data reveal nothing new, when the category is said to be 'saturated'. Glaser and Strauss (1967) describe theoretical saturation occurring when:

*'...no additional data are found whereby the sociologist can develop properties of the category ... one reaches theoretical saturation by joint collection and analysis of the data.'* (Glaser and Strauss (1967: 61)

and Strauss and Corbin (1990:188) provide criteria for saturation as

- No new data appear to further dimensionalise a category
- The category development is dense
- Relationships between categories are established.

### 3.4.3. Concept modification and integration

Increasingly general and abstract expressions of the categories are made to achieve parsimony whilst:

*'... retaining scope in the applicability of the theory to a wide range of situations ...'* (Glaser and Strauss, 1967: 111).

Tentative links between categories are made in the form of hypotheses, and these are tested by examining data already collected, or by obtaining new data aided by theoretical sampling. A core category (or categories) is identified that accounts for the substantive categories and the way they are linked together, represents the underlying 'story line' of the study. Strauss (1987: 36) describes a core category as being central in its relationship to other categories, appearing frequently in the data, having clear implications for a more general theory, and *'allowing for building in the maximum variation to the analysis'*. Theoretical sampling is focused upon:

*'...verifying the story line, relationships between categories, and for filling in poorly developed categories.'* (Strauss and Corbin 1990:187)

A theoretical framework is constructed by linking the dimensionalised core and substantive categories. This is tested 'in the field' and modified and retested as necessary, until a robust theoretical framework is formed.

3.4.3.1 Closure Glaser (1978) warns against 'premature closure' when the theory may have gaps, be thin, weak, or even wrong (Morse 1994: 33). Ammon-Gaberson and Piantanida (1988) describe two forms of premature closure: thin sampling, when insufficient data have been collected, or stopping before an adequate theory has been constructed. They warn that



doctoral theses are particularly at risk of premature closure because of time constraints. In order to refute accusations of premature closure, sampling of participants and events needs to be sufficiently wide to enable collection of sufficient data, the analyst's theoretical sensitivity to the data needs to be well developed, and saturation of categories needs to have been achieved.

### **3.5 Trustworthiness of data and their analysis**

Much has been written about the reliability and validity of constructivist research. Although many writers point out that the positivist concepts of internal and external validity, reliability and objectivity do not translate well into the constructivist paradigm (for example, Lincoln and Guba 1985), these terms are nevertheless extensively used in relation to qualitative research (Brink 1989). Constructivists, as Schwandt pointed out, celebrate their personal involvement with the inquired-into but, paradoxically, may seek:

*'...in true Cartesian fashion ... to disengage from that experience and objectify it.'*  
(Schwandt 1994:119)

Although constructivist inquiry embraces the philosophy that objectivity in its pure form is unobtainable, Lincoln and Guba (1985) insist that trustworthiness of the data and its interpretation must be demonstrated, and instead of reliability and validity suggest 4 alternative constructs to demonstrate trustworthiness, as follows.

#### **3.5.1. Credibility (instead of internal validity)**

In a grounded theory study the resulting theory must be integrated, testable and true (Stern 1985). The size of the sample and richness of the data need to be sufficient to allow categories to be identified and dimensionalised in adequate depth and breadth. The truth of the data and their interpretation are cross-checked through multiple data sources, constant comparative analysis (Brink (1989:179) and through searches made for negative instances or alternative hypotheses (Glaser and Strauss 1967). As Hutchinson wrote:

*'The researcher continually formulates hypotheses and discards them if they do not seem accurate. A grounded theorist looks for contradictory data by searching out and investigating unusual circumstances or occurrences. If such data do not fit what has already been found, they will not be discarded but will contribute to the richness of the theory in process. Data are compared and contrasted again and again ... distortions or lies generated by the participants will gradually be revealed.'* (Hutchinson 1986:116)

Brink (1989: 179) pointed out that, when interviewing participants, the researcher may check for consistency and truth of information by phrasing the same question in different ways and comparing the replies.

### 3.5.2. Transferability (instead of external validity).

This relates to the generalisability of the findings, and the applicability of the resulting theoretical framework to other situations. Hutchinson (1986) wrote that a substantive theory may be relevant only to the population studied, but a quality core theory will be applicable to a wider population. Lincoln and Guba (1985) point out, however, that the responsibility for demonstrating this would lie with other researchers wishing to use or test the framework in other settings.

### 3.5.3 Dependability (instead of reliability).

This construct acknowledges fundamental differences between positivist and constructivist paradigms in that the former assumes an unchanging world in which conditions under which data are collected do not change, and thus findings can be replicated. The constructivist paradigm assumes the world is continually changing, and findings cannot necessarily be replicated. Dependability is demonstrated by the researcher describing and accounting for changing conditions in or increased understanding of the setting. For example, participants may be repeatedly interviewed to assess whether the information they provide changes over a period of time (Brink 1989:177).

### 3.5.4 Confirmability (instead of objectivity)

In constructivist research, the subjectivity of the researcher is acknowledged (and indeed, may be seen as essential if she is to demonstrate empathy for participants when entering their world), but concerns that this subjectivity will affect the conduct and findings of the study need to be addressed. Lincoln and Guba (1985) suggest the following strategies:

- Data and their interpretation are referred back to the respondents for verification or correction.
- Discussion of the research methods, the data and their interpretation with experienced mentors.



- The use of a reflexive journal, which displays the researcher's thought processes.
- Bracketing out self; examining prejudgements and commitments so as to be a clear receptor of the data (Cohen 1987).

Kahn pointed out that objectivity can be demonstrated:

*'...when the researcher is able to come closer to seeing things as they are than as she or he would have them.'* (Kahn 1993:122)

To conclude, Strauss and Corbin (1990:249) stress the importance of grounded theorists being sufficiently explicit about the procedures they have used in order that their appropriateness may be judged. Chapter 4 will explicate data collection and analysis in this study, and the trustworthiness of the data and its analysis will be discussed in Chapters 4 & 8.

### **3.6 Summary: The application of the grounded theory approach**

Grounded theory is constructed by an individual (that is, myself) from data acquired from other individuals. Consequently, the theory will represent a version of reality constructed by myself from my interpretation of data supplied by the midwives and their clients participating in this study. These data will reflect the multiple realities experienced by participants, and will need to be gleaned from a sufficiently wide base to enable the resulting theory to 'fit' the area of decision-making in pregnancy and to make sense to participants and practitioners. Theoretical sensitivity is a concept central to grounded theory and concerns the ability of the researcher to identify, from her or his professional and personal experience, what is important in the data (Strauss and Corbin 1990: 41). My task is to make sense of these multiple realities by constructing a process in terms of a theoretical framework which accounts for, and describes, the realities contained within it. As with other grounded theory studies, the theory will need to be tested by, and with, other individuals, in other situations, when it may be expanded and refined to reflect a wider truth and consequently a wider applicability. Glaser and Strauss (1967: 22) point out that a characteristic and strength of grounded theory method is that the theory may be developed by adding data and new categories as they are discovered. The underlying theory is not thereby '*debunked, disproved or discredited*', but added to and enriched.

In conclusion, the interpretive stance taken in this study is congruent with the concepts of symbolic interaction (Firestone 1990:110) in that individual experience is studied within an interpretative framework, and the acknowledgement that situations are constantly changing and constantly re-evaluated. The framework of symbolic interaction will guide the grounded theory study towards an understanding of the meanings and interpretations that midwives and their clients construct in the processes of facilitating and making choices in pregnancy. The following Chapter describes the operationalisation of the grounded theory approach in practice.



## **CHAPTER 4**

### **METHOD**

#### **4.1 Introduction**

The aim of this study is to develop middle range, substantive grounded theory regarding the processes involved when midwives facilitate, and their clients make, choices during pregnancy. The study is based upon the assumption that informed choice is a desirable feature of midwifery care and this value is inherent in the study. Stern (1980) recommends the use of grounded theory when investigating hitherto unresearched areas where there is little or no theory, which is the case in this study. The purpose of this Chapter is to describe the grounded theory approach, and then to detail the methods of data collection and analysis.

As noted in Chapter 3, Stern (1985) describes 5 stages in the grounded theory process as

1. Collection of empirical data
2. Concept formation
3. Concept development
4. Concept modification and integration
5. Production of the research report.

This Chapter will detail the first four stages in this process. The final stage, the production of the research report will be discussed in Chapter 8.

Data collection was divided into 2 stages of initial and subsequent data collection.

#### **4.2 Initial data collection**

Data were collected primarily by open-ended interview (Field and Morse 1990:65) and also by observation of midwives and childbearing women.

#### 4.2.1 Initial recruitment strategies

Three maternity units were involved and are described below. They were chosen because of their convenience and proximity to where I lived and worked, in order to enable a time efficient approach to data collection, and because they represented a variety of maternity care settings from which participants could be invited to join the study.

At an early stage in the study I approached the appropriate midwifery managers of the Units to explain the study and obtain their co-operation and agreement in principle to the study. Following Ethics Committee approval (4.2.4) I explained the study to the staff working in the antenatal clinics of the Units, personally where possible or failing that, by providing written information. Staff were assured that participation was entirely voluntary. At this stage, most midwives appeared to be willing to join the study; a few expressed some reservations about being observed and interviewed but nevertheless said they would participate, and one midwife refused absolutely. I made it clear that I would respect her decision and not attempt to persuade her to participate, not only to reassure that particular midwife but also to convince the other midwives present of my sincerity that participation was voluntary.

I arranged dates and times of my attendance at antenatal booking clinics with the midwives in charge of the clinics. On my arrival, the midwife in charge directed me to midwives involved in the booking clinics and I approached them to remind them of the study and to invite their participation. No midwife refused but it is possible that those who did not wish to participate secreted themselves away from my view! Having obtained the consent of the midwife to join the study I then approached the woman she was due to 'book'. I gave a verbal and written explanation of the study and invited the woman to participate. Every woman approached agreed to join the study.

During this initial phase of data collection, 4 midwife/women 'pairs' were studied from each of the following 3 Units.

Consultant Unit A. This obstetric consultant unit is situated in a District General Hospital serving a cathedral city and its rural surrounds, on the border between the South Midlands



and East Anglia. There are small ethnic Indian and Chinese communities here.

Approximately 2000 women are delivered here annually. There is no system of team midwifery in place.

Consultant Unit B. This unit is situated in a District General Hospital serving a large East Midlands town, and an extensive rural community with a very small ethnic minority population. Approximately 2000 women are delivered here every year. There are hospital and community midwives attached to the unit, but there is no system of team midwifery in place.

GP Unit C. One of the few GP units to survive Health Service economies, this is a small GP, midwife run maternity unit undertaking normal deliveries and postnatal care. It is situated in a small town in the Fens, and serves a mainly rural community. Approximately 200 women are delivered here annually. The unit is administered by Consultant Unit B, from where women living near to the GP unit are transferred for postnatal care. The (mostly part-time) midwives work here with no immediate medical cover, and so all were senior G-grade midwives. They work as community midwives as well as at the GP unit (for which they provide 24 hour cover on a rota system), and aim to provide continuity of care to women during pregnancy, labour and the postnatal period.

#### 4.2.2 Initial sampling strategies

Convenience sampling was used. The sample comprised midwives and the women in their care. (NB although it is recognised that midwives are usually women too, the term 'women' in this study refers to their patients or clients - none of the terms women, patients or clients is entirely satisfactory. 'Women' appears to be the best choice).

Midwives Twelve midwives working in hospital and/or community settings, and caring for women during pregnancy participated.

Women Twelve pregnant women 'booked' by the midwives above participated. They were required to be literate and English-speaking. To meet requirements stipulated by the Ethics Committees, all participants were aged at least 18 years and not pregnant as a result of sexual abuse (as far as could be determined; they were not asked specifically about this). No other sampling criteria were stipulated.

Characteristics of participating midwives and women are outlined in Appendix 2.

#### 4.2.3. Initial data collection and data management

Initial data were gathered in order to obtain rich data from which to develop codes, categories and tentative frameworks. Data were collected by the following strategies:

- Observation and tape recordings of interactions between midwives and pregnant women
- 'Follow up' tape recorded interviews between the above midwives and myself
- 'Follow up' tape recorded interview between the above pregnant women and myself

Twelve interactions were observed which were thought likely to involve the sharing of information, and decision making. These took the form of 'booking interviews' (see glossary), which took place in maternity units. The woman's partner, or her children, were occasionally present.

Booking interviews took place in private rooms which invariably contained a desk and wooden chairs. I sat as inconspicuously as the room lay-out allowed, and recorded field notes regarding the environs and context of the interaction, together with any episodes of, for example, notable non-verbal communication. These field notes contributed to the data, but the main data comprised the verbal interaction between midwife and woman. The interactions were tape recorded, by means of a small Sony (Model TCM S68v) tape recorder with an omni-directional microphone. This was positioned as inconspicuously as possible, whilst congruent with adequate recording.

My role was that of observer-as-participant (Patton 1980:138) in which I (as far as possible) avoided playing any active part in the interaction. I adopted this role because, although I was aware that my presence was bound to have some effect upon the interaction between midwife and woman, I wished this to be as minimal as possible. I also wanted to be free to observe - to see and listen to - what was going on without the distraction of thinking of responses to comments or questions. Both the midwife and the woman were aware that I am a midwife, however, and occasionally I was invited to comment upon some issues. I did then contribute since it would have appeared churlish not to do so, but as minimally as



possible in order to avoid influencing the situation and in as friendly a fashion as possible in order to reduce any threat my presence caused. Usually, I was able to restrict my input to social exchanges only. After the interview, if the opportunity were present I expressed the hope that my presence had had no undue effect. Invariably I was assured it had not (whether this was the truth or just an expression of courtesy by the midwife or woman I have no means of knowing). I will reflect further upon my role as observer-as-participant in Chapter 8.

The tape was transcribed as soon as possible by myself (within 48 hours of the interview in order that recall of the context related to the content should not be lost), using a computer, the Microsoft © Works for Windows word-processing package, and the Ethnograph © package (Seidel, Kjolseth and Seymour, 1988). As advised by Seidal et al, text was entered into the word processing package, formatted to produce a wide right margin (into which codes and comments could be later hand written when the text was printed), and then converted into ASCII computer code. These ASCII data were then entered into an opened Ethnograph file, where they were converted back into readable text that could be either displayed on the computer screen or printed as hard copy. The Ethnograph program enabled codes to be attached to the stored text, and coded data could be stored and retrieved easily. Codes could be added to or changed easily which was particularly valuable in the earlier stages of analysis when different coding patterns were tried and refined. The actual coding was not performed by the Ethnograph; this had to be done by myself, but the Ethnograph proved an invaluable tool in facilitating the storage and easy retrieval of the coded data.

From the transcript I identified and extracted passages of text relating to the facilitating or making of decisions. These were used in the 'follow up' interviews (see below) to 'trigger' comments from participants. An example of a 'trigger' is as follows:

*Midwife C And have you thought about how long you'd like to stay in?*

*Woman C Yes, a few days for a rest!*

*Midwife C It's up to you, you can stay as long as you like!*

#### 4.2.4 Follow up interviews of midwives and women

These twelve midwives and women were interviewed separately as soon as possible following the initial interaction. The purpose of these interviews was to show participants the 'triggers' identified from the transcripts of the initial interaction and to record their comments regarding what they perceived was happening at various points, together with their views on more general aspects of the interaction in relation to choice and decision-making. The interviews were as loosely structured as possible; as Sorrell and Redmond (1995) point out, in qualitative studies the interviewer needs to develop a balance of structure and flexibility. The 'triggers' provided the structure for the interviews. Flexibility was enabled by allowing the responses of the participants to guide the direction of interviewing. Responses were probed in order to acquire depth and clarity of information and I tried to remain alert for cues (both verbal and non-verbal) that would initiate such probes and directions for interviewing.

Interviews occurred at venues preferred by the participants. In the case of the midwives they were held either in the maternity unit or the midwife's own home, and in the women's case, her home. On one occasion the women's partner was present and although I preferred to obtain the woman's comments only, I invited him to participate since any attempts to exclude him may have been seen as offensive, especially as the interview took place in their home. Furthermore, whilst not actively sought, the partner's comments were thought likely to add to the richness of data.

Interviews lasted from 30 to 70 minutes and were tape recorded and transcribed verbatim. From each midwife/woman 'pair' it was intended that three tape-recordings and transcribed scripts would be produced, that is 36 transcripts. Unfortunately, in my anxiety regarding the early interviews, I omitted to switch on the recorder and thus failed to record data from Midwife B; consequently 35 transcripts resulted.

My aim during initial data collection was to use the 'booking' and 'follow up' data transcripts to identify as many concepts as possible and observing and interviewing midwife/women 'pairs' provided extensive, rich data for this. Data collection and analysis proceeded in tandem, and by the time the 12th midwife/woman 'pair' had been observed and



interviewed, theoretical frameworks (examples of which are shown in Figures 4.2 and 4.3) were well developed. The later observation/interviews were adding little that was new to the categories, however, and it became obvious that the approach to data collection needed to be changed in order to facilitate further exploration and dimensionalisation of the categories.

### **4.3. Later stages of data collection**

In order to explore the developing categories I needed to interview midwives and women about the specific topics identified in the analysis to date. For example, the importance of the concept of crisis had emerged from the women's data, and this needed to be explored. I changed my strategy of sampling because I no longer needed to observe interactions between midwives and women, instead straightforward interviewing was more likely to provide the information I required.

#### **4.3.1 Subsequent recruitment and Theoretical sampling**

Four midwives who had not taken part in the initial data collection were recruited from the following Units

Consultant Unit B (described above) 1 midwife

Midwifery Unit C (described above) 3 midwives

All were interviewed in their Unit.

GP Practice Pregnant women were recruited from the antenatal clinic of a local GP practice which had strong links with Consultant Unit B and Midwifery Unit C. The GPs in the practice agreed that I could sit in the waiting room and invite women attending the clinic to participate, on condition that I did not cause any delay, or inconvenience to the practice. There were other clinics running at the time and all patients shared the same waiting room. I did not have access to the names of clinic attenders and so had to identify the women attending the antenatal clinic by the obvious signs of their pregnancy. Consequently all those approached were in advanced pregnancy. Six women were approached and 4 agreed to be interviewed. (1 woman refused because she expected to be delivered within the following 24 hours; the other woman who refused to participate said she disliked the thought of being interviewed). All four women were interviewed in their homes.

These individual midwives and pregnant women were interviewed using a loosely structured interview schedule. Interviews were tape recorded and transcribed, as above. During these interviews a critical incident approach was used to gather perceptions of, for example, crisis from midwives' and women's perspectives. Participants were asked to cast their minds back to events (perceived by themselves as, for example, a crisis) and to tell me the circumstances of that situation and how they felt about and dealt with it. A balance had to be struck, however, between asking the questions to which I needed answers, and not being so focused that the emergence of new issues would be impeded. The data obtained added significantly to the dimensionalisation of categories and construction of theoretical frameworks.

In the later stages of theory construction it became apparent that data were needed related to the fields of more independent midwifery practice and the use of computers in midwifery information-gathering. I therefore recruited a midwife/woman 'pair' from Midwifery Unit D.

Midwifery Unit D. This is situated in the inner city area of London and is a progressively run midwife led unit. There is a system of team midwifery in place and the midwives have considerable autonomy in the way they run their unit. Women in the care of this practice have a high rate of obstetric abnormality, however, and the midwives work closely with GPs and Consultant Obstetricians. Women with a normal pregnancy are often delivered at home if they so wish.

At this stage I reverted to the original approach to data collection by observing and tape recording an interaction between the midwife and woman. The woman was in late pregnancy, booked for home birth, and the interaction which lasted over an hour was observed in the woman's home. 'Triggers' were identified from the resulting transcript. For a number of reasons it was not possible to carry out 'face to face' interviews with the midwife and woman. For example, the woman was near to delivery and it was not possible to arrange a mutually convenient time within the following few days to interview her. Follow up telephone interviews with the midwife and the woman were therefore carried out. These each lasted approximately 30 minutes, and were tape recorded and transcribed.



To acquire data on the use of computers, at a Midwives Refresher Course (at which I was presenting the initial findings from the study), I invited participation from midwives who used computers to 'book' women in pregnancy. From this, I interviewed by telephone 2 midwives. These telephone interviews were tape recorded and transcribed as described above.

At this point in the study documents were accessed, such as pertinent research papers, Government and other reports, and 'opinion papers'. Concepts identified from them were used to dimensionalise the theoretical frameworks. Theoretical sampling was also directed towards rescrutiny of 'old' data. As theoretical sensitivity increased sections of data took on new meanings and significance, confirming the hermeneutical, spiral nature of the grounded theory process.

As will be clear from the information above, data were collected primarily by interview. These interviews were not conducted as a discrete stage of the research process, but continued throughout a large part of the study. There were three main reasons for this. Firstly, according to grounded theory method described in Chapter 3 data are analysed as they are collected. Therefore, for logistical reasons interviews could not follow closely together as this would not provide sufficient time for the transcription and analysis of data. Secondly, by constant comparative analysis codes and categories were gradually formed. Constant comparative analysis (see 3.4.1.5) is a lengthy, painstaking activity as each piece of newly collected data has to be compared with existing data. Thirdly, during this process questions regarding, for instance, the properties of categories arose which helped to shape the content of further interviews. Time was needed between interviews to allow these questions to coalesce, and, most importantly, to permit thought to be given to them. Thus interviews continued for well in excess of a two year period.

To summarise, theoretical sampling comprised

- changing the direction of sampling
- using an increasingly focused approach to interviewing

- utilising published material
- re-examining data in the light of 'new' data

#### 4.3.2 Ethical issues

- The protocol was approved by the four local hospital Ethics Committees concerned.
- The full purpose of the study was explained verbally and in writing to each potential participant, and her consent sought. (Appendices 3 and 4)
- Participants were aged at least 18 years in order that consent could be given legally.
- Confidentiality between participants and myself was assured. There was no way by which an individual could be associated with any particular aspect or interaction; 'identifying features' were masked in the report and pseudonyms used. Transcripts were identified by sequential initials.
- The follow-up (and any subsequent) interview of each 'pair' was confidential between that individual and myself. No feedback was given to the other member of the 'pair'.
- Participating institutions are not directly identifiable in any published report.
- No woman whose pregnancy was known to be the result of sexual abuse was invited to participate.
- In order to store data in my computer I became registered under the Data Protection Act (HMSO 1984).

(The last two conditions were stipulated by the Ethics Committee serving Consultant Unit A and the midwifery manager of Consultant Unit A respectively).

#### 4.4 Summary of data collection strategies

A total of 48 transcripts were produced. Table 4.1 summarises data collection strategies.



**Table 4.1****Data collection strategies**

<b>Stage of data collection</b>	<b>Venue of recruitment</b>	<b>Type of sampling</b>	<b>Number of participants</b>	<b>Data format</b>
Initial	Consultant/ Maternity Units A, B, C	Convenience	12 midwife/ women 'pairs'	Observation & transcript of 'booking' interview x12  Follow up interviews x23
Subsequent	Consultant/ Maternity Units B, C,	Theoretical	4 midwives	Individual interviews
	GP clinic		4 women	Individual interviews
	Maternity Unit D		1 midwife/ woman 'pair'	Observation & transcript of 'booking' interview. Follow up telephone interviews
	Midwives Refresher course		2 midwives	Telephone interviews

**4.5 Data analysis**

Several publications exist which offer advice on the grounded theory approach to data analysis (for example, Chenitz and Swanson 1986, Strauss 1987, Strauss and Corbin 1990) and these (described in Chapter 3) have been followed to a large extent. This section will explain how and why certain approaches to, and decisions regarding, data analysis were taken, illustrated by examples of interviews together with their coding and memos. This section will also describe how the concepts relating to facilitating and making informed choices in pregnancy were formed, developed, modified and integrated into theoretical frameworks.

#### 4.5.1 Concept formation: open coding

In accordance with the grounded theory approach, a start was made upon data analysis as soon as the first interviews were transcribed. Preliminary, tentative codes were given to the data as they were collected by analysing the text word by word, line by line, or segment by segment. Some passages of text which appeared particularly rich were analysed word by word. There were too many data to code so intensively throughout every transcript, however, and consequently most of the data were coded line by line, and the remainder segment by segment. Strauss and Corbin (1990: 72) note that word by word analysis is the most generative of codes and categories, but is time consuming and often tedious. They recommend its use for initial data. This advice proved sound; I found it was not necessary to apply the same minuteness of analysis to every piece of data, since the tentative framework arising from analysis of the early interviews could be developed by a combination of a more holistic view of larger segments of the data, together with minute scrutiny of selected passages of text. A concern remained, however, that by taking an holistic view of some of the data important codes or ideas may be missed and so a few pages of these data were selected at random and analysed line by line. Nothing new of any consequence emerged, which increased my confidence that my approach to analysis was valid.

Throughout the detailed scrutiny of the data it was important not to lose sight of the stories midwives and their clients were telling, and the underlying assumptions and expectations revealed by these accounts. Questions asked of all the data, whether they had been analysed minutely or more holistically, were 'What is going on here?' 'What is the story?' 'What is the context?'. These questions often stimulated new ideas for coding and their organisation into substantive categories.

Notes pertaining to story lines, codes and ideas were made in the margins of the transcripts, and these notes formed the basis of the more detailed memos, again in accordance with grounded theory method.

The above strategies proved useful in provoking questions and hypotheses, and in identifying codes and categories. They also provided a forum for identifying 'negative cases' (Glaser



and Strauss 1967:230) in which occasions are sought when phenomena do not occur as expected.

Preliminary coding facilitated immersion in the data, and the process of coding stimulated reflection about the issues contained within the data.

Appendices 5 and 6 comprise complete transcripts together with preliminary codes and memos of the first complete pair of interviews: that is, those between Midwife C and VL (myself) and Woman C and VL. My purposes of reproducing these transcripts in full are to

- Indicate how ‘triggers’ from the booking interviews were used to stimulate discussion
- Provide a flavour of the interactions between the midwives and their clients, and between them and myself
- Show the preliminary coding and memos. An account of their development into substantive and core categories follows in Figures 4.2 and 4.3.

Midwife C was a part time Grade G midwife in her mid 30’s, with a 2 year old child, working in the GP unit and the community. In her early 30’s, Woman C lived with her partner near to the town centre in a 3 bedroomed Victorian terraced house, had one child of school age, and worked part time as a doctor’s receptionist. As described earlier, I had previously sat in on and recorded a booking visit during which Midwife C and her client, Woman C, talked about matters relating to the pregnancy. I extracted excerpts (‘triggers’) from the recordings in which the midwife appeared to be facilitating or offering choice to her client, or the woman appeared to be making a choice, transcribed them, and then in follow up interviews (reproduced below) asked the midwife and her client to comment upon the transcribed excerpts. These ‘triggers’ are included in the reproduced transcripts and can be identified by the shaded printing format.

The codes are preliminary and tentative, some taking the form of gerunds (as advised by Stern 1985) indicating a process in some form, others merely indicating a description of what is happening at that time. A few are in the words of the participants (‘in vivo’ codes: Glaser and Strauss 1967).

As new data were collected preliminary codes were compared between transcripts during the process of constant comparative analysis. Preliminary codes were reorganised into substantive codes. For example it was soon apparent, and hypothesised, that several preliminary codes such as ‘Asking indirectly’ and ‘Sussing out’ could be clustered into the tentative substantive code ‘Fishing for information’. This hypothesis was supported from existing and newly collected data.

#### 4.5.2 Memo writing

The hermeneutical, spiral process of constant comparative analysis, coding and categorisation was aided by the writing of memos, which noted and explored ideas regarding

- my interpretation of the data
- possible new codes and categories, and ideas for linkages between them in the form of hypotheses, sometimes expressed in the form of diagrams
- directions for future sampling (theoretical sampling)
- a possible focus for future interviews.

Memos were recorded ‘formally’ in a notebook kept specifically for the purpose, and also ‘informally’ in the margins of transcripts. These latter memos often formed the basis for more detailed ‘formal’ memos. To illustrate this, examples of memos relating to ‘crisis’ are provided in Table 4.2 . Strauss and Corbin’s ‘paradigm coding’ (1990:99) guided many of the memos, and influenced the coding and categorisation of data. To illustrate this, examples follow below concerning the category ‘Exploring’, an activity carried out by midwives forming part of the larger category of ‘Sensitising’ to the needs and situation of women. A phenomenon noted was that of ‘Fishing for information’.

1. Causal (or antecedent conditions) of a phenomenon. The identification of the phenomenon ‘fishing for information’ was helped by noting what the midwives said about their reasons for doing this. For example, midwives said they ‘fished’ when not wishing to sound as though they were interrogating the woman, particularly when asking about sensitive topics :



Table 4.2 page 2

**Table 4:2 Transcript and related Memo: Crisis**

Interview transcript	Memo
<p><b>WA's transcript:</b></p> <p>WA The only other thing, when we first found out that there might be a problem and the midwife phoned us she said go home and have a look in the books you've got and find out about spina bifida, but there wasn't an awful lot about what it was, you know, the actual information it said the chances of this that and the other happening and the alpha fetoprotein - what it could show, but it didn't tell you anything about spina bifida, the information about spina bifida wasn't there, to go and look at -</p> <p>VL The implications of having a child with spina bifida?</p> <p>WA Well, what it would actually involve should it be housebound, you know what I mean</p> <p>VL What it would actually mean to have a child with spina bifida? How it would affect the child and how it would affect you?</p> <p>WA Yes, everything like that, because there's not really the information - everyone can turn on the TV and there's pictures of children with Down's syndrome but you don't see people with spina bifida. So, you know, there wasn't the information to look up, was there?</p> <p>WA Even the leaflet they give you doesn't explain an awful lot, that's what I was saying before, it didn't tell you what it actually was, spina bifida or Down's syndrome, it just said that the risk is there.</p> <p>Husband OK, if the test went through and you weren't recalled you aren't going to reflect back on that small piece of information, but having been recalled and then you're asked to reflect back on that, it wasn't enough at the time.</p>	<p>There appears to be a mismatch between information given (eg risk of Down's syndrome etc) and the information needed (eg implications of having a child with Down's, what Down's actually is. If the situation actually arises, the 'worst comes to the worst', more specific, focused information is needed, quickly. Small pieces of information may take on a great importance later - a part of 'making sense of a situation' (Possibly a category linking with or containing 'need to know?') 'Making sense of a situation' - the 'situation' could be a particular situation (eg crisis - implications of a positive screening test) or perhaps the overall experience of childbirth. This implies that information is needed in an overall general sense, narrowing to specifics when required. Concept of 'crisis' probably important here : compare with another 'crisis' ?that experienced by WG.</p>
<p><b>WG's transcript:</b></p> <p>WG ... right at the beginning of the pregnancy, about 5 weeks, I really didn't feel too good, actually I think I got away quite lightly but I didn't feel like that at the time, you know, but one day I had this terrible throbbing headache, and I</p>	<p>This was a crisis to her but she recognises it will not be seen as such by medical staff. She was assertive and went ahead anyway but others may not have. WG also recounted another similar 'crisis' where she spent almost a whole day trying to get advice on what she could safely take for constipation, she was angry at the lack of information available.</p>



**Table 4:2** page 2

Interview transcript	<u>Memo</u>
<p>don't normally get headaches, it was really bad, and I was lying in bed and I thought I must take something, but didn't dare, so I phoned the doctor and I felt such an idiot ringing up just for a headache, and they said 'oh we'll have to phone you back'</p>	<p>Are there separate discourses here? Compare the crisis situations between WA and WG - to midwives and no doubt to the women the crisis WA experienced would be seen as a different (? a more legitimate crisis - but this is my interpretation!) but both share similar characteristics. WA's crisis involves a possible diagnosis of a fetal abnormality that will have lots of repercussions and implications. WG's crisis involves a need to take medication but this medication could lead to a fetal abnormality. WG had the option of not taking any medication but that would have prolonged her physical discomfort and she wanted that resolved. WA had no discomfort - they could not take any action at that point. WA needed information to discover the implications of the possible fetal abnormality so she could determine future action. WG needed information to enable her to take immediate action.</p> <p>How do people behave when they see different perceptions of crisis? Future interviews need to be directed towards this. What are the properties of a crisis? What tactics are used to resolve them? in order that decisions may be made.</p> <p>There are 3 possible scenarios here re perceptions of crisis:</p> <ul style="list-style-type: none"> <li>a) Woman and midwife both acknowledge 'crisis' (eg abnormal screening test, aim is to provide/get highly specific information quickly)</li> <li>b) Woman perceives 'crisis', midwife does not (woman has bad headache, wants specific information quickly to enable her to take 'safe' tablets but midwife does not perceive this as high priority and does not give the info)</li> <li>c) Midwife perceives 'crisis', woman does not (eg woman has severe hypertension of pregnancy and midwife knows she needs urgent admission. Woman feels fine and refuses admission).</li> </ul> <p>Women may experience one or more crises during pregnancy, where specific information is needed quickly for them to make decisions, but they also experience other situations where specific info will be needed at some point, but not urgently.</p> <p>Specificity of info necessary to contextualise it - if info not sufficiently specific, contextualising not possible. ('Contextualising' may be a category). Specificity may also be linked to coercion, legitimising and 'nuisance'. Some women comment there is no previous experience upon which to draw in a crisis. The control to resolve this crisis did not rest with the parents, it depended solely upon the outcome of the test, which turned out to be OK.</p> <p>Regarding WG's crisis, however, resolving it was within her power, given some advice from professionals. An important differentiation to make is whether the crisis is controllable by the woman (or potentially so). If controllable, how? If not, what happens?</p>



*MK: ... because I am trying not to sound as though I am barking questions at her (related to enquiring about fetal screening tests for spina bifida and Down's syndrome) or wanted to hide their ignorance of a situation*

*MH: I thought it was a heart problem, I have to say I was very pleased that she elaborated. So that is why I would be saying this in a vague sort of way hoping that she would then explain, I think.*

**2. Context.** This refers to the setting within which the phenomenon occurs, and the meaning it has for individuals. In these terms, it also describes the dimensions or properties of the phenomenon. Continuing the example of 'fishing for information' this is most likely to happen when the midwife does not wish to betray her ignorance of a situation, the topic is sensitive, and the midwife does not want to appear to interrogate the women.

**3. Intervening conditions.** These are the factors which modify the causal conditions and context. Negative cases may be identified by this strategy. For example, although the midwife may not usually wish to betray her ignorance she may feel so secure in her relationship with a particular client that this is not an issue and instead of fishing she will ask directly for information. Other factors, such as the personality and attitudes of the midwife, as well as many others, will also influence her action.

**4. Interactional strategies.** These describe the actions taken. For example, in order to 'fish' a midwife may 'dither':

*MK: I suppose what I was doing was dithering and hoping that she'd pick up and finish off the sentence for me. Without coming out and saying 'Oh, by the way, this has happened'.*

Or she may be alert for clues in more general conversations:

*MF: ... we go in and get the girl to talk if she wants to, lots of times we talk about breast feeding or whatever, but we often pick up social problems ...*

This midwife used the strategy of encouraging her client to finish her (the midwife's) sentences :

*MK: The first time you came you saw one of the doctors - normally women come for a scan at 9 to 10 weeks, you did that, and they found a second sac ....?*

*WK: I had a scan before ... because I had quite a bit of bleeding, so I knew that one was OK as far as they could tell, but small*

*MK: Yes, it was quite a worry, wasn't it, because they'd been 2 sacs there originally, and the bleeding started and one sac ....?*

*WK: - was still there, and there's still a little bit, and the lady thinks who did the scan last week which is why I've had another one, but the baby's OK.*

**5. Consequences** A consequence of 'fishing' is that relevant information is gained (as can be seen in several of the transcript excerpts cited above), but it could also result in missing information, or gaining irrelevant information and losing time.

#### 4.5.3 Concept development : axial coding

Having broken the data down into coded segments, the next task was to put it together again by the process of axial coding. Strauss and Corbin (1990) define axial coding as:

*'A set of procedures whereby data are put back together in new ways after open coding, by making connections between categories. This is done by utilising a coding paradigm involving conditions, context, action/interactional strategies and consequences.'* (Strauss and Corbin 1990:96)

An important feature of grounded theory is the progressive abstraction of categories; as the classification and ordering of categories proceeds they should become increasingly abstract (Glaser and Strauss 1967). Categories were identified and developed into larger, more abstract ones by

- Linking codes to form tentative categories.
- Recoding the data according to these categories
- Re-examining the data, category by category. I found this process particularly helpful as it allowed me to view together all the data I thought related to a particular category.

This enabled me to 'see' the data afresh. In the case of the Women's data, it was immediately obvious, not only that my initial categorisation was clumsy, but also how the data could be more effectively categorised. The process was repeated with a more rewarding outcome. In the Midwives data, one tentative category was 'locating (personal) power'. This contained all the data pertaining to how midwives perceived, and organised, their power to facilitate and influence informed choices. When all the data in this category were collated and examined, it became apparent that what was really happening was 'territory mapping', and this replaced 'locating power' as the name of this category.



I found that the process of linking coded data to form categories is not one-way; when categories were identified more codes become apparent, thus enriching the categories. I believe this hermeneutic, dialectic process between coding and categorisation helped to validate my conceptualisation of what the categories were about, in that viewing the collated data from an identified stance enabled me to focus and refine my interpretation of the data, confirming earlier codes and 'seeing' new ones.

Hypotheses were constantly formulated and tested within the data, checking out ideas for coding and clustering codes into categories. For example, the codes 'Asking for information' and 'Fishing for information' were combined into the category 'Exploring'. Hypotheses that these codes belonged together in a category were tested by examining and coding new data and adding them as appropriate to the category, thus dimensionalising and strengthening the category. This process involved moving between deductive and inductive thinking, in that relationships or properties within categories were proposed deductively, and then checked out inductively by examining the data (Strauss and Corbin 1990:111).

This whole process was hermeneutical and dialectic, and spiral rather than linear. Each section of data was scrutinised many times, particularly when new data were added. Re-scrutiny often produced new codes, which in turn needed exploring and integrating into categories. This rescrutiny and reordering tended to provide new perspectives upon the conceptualisation of the codes and categories, leading to their revision. Re-examination of the data in the light of the new codes and categories tended to generate new codes and lead to the rejection of others. This process was repeated many times until a reasonably stable framework appeared. In the early stages of analysis frequent major revisions were required but as the analysis reached its final stages revisions became progressively minor and infrequent. As Glaser and Strauss (1967:22) point out, however, no grounded theory is ever complete, and the data are open to fresh interpretations as the interpreter and circumstances move on.

Constant repetition of coding, constant comparative analysis, memo writing, hypothesising, searching for negative cases and categorising led to the identification of substantive categories, and concept development.

#### 4.5.3.1 Theoretical sensitivity

Theoretical sensitivity is central to grounded theory, underpinning concept development. It concerns the

*‘...personal quality of the researcher .... the ability to recognise what is important in the data and to give it meaning.’ (Strauss and Corbin, 1990: 41 & 46).*

Factors influencing theoretical sensitivity reflect the researcher’s professional and personal experiences shaping her or his perceptions of and sensitivity to the topic under study.

Theoretical sensitivity is aided by the analytic process itself, by interacting with the data and reading literature pertaining to the topic. I have attempted to describe my personal interpretation and application of theoretical sensitivity in Figure 4.1

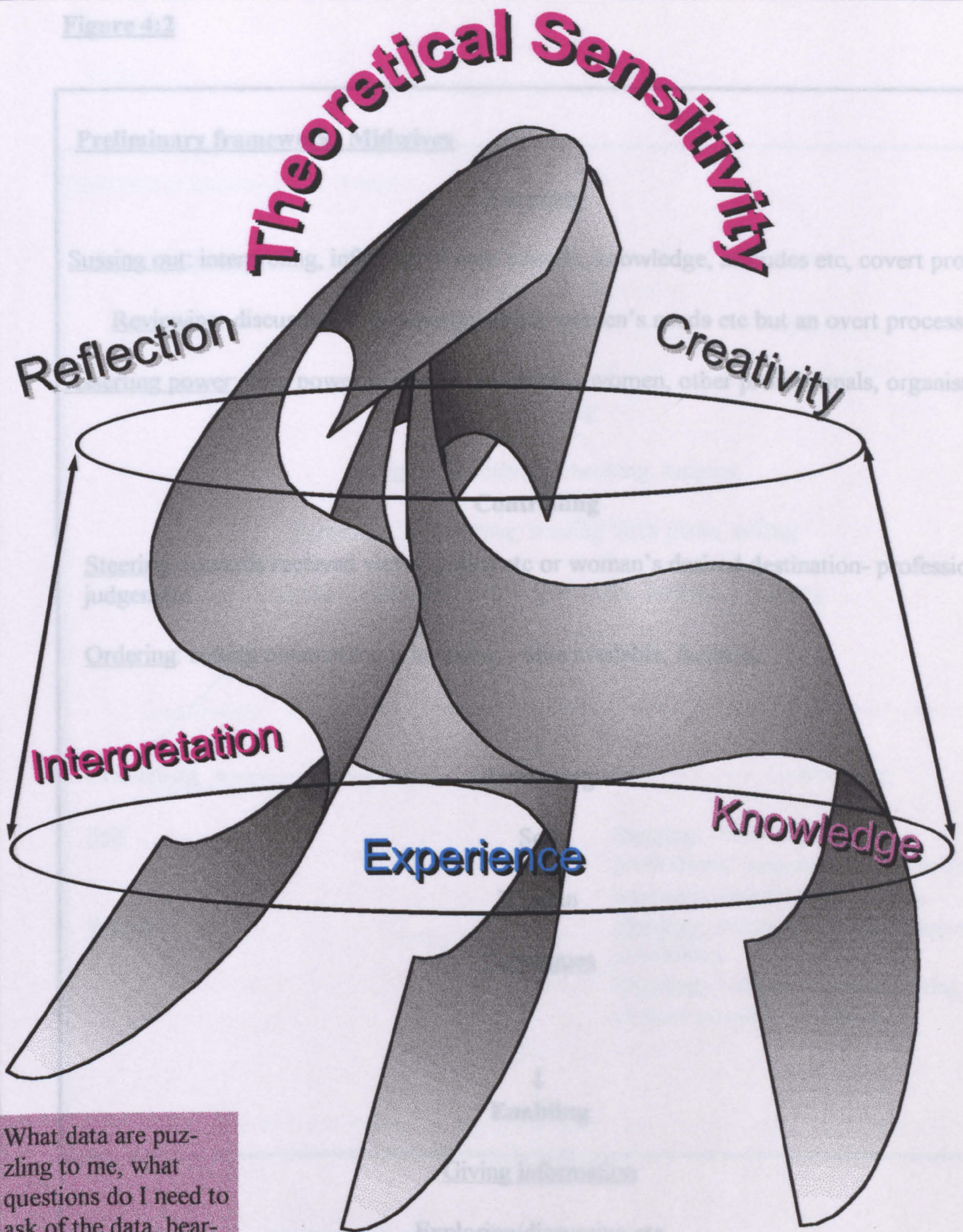
#### 4.5.4 Concept modification and integration

By hypothesising links between categories tentative theoretical frameworks were constructed to describe the processes identified within the Women’s and the Midwives’ data. Constant comparative analysis and theoretical sampling enabled development and testing of the conceptual links. This process was similar to that of axial coding, except that (as noted by Strauss and Corbin 1990:117) it occurred at a higher, more abstract level. As in the other stages of analysis, this was a difficult and time consuming activity, rather like solving a three-dimensional jigsaw puzzle with no picture to refer to of the desired result.

Memoing continued, often in the form of diagrams hypothesising links between categories. Appendices 5 and 6 provide examples of these memos, illustrating early steps in the process of making and refining links between substantive categories into preliminary theoretical frameworks. (Figures 4.2 and 4.3). The framework described in Figure 4.2 was refined into that described in Figure 4.3, which in turn was developed into the final framework described in Chapter 5. Similarly, the preliminary framework described in Figure 4.4 was developed into that in Figure 4.5 and the final framework is described in Chapter 6.



Figure 4:1

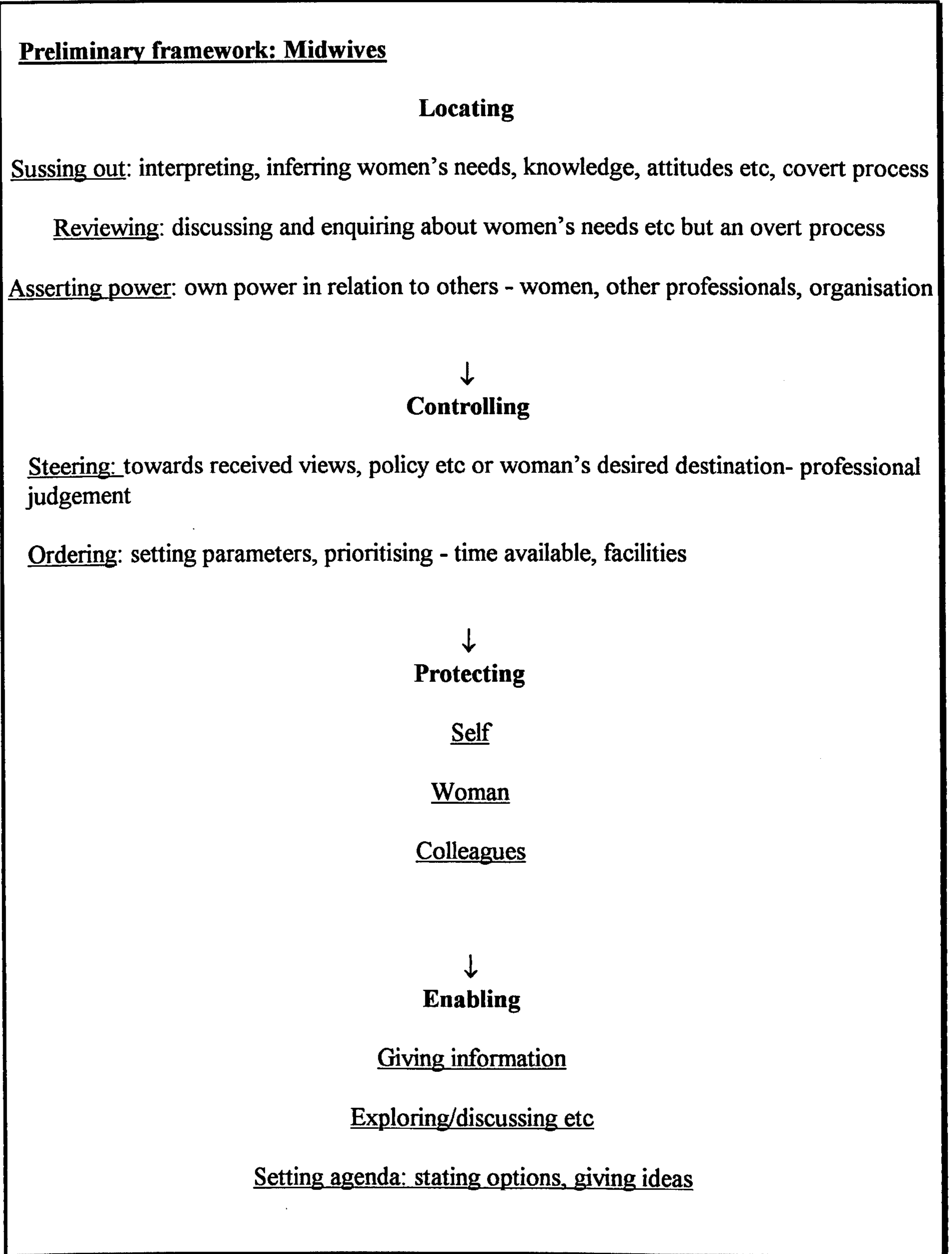


What data are puzzling to me, what questions do I need to ask of the data, bearing in mind the need to be wary of preconceptions, biases, etc. Questions may lead to particularly illuminating insights.

How much of my own experience is reflected in the data? How true do the data ring? Not only to the actual experience (as I remember it) but also to my rapport (as I perceive it) with participants

Drawing extensively on my own experience and knowledge (including that drawn from the literature), constant reflection and re-ordering and re-interpreting experiences in a 'hermeneutic circle', identifying and re-thinking pre-conceptions



**Figure 4:2**



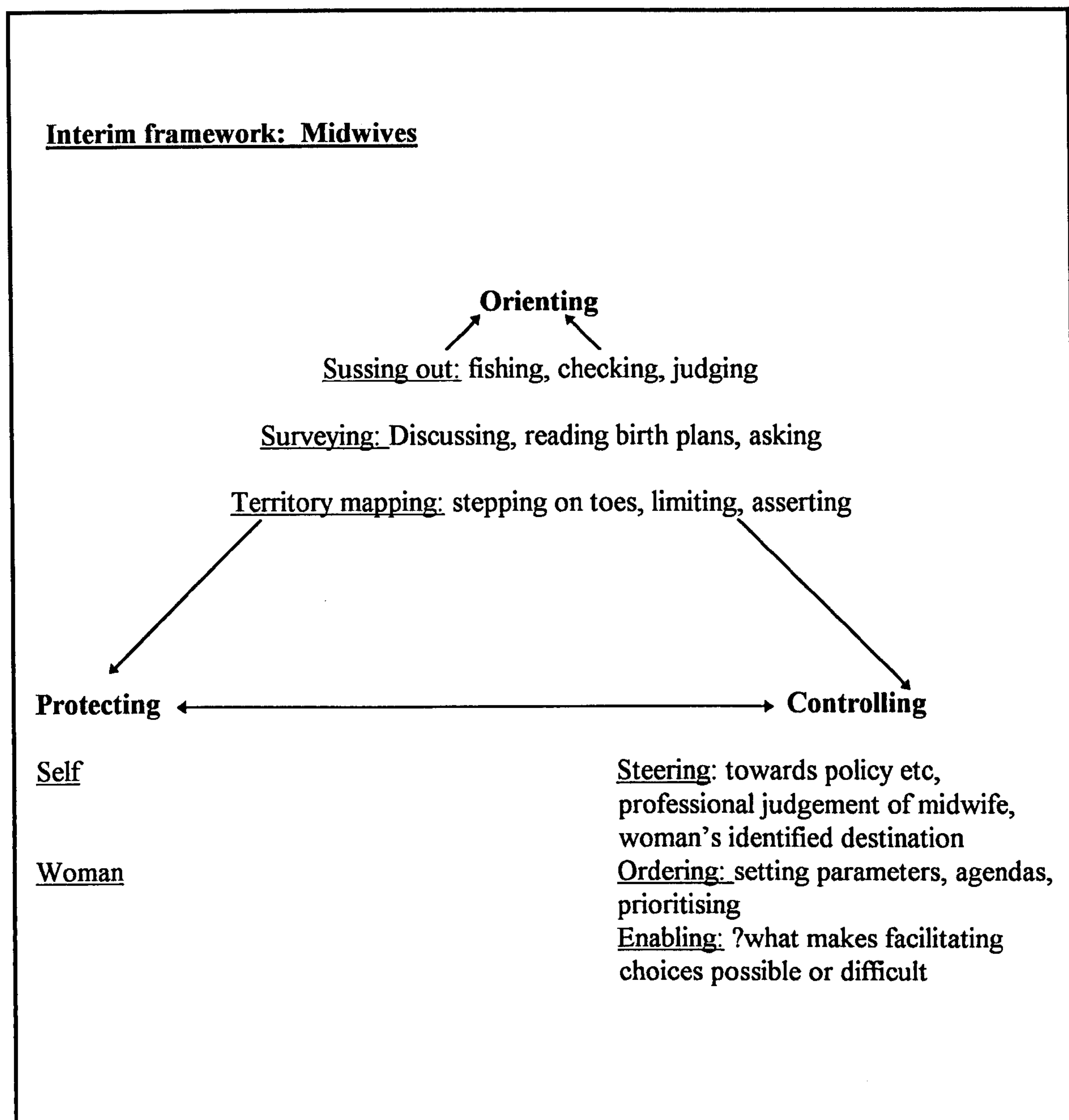
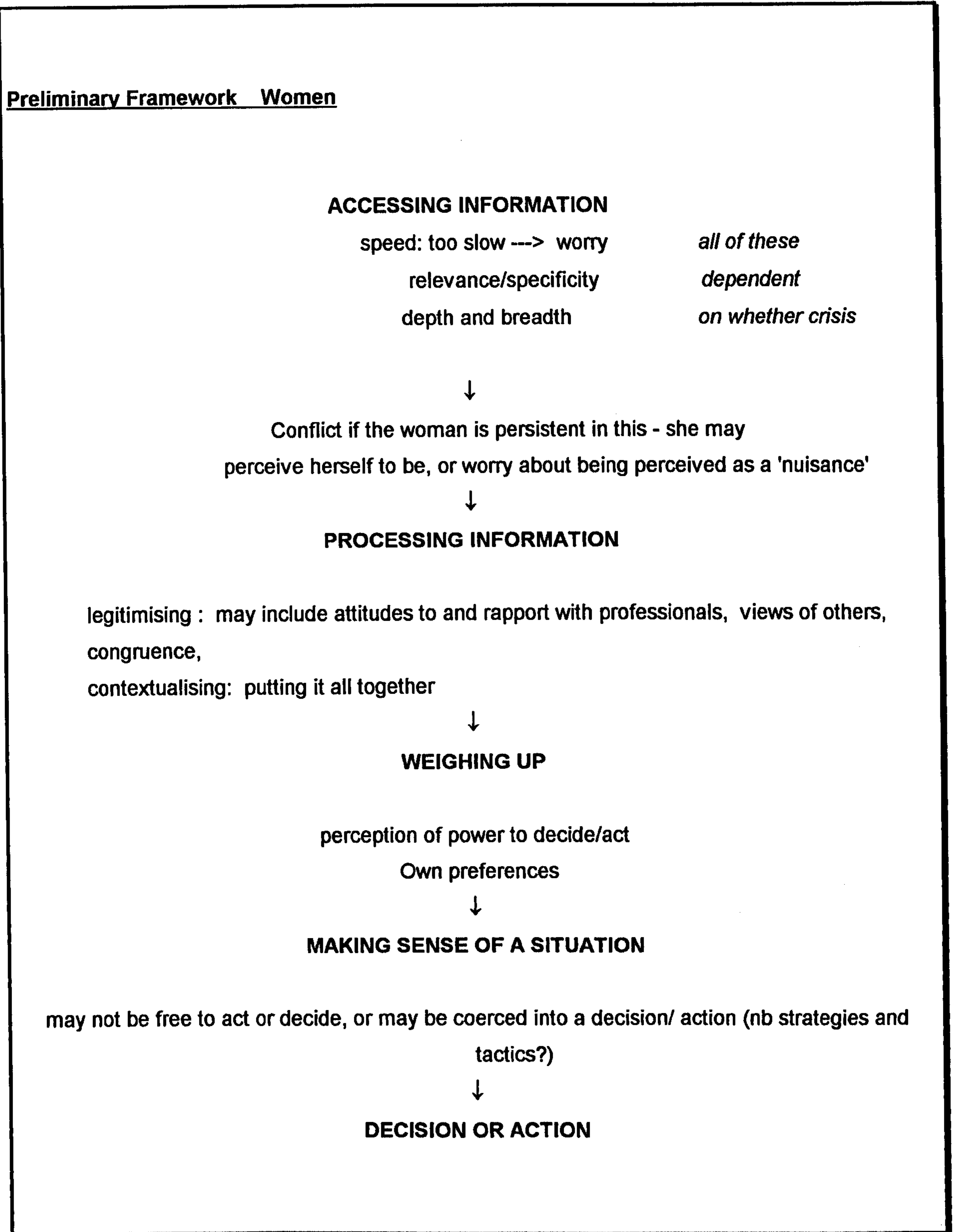
**Figure 4.3**



Figure 4:4





**Figure 4:5**

<b><u>Interim framework: Women</u></b>		
<b><u>Substantive category</u></b>	<b><u>Category</u></b>	<b><u>Notes</u></b>
<b>1. Pursuing information</b>	a) Committing	<i>Does she really want to know?</i>
	b) Prioritising (?or regulating)	<i>Timing the information This may be required immediately (in a crisis) or may be delayed until later</i>
<b>2. Contextualising information</b>	a) Legitimating	<i>Checking and feeling that the information is correct and up to date</i>
	b) Personalising	<i>The specificity of the inform- ation to the individual woman. In a crisis it needs to be highly specific.</i>
<b>3. Balancing needs</b>	a) Needs of self b) Needs of fetus/baby c) Needs of others	<i>There may be conflict between these</i>
<b>4. Self actualising</b>	a) Assessing own power	<i>Deciding whether she has the power to act on the decision she has made</i>
	b) Rationalising use of power	<i>Does she wish to use that power? If so, to what extent?</i>



Hypotheses regarding the dimensions and linkages of categories were tested by further examination (constant comparative analysis) of the existing and newly collected data. Many of the categories were reformulated and other categories emerged which fitted the data better, for example, instead of 'Weighing up', 'Balancing' appeared to be a more appropriate description, and categories were identified and named as 'Regulating', 'Committing', and 'Legitimizing'. These categories were renamed and reformulated as the analysis progressed. For example, it became apparent that 'Balancing needs' (Figure 4.5) was the core category, and was developed and renamed as 'Maintaining Equilibrium'.

#### 4.5.6 Identification of the Core Categories

The purpose of this study was to produce two theoretical frameworks; one relating to the midwives' data, the other to the women's data. Throughout the concept modification and integration phase, I was aware of the need to identify the main story lines which would be developed into core categories. A grounded theory essentially describes a process (Strauss and Corbin 1990:143). In describing process it is necessary to account for the evolution of events, that is, what has influenced events, and what the outcomes were. The core category is the basic story line; the category that accounts for most of the variation in behaviour (Strauss 1987:34). Strauss provides criteria for identifying the core category:

- It must be central, accounting for most of the variation in behaviour
- It must appear frequently in the data
- It must relate easily to the other categories
- It must indicate a wider applicability, for a more general theory
- Dimensionalisation of the core category should move the theory on appreciably
- It must allow for building in maximum variation to the analysis

After several months and false trails I succeeded in identifying core categories which accounted for the Midwives' and Women's data. The core categories are in the form of basic social processes; respectively those of 'Protective Steering' and 'Maintaining Equilibrium'. Once I had identified these core categories to which other categories could be related, integration proceeded more quickly and easily. The resultant theoretical frameworks will be described and discussed in Chapters 5 and 6.



#### **4.6 Assessing Trustworthiness**

Theoretical frameworks were constructed to explain the midwives' and the women's data. These frameworks and the categories and concepts comprising them required assessment to check the credibility of my analysis. A variety of strategies was used to achieve this, summarised in Table 4.3.

**Table 4:3**

#### **Summary of strategies used to establish trustworthiness**

<b>Assessment of:</b>	<b>Strategy</b>
<b>Credibility</b>	Constant comparative analysis, identification of negative cases, cross checking of categories, saturation of categories
<b>Confirmability</b>	Frameworks checked by 6 'women', 3 midwives who had participated and by approximately 80 non-participating midwives  Frequent discussions with research supervisor  Maintenance of a reflective journal
<b>Transferability</b>	Presentation of frameworks to approximately 45 nurses

##### **4.6.1. Assessing credibility**

Credibility refers to the truth of the data, and its richness and breadth in enabling a believable analysis. Credibility was checked by

1. Constant comparative analysis, revealing that many of the codes and themes identified originated from a variety of sources, that is, several women often made similar comments. Constant comparative analysis also enabled testing of hypotheses, the identification of negative cases, and cross-checking of the categories and their links to form integrated theories.



2. Saturation of the categories. Saturation is said to occur when nothing new is being added to the dimensions of categories. Towards the end of data collection saturation was evident, but there is of course no guarantee that if data collection had continued that new dimensions would not have been discovered.

#### 4.6.2 Assessing confirmability

This mainly concerns the degree to which my analysis reflects the truth. This was addressed by

1. Taking my analysis back to a sample of participants. Towards the end of my analysis I met with six women who had provided data in order to explain to them the theoretical framework pertaining to the Women's data, and to receive their opinions regarding my analysis. These interactions were tape recorded and transcribed. Efforts were made to contact all the women who had participated, but several had moved house or were otherwise difficult to contact. It was thought, however, that a sample of 6 would be large enough to provide feedback regarding the plausibility of the framework.

The theoretical framework pertaining to the midwives' data was explained to the following groups of midwives (most of whom had not participated in the study) in order to check the credibility of my analysis and to gain further data. These interviews were not recorded, due to the logistic difficulties of recording the responses of groups of people in acoustically challenged environments.

- 4 midwives from Maternity Unit A, three of whom had participated in the study
- 8 midwives studying a post registration research course
- 6 midwives studying a post registration course in contemporary issues in midwifery
- 18 midwives and 50 midwives respectively, undertaking midwives statutory refresher courses.

Every one of the six participating women to whom the analysis was shown commented that the analysis reflected their experience and that they could 'see themselves' within the frameworks and categories. The midwives who had participated also recognised their own contributions within the frameworks, and other midwives commented that they could see



their own situations and experiences in the frameworks. No comments were received that challenged the truth of the analysis; I heard instead a sigh of recognition that which signified identification with the analysis as a true representation of individual reality.

These interactions invariably stimulated further discussion of the making of informed choices during pregnancy, and I tape recorded and transcribed them. No new categories or important dimensions arose from these data, but they served to confirm the truth of the analysis.

2. Data and their analysis were discussed with my research supervisor at frequent intervals.
3. I maintained a reflective journal which, along with the memos, recorded my thoughts and feelings about the study in general, and the analysis in particular. Some notes concerned my thoughts about feminist issues and power structures that I did not wish at that time to intrude upon my analysis. I attempted to bracket these issues; that is, to consciously identify them and put them to one side to be considered later (Lipson, 1991:73). For example, although I did not express my feelings to participants, I was disturbed by some remarks and information given by midwives to women especially when I perceived attempts by the midwife to frighten the woman into taking a particular course of action. On reflection, however, by bracketing my feelings towards these interactions, I was able to acknowledge the reality of these situations and that the midwife was acting in what she thought was the best interests of the woman. I focused instead upon the usefulness of the data and, as Lipson (1991:80) advised, noted the circumstances surrounding these interactions. This helped to lead to the development of the category Protective Gatekeeping, described in Chapter 5. More discussion on the use of reflection in the study will follow in Chapter 8.

#### 4.6.3 Assessing Transferability

This refers to the potential for application of the theory to other situations. As well as discussing the frameworks with participants and groups of midwives, I also presented them to 3 groups of approximately 15 nurses studying post registration and postgraduate research modules. The reaction was overwhelmingly that the frameworks described their personal experiences, as both professionals and patients, in facilitating and making informed choices.



#### **4.7 Summary**

This Chapter has described strategies for recruitment, sampling, data collection and analysis, and for assessing the trustworthiness of the data and their analysis. The following Chapters describe and discuss the resulting categories and their linkages to form theoretical frameworks accounting for the processes involved when midwives and pregnant women are engaged in facilitating and making informed choices.



## **Part 2**

### **Findings**

This section is organised into two Chapters, 5 and 6. These describe and discuss the findings from the midwives' and the women's data respectively. Chapters are divided into sections related to the substantive categories comprising the theoretical frameworks developed from the data. Each section is prefaced by an introduction which is expanded upon and illustrated by excerpts from transcripts. Issues arising are discussed in relation to extant theories.

Issues of power and control featured prominently in both Chapters, and will be discussed in depth in the following section, Chapter 7, which will draw together these and other overarching issues identified in both the midwives' and women's frameworks.

Speakers quoted in excerpts from transcripts are indicated by initials. For example, VL represents the author. MA indicates Midwife A, and WA Woman A.



## CHAPTER 5: FINDINGS

### THE MIDWIVES: FACILITATING INFORMED CHOICE

#### 5.1 Introduction

The midwife's contribution to facilitating informed choices is sometimes seen as merely providing the information and facts which raise women's awareness and guide them towards a choice. For example, the 'Changing Childbirth' document advocates (perhaps rather glibly) that:

*'The woman ... should be encouraged to be closely involved in the planning of her care', (DoH 1993: 5), and*

*'The woman must be the focus of maternity care. She should be able to feel that she is in control of what is happening to her and able to make decisions about her care, based on her needs, having discussed matters fully with the professionals involved.' DoH 1993: 8)*

Such statements appear to make many assumptions; for instance, that the woman's needs can and will be identified, and that professionals are able and willing to 'discuss matters fully' with her. This Chapter will argue that facilitating informed choice is, in fact, a highly complex process involving many pragmatic, personal and moral issues which are rarely, if ever, addressed in publications such as 'Changing Childbirth'. The purpose of this study is to identify these issues.

The previous Chapter detailed the analysis of data provided by midwives and pregnant women, indicating the processes by which data were coded and categories identified and linked to form theoretical frameworks. The aim of this Chapter is to dimensionalise and integrate these core, substantive and sub-categories, providing theoretically rich explanations of the processes operating when midwives facilitated informed choice in pregnancy. Figure 5.1 illustrates these categories.

## **5.2 Protective Steering: ‘Picking your Line’**

The core category was identified as Protective Steering: ‘picking your line’. (Figure 5.1). When facilitating informed choice midwives ‘walked a tightrope’ (see Figure 5.2 and Chapter 7) in attempting to meet the wishes of women, steering their way through several dilemmas. For example, midwives were anxious to meet the wishes of women and to appear unbiased in their advice, but acknowledged their own strong feelings regarding certain issues. Midwives also had to strike other balances, for instance between giving enough information for the woman to make a choice but not giving too much information and frightening the woman, particularly when talking about, for example, screening tests for fetal abnormality. Goffman wrote:

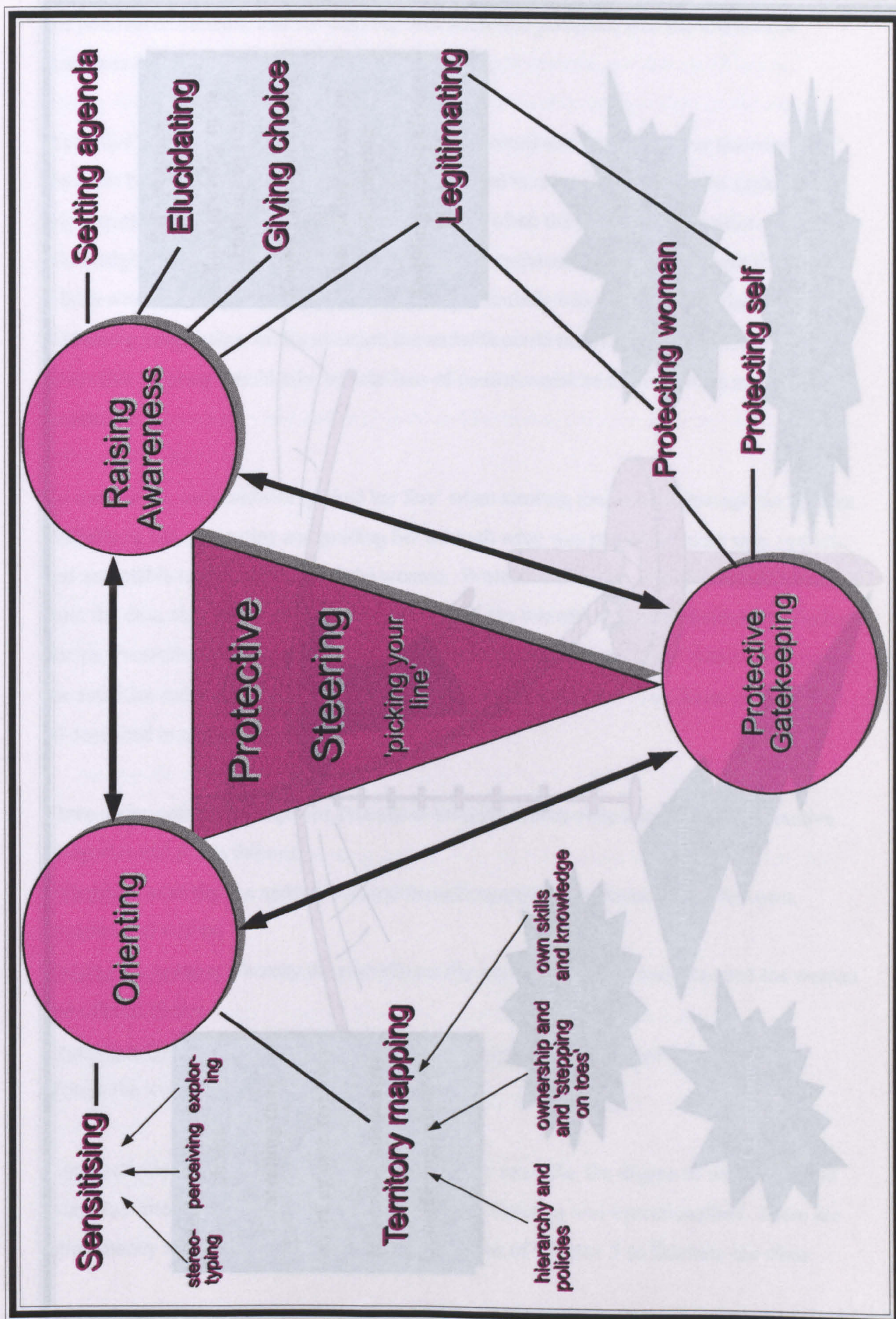
*‘Every person lives in a world of social encounters ... In each of these contacts he (sic) tends to act out what is sometimes called a ‘line’; - that is, a pattern of verbal and nonverbal acts by which he expresses his view of the situation and through this his evaluation of the participants, especially himself.’ Goffman (1967:5)*

Protective steering involved making the woman aware what options were, and were not, open to her. Midwives recognised that many women had strong feelings regarding their care, but whether they did or not, women often needed the opportunity to talk through the issues involved with a midwife who would provide facts and information tailored to the individual woman’s circumstances and wishes. This required both time and knowledge on the part of the midwife, which were not always perceived by the midwife as adequate. Time in particular was often at a premium and the midwife needed to limit the amount of time she could spend with a woman, whilst trying to appear not to do so.

If the ‘right line’ was not ‘picked’ highly undesirable outcomes could result. For example, the woman could be frightened, or feel patronised, colleagues could be upset, unrealistic expectations could be encouraged, and the woman’s (and the midwife’s) well-being and safety compromised. Protective Steering was thus a fundamental as well as a highly complex activity which required considerable personal sensitivity, together with professional skills and knowledge, on the part of the midwife. When engaged in Protective Steering, midwives retained control of the situation, that is, they had control over the information they provided to the woman and the use the woman made of it. When Protective Steering was

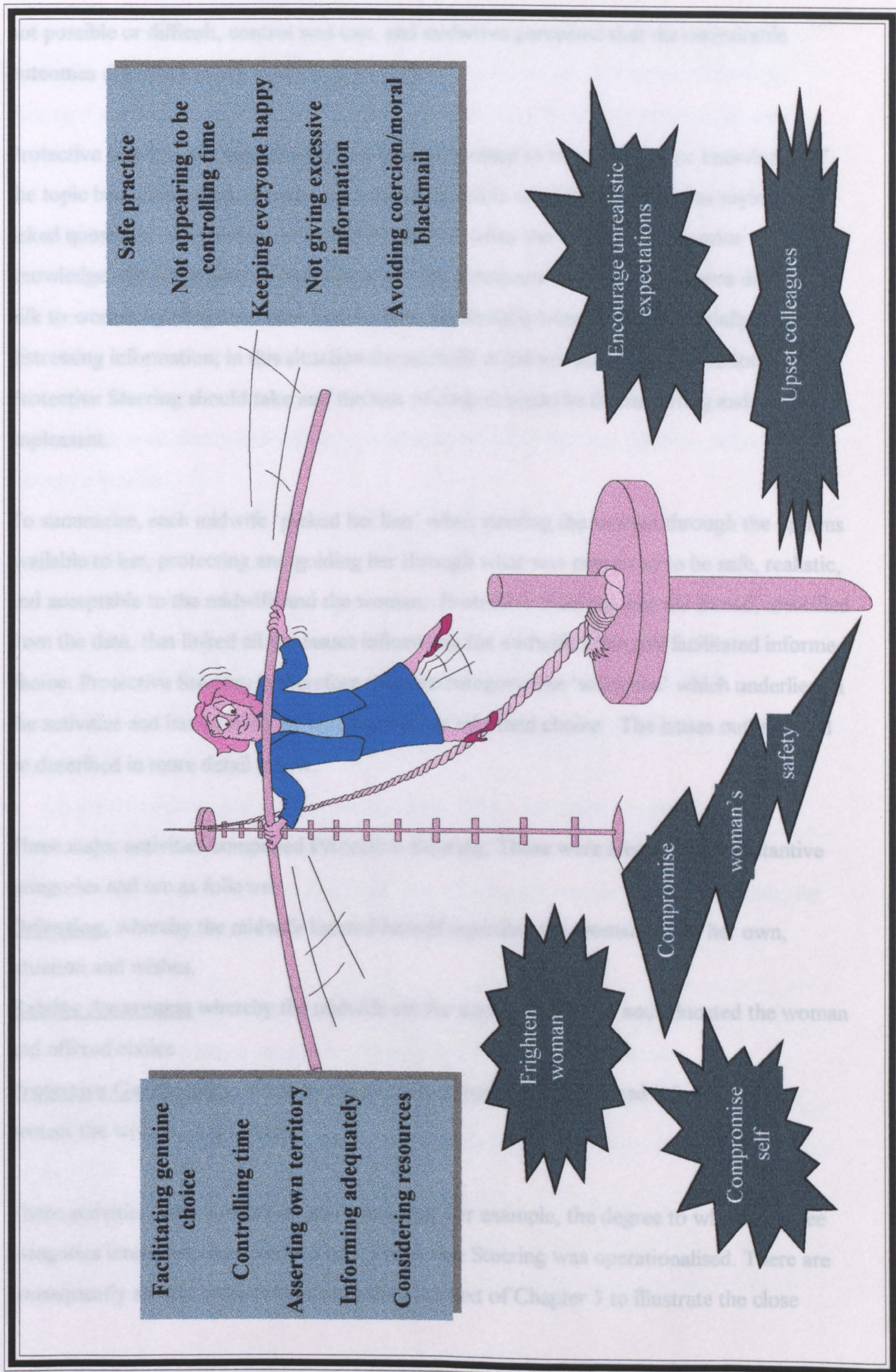


Figure 5.1 Midwives framework





**Figure 5,2 Protective Steering: 'picking your line'.**





not possible or difficult, control was lost, and midwives perceived that the undesirable outcomes described above were likely to occur.

Protective steering was easiest when the woman seemed to have some prior knowledge of the topic being discussed, showed she was interested in what the midwife was saying and asked questions. Conversely, it was more difficult when the woman had no prior knowledge, did not appear to understand or was unresponsive. It was far more difficult to talk to women by telephone than face-to-face, particularly when giving potentially distressing information; in this situation the midwife could not judge what direction the Protective Steering should take and the loss of control could be disconcerting and unpleasant.

To summarise, each midwife 'picked her line' when steering the woman through the options available to her, protecting and guiding her through what was perceived to be safe, realistic, and acceptable to the midwife and the woman. Protective Steering was the thread, identified from the data, that linked all the issues influencing the midwife when she facilitated informed choice. Protective Steering is therefore the core category; the 'story line' which underlies all the activities and issues involved with facilitating informed choice. The issues outlined will be described in more detail below.

Three major activities comprised Protective Steering. These were identified as substantive categories and are as follows:

**Orienting**, whereby the midwife located herself regarding the woman's, and her own, situation and wishes.

**Raising Awareness** whereby the midwife set the agenda, informed and educated the woman and offered choice

**Protective Gatekeeping**, whereby the midwife suppressed or released information to protect the woman, and herself.

These activities were concurrent and interacted; for example, the degree to which all three categories interacted characterised how Protective Steering was operationalised. There are consequently several cross references within the text of Chapter 5 to illustrate the close



relationships between these categories, particularly between Raising Awareness and Protective Gatekeeping. Chapter 5 will explain, dimensionalise and discuss Orienting, Raising Awareness and Protective Gatekeeping in terms of how they relate to the core category of Protective Steering.

### **5.3 Orienting**

The substantive category named Orienting involved two major activities. The first of these was Sensitising to the woman's individual needs, circumstances and attributes, enabling the midwife to judge her needs regarding information, and how the information should be delivered. The second activity involved the midwife mapping her own territory, enabling her to assess her own power and ability to provide information that was likely to influence the woman's actions.

#### **5.3.1 Sensitising**

The midwife sensitised to the woman's circumstances, enabling the midwife (as Midwife E said) to '*pick your line*' when giving information. Sensitising allowed the midwife to assess the information needs of the woman together with her ability to understand and contextualise it. Information was considered in terms of its content, quantity, and delivery. The midwife sensitised to

- the specific information the woman required, that is, the subject matter,
- the depth and breadth of detail the woman needed and/or wanted,
- the woman's ability to understand and contextualise information in order to guide, for example, the language used to deliver it, and the speed at which it was delivered.

Sensitising was easier when the midwife had face to face contact with the woman. Midwife L said about telephoning a woman to tell her the triple test was abnormal:

*ML Oh, it is horrible. I prefer to be face to face with someone when I tell them something....*

*VL Can you tell me why it is hard on the phone?*

*ML Well, no eye to eye contact ... you can't see how she is going to react ... it is awful, it makes me feel awful*

and Midwife H said:



*MH Not being able to be face to face makes it more difficult talking it over. You can't see facial expressions and I think your explanation is limited ... I suppose I am wary ... I would be holding back a little, saying we can talk about that when you come in*

Sensitising was also easier if the midwife were involved from the outset. If other professionals had been involved the midwives were often unsure whether they could trust the other professional to have given sufficient correct information, and a dilemma could result regarding whether to repeat material unnecessarily or to risk the woman not receiving the information. Sensitising was approached in three ways, namely:

**5.3.1.1 Stereotyping**, in which the midwife made assumptions based upon generalisations about the woman. As Green, Kitzinger and Coupland wrote:

*'We all use internal models and sets of assumptions in the way we think about and interact with other people... we all use stereotypes to help us to behave in what we hope will be appropriate ways towards people we have not met before.'* (Green et al 1990:125)

Women were labelled as 'primips', 'multips', 'Asian', 'NCT members', 'older mothers' et cetera, and these suggested to the midwife an approach based upon her assumptions of the woman's attributes and needs:

*MG: .. the Asian ladies, when they go back to Pakistan ... I always make sure that they know that after 28 weeks the airlines will not fly them, lots of them don't know that.*

*MC: .. the primigravidas we recommend to come because they've never been through pregnancy or labour before...*

*MF: ...most of the girls do what their mothers tell them to do...*

Expectations of the woman could be formed, for example if the woman was herself a health professional the midwife tended to assume a certain level of knowledge and insight, which may or may not have been justified:

*MC: .. with (WC) being part of the health service I expected her to know about diet and a healthy diet, what she should be eating, and what to avoid ..*

These assumptions could be revised at a later stage if the midwife gained knowledge of the woman as an individual and not bound by the stereotype. This appeared to be unlikely in the course of the initial interview as this tended to be a fairly short encounter, especially in



hospital clinics. Continuity of carer and lead professionals are concepts advocated in the Changing Childbirth Report; the need for midwives to know the women they are caring for in order to see beyond stereotypes supports the implementation of these concepts. Indeed, Radwin (1996) suggests that expert practice in terms of decision-making is possible only if the nurse (sic) knows the patient and is able to perceive the meaning of situations to the patient.

5.3.1.2 Perceiving describes the process whereby the midwife acquired an impression of the woman during their interaction. This may have resulted from the woman actually telling the midwife what her needs or wishes were, for example:

*MF I had one lady at a booking clinic who walked through that door and said 'before you start I'm not breast feeding and I don't want anyone talking to me about it, I just don't want to know' so I wrote in her notes 'does not wish to breast feed, do not approach about this!'*

Midwives accepted women's statements regarding what they wanted if their expressed needs did not cause particular problems for the midwives and were within the midwife's power and code of practice to meet them. Problems could arise, however, if the woman wanted something outside the midwife's ability to provide it, or which went against the midwife's judgement about what was safe and desirable, and this is discussed further later in the Chapter.

Besides perceiving the expressed wishes of the woman, the midwife also formed an impression of her unexpressed needs, often based upon a stereotype. For example:

*MC .... a lot of the multips don't want to come to the talks, they just want a refresher on their breathing techniques and relaxation*

The midwife also perceived the woman's ability to understand information, and this influenced the way in which the midwife attempted to convey information. The midwife also assessed the degree of control the woman wished to have over her care, and the willingness of the woman to co-operate with the midwife and her colleagues. Some idea of these issues could be obtained by reading birth plans written by women; some were very detailed and assertive, whereas others indicated no preferences, leaving details of their care to the midwife and her colleagues. For example:



*M3 I mean, I think the issues in general really is how much information have the parents got before they make the choice ... they may feel they have got enough information but they probably really do not know hardly anything about it at all ... it comes up in labour doesn't it, with the birth plan...*

**5.3.1.3 Exploring** Whereas stereotyping and perceiving were relatively passive activities on the part of the midwife, exploring was an active process by which the midwife sought information to enable her to sensitise to the wishes, attitudes and needs of the woman. Exploring was a covert or an overt process, the midwife using strategies of either 'fishing' for information, or asking directly, depending upon various conditions.

**Fishing for information** The midwife 'fished' for information when she did not want to sound as though she were interrogating the woman. The midwife also 'fished' when she did not wish to betray her ignorance of a situation. Woman H's last baby had been born with 'defective valves'. Midwife H did not know which valves were defective but did not wish to reveal this. She suspected it may have been heart valves, but if she were wrong it may have caused the woman to believe that proper notes had not been made about her baby, which could have resulted in offence being taken by the woman, and embarrassment on the part of the midwife. The midwife therefore fished successfully for information:

*MH We ask you to put on the form if there is any abnormality your last baby was born with, and there's something here -*  
*WH It's his kidneys, he had defective valves.*

*MH (in follow up interview with VL) ... I have to say, I was very pleased when she elaborated. Yes, that is why I am a bit vague there ... that is why I would be saying that in a vague sort of way hoping that she would explain.*

By fishing, midwives gained insights into women's needs, knowledge, understanding and attitudes, and were then able to respond without inadvertently offending or interrogating them, or giving inappropriate information and wasting time. This involved highly developed skills of perception and contextualisation, and accords with Benner's (1984) notion of proficient and expert practice. Most examples of fishing were provided by G and H grade midwives, who could be expected to be practising at a relatively high level, which reinforces Benner's view. It is therefore hypothesised that fishing for information is an activity associated with advanced or expert practice. This was supported when the data and their interpretation was taken back by VL to the midwives, one of whom said:



*MH Midwives come down from the wards to help us out with bookings when we're busy, they ask direct questions, it takes them time to get in with the swing of things again and 'fish'!*

The midwife could 'fish' for information that would confirm the woman had carried out a specific action, thereby indicating the woman had understood and used information given to her previously. By 'fishing' the midwife could avoid risking 'interrogating' her. During this process the midwife was alert for clues to the woman's needs; although a specific topic may have been under discussion, other needs would sometimes become apparent and the midwife needed to identify these by the clues alone which she would then follow up. For example:

*MF ... we go in and get the girl to talk if she wants to, lots of times we talk about breast feeding or whatever, but we often pick up a social problem, we pick up so many ...*

When 'fishing' for information the midwife also used strategies such as encouraging the woman to talk by asking vague, general questions, and allowing the woman to finish off sentences begun by the midwife. The first ultrasound scan of Woman K's uterus, performed earlier than usual in pregnancy because of vaginal bleeding, had revealed two gestation sacs indicating a twin pregnancy. A subsequent scan showed one sac along with the remnants of another which indicated that one embryo was no longer viable. This was Midwife K's first meeting with Woman K and she 'fished' for information which would tell her not only the medical information (most of which she was able to gain from the medical notes, although in this case the fact that Woman K had recently had a third scan was not immediately apparent to her) but also how Woman K felt about the situation:

*MK: ... it was quite a worry, wasn't it, because there had been two sacs there originally, and the bleeding started and one sac .... (hesitating)*

*WK: Was still there, and there's still a little bit, and the lady thinks who did the scan last week ...*

*MK (Looking puzzled and breaking eye contact to consult medical notes) Oh yes, I see (finding the result of this other scan in the notes)*

*WK: Yes, I've had another one (scan) but the baby's OK.*

In the follow-up interview, when discussing this excerpt Midwife K said:

*MK: I was trying to find out really how much she knew was happening. This was my motive here, because I find I like to know how much the women know what has happened to them. Then I feel I can either expand or maybe explain, in the first place it may be that they can't understand, I was to find out if she understands what has happened to her ... I wanted to find out a bit about the worry, how much, you know, what was going on there, whether she knew what had happened, whether she had accepted that ... it is a problem to some women coming to terms with the fact that they have twins and one is lost at this early stage in the pregnancy*

*VL: So you are finding out without asking her directly?*



*MK: Yes, I am trying to ease the information out of her, fairly successfully I think with this one because she was fairly responsive, she knew what was happening.*

Non-verbal communication was important when 'fishing'; the interaction needed to be face to face, otherwise it was difficult for the midwife to assess what was happening as she could not see the woman's reactions and facial expression, and therefore was unable to assess what a suitable response would be. 'Fishing' was also difficult, if not impossible, when using a computer to direct the interaction and record responses. Midwife 6 said:

*M6: I'm used to doing bookings quickly, you sort of know the questions you need to ask, but the computer - if you don't ask the questions it wants you to ask you can't go on. Like fractures, a broken finger, I wouldn't bother with this usually but with the computer you have to put it down. So I'm more concerned with the computer, getting the questions right, thinking what I'm putting down. But I should be, I want to be listening to the mother more, talking about more relevant issues and following them through, concentrating - not just what the computer wants me to. But I suppose it will get better, but it does affect the booking.*

Asking for information This was an overt process, in which the midwife asked directly for information. Midwives engaged in this when they required specific information and there was little perceived risk of offending the woman by asking directly, or the woman thinking the midwife ought to have known. Home visits were seen as particularly helpful in this respect, possibly because the woman, being on her own territory, was thought to be more relaxed and likely to talk openly. The topics asked about directly tended (unsurprisingly) to be those unlikely to engender intense feelings. More sensitive topics were, however, sometimes approached directly, rather than 'fished' for, if the midwife wished to provide an entry for supplying further explanation:

*MG: Now, you've had your scan? And that agreed with your dates - fine. When you came for your scan were you given some forms about your blood tests?*

*WG: Yes*

*MG: And do you want those blood tests done?*

*WG: I'll have anything that's going.*

*MG: Let me explain them to you ....*

Occasionally the midwife asked questions that revealed she did not have the information when perhaps she should. This was more likely to happen if the midwife thought the risk of 'loss of face' was minimal, for example, if the woman and she knew each other well, or if the midwife considered her lack of knowledge legitimate:

*WC: .... (having been asked if she understood her entitlement to benefits) Not particularly, no, because it's all changed, hasn't it? And with only working part-time I'm not sure - No, I don't know*



*MC: I don't think I can tell you either, because they've recently changed ... the best thing to do is to go to the DHS and pick up the new leaflet which we haven't got as yet - they're months behind sending them to the people that need to know!*

The midwife commented that she felt it legitimate that she did not know as the rules had recently changed. The woman, however, said she was surprised she had not known, but excused the midwife by saying she had a lot of information to store and could not be expected to know everything and did not appear to be concerned in any way about the midwife's lack of knowledge.

To summarise, Sensitising was an activity that contributed to the substantive category of Orienting and enabled the midwife to sensitise herself regarding the information needs of women, together with how this information should be presented, and its depth and breadth. The relatively passive processes of stereotyping and perceiving, and the more active process of exploring, were the strategies used by midwives to enable Sensitising. Together with Territory Mapping, Sensitising facilitated Protective Gatekeeping, described below in section 5.4.

### 5.3.2 Territory Mapping

Midwives defined and located themselves as practitioners working within an hierarchy in terms of their power and knowledge. Constraints were perceived as being imposed either externally by the structure within which they worked, or internally when they were self-imposed. When mapping their territory, midwives steered between, and balanced, these constraints and their perceived territory.

Midwives demarcated their territory from that of other professionals such as obstetricians and other midwives, taking into account

- their place in the organisation's hierarchy
- the policies and procedures of the organisation within which they worked
- the extent and adequacy of their skills and knowledge
- their perceived professional role



**5.3.2.1 The Hierarchy, Policies and Procedures.** Midwives in this study tended towards subservience to hierarchical controls imposed over their practice by medical and organisational models. Medical power was referred to frequently as a factor guiding what information midwives could give; even though they felt competent to take or advise certain courses of action, midwives often acceded to policies made by more powerful others, such as GPs:

*VL When the ladies come here do you actually offer them home births?*

*MF No, but if they ask about it then we go into it, but we don't offer it because we find the GPs very much - we've two GPs actually who would do it, but their partners won't support them .... But if we do have a lady that insists, we do occasionally do it.*

*VL Without the GP?*

*MF It is ironic really, because we really can cope, and in an obstetric emergency, they're all on the obstetric list, so we might find we've called in her own doctor to deal with the emergency .. and what we have to do for the baby's examination, we have to call in the GP, and usually one of the practice.*

Midwives used various strategies to circumvent medical dominance. The place of delivery was a common topic for discussion between midwife and woman and could not easily be avoided, even if the midwife had wished to. If the topic was less contentious some midwives consciously avoided broaching it if they felt powerless to influence the outcome, or if a lot of trouble would be caused. The example below relates to the referral by the GP of the woman to a named Consultant. In this maternity department women were rarely offered any choice in the Consultant they were booked with:

*MG: Initially when we started talking about helping them to make choices I used to say to them when I first started booking them, 'you have been referred to X' but I don't anymore, because if they say 'No, I don't want to be under X', I can't do anything about it, you see. It becomes very complicated, they have got to go back to their GP and they have got to be referred to another Consultant. I know that it is probably opting out a bit but I don't say that to them anymore.*

The midwife may use an alternative strategy by indicating strongly to the woman that she has a choice, stopping short of actually advocating what the choice should be. The midwife's views are thereby made implicit rather than explicit, and she merely hints at a difference of opinion from the received 'official' view:

*MG: ... I do not believe in giving them (prophylactic iron tablets) either but I have to do it because it is policy. I can't not do it ... if they seem to be a bit hesitant I say to them 'It is your choice. You do what you like'. I have to give it to them, and it's not really right, but I have to give it to them.*

*VL: Would you have the power to say that you are not going to advise taking the iron tablets?*



*MG: No I can't do that. I can say to them, like I did to her, that once you are at home and out of here you can take them if you like, but if you feel you don't need them then you do what you like, but I can't say to them I disagree with what (Consultant) says, and I will therefore say to you I don't recommend that you take them, when she has laid down as policy that she wants all her patients to have them. I can't do that.*

Policies and procedures are set by the senior staff of hospitals and other medical institutions, and midwives are required to know what these policies are (UKCC 1994). Some midwives felt themselves bound, not only to know the policies, but also to follow the detail of these policies and procedures and felt powerless to make autonomous decisions. This depended to some extent upon the personal confidence of the midwife, and the perceived 'ownership' of the area of the decision. The following is extracted from an interview of a newly qualified midwife who saw herself as relatively inexperienced and powerless, and said she was disillusioned with midwifery for a number of reasons:

*ME I think it's something that should be discussed in antenatal clinic (the administration of intramuscular Konakion to the baby at birth to prevent haemorrhagic disease of the newborn). As far as I'm aware it isn't ... we did bring it up (in a policy meeting) when we were told about it last December, we did think it would be a good opportunity to talk about it in clinic, but we haven't been told to ... And I think they should be told then, if they asked I would definitely tell them, but we haven't been told to tell them at booking, hospital policy, really.*

Other midwives chose not to follow the policies and procedures, adapting their practice as they perceived it safe and reasonable to do so; these tended to be more senior (and therefore, presumably, more experienced and confident) midwives who appropriated the power to self-direct their practice. Experienced and confident midwives may also directly challenge the dominant group, refusing to acknowledge the authority of the dominant group in one or more respects. Midwife L had worked in the Unit for several years and was sufficiently confident to refuse to follow a procedure set by Consultants and senior midwife managers that made little sense to her:

*ML: I just ignore that little box (length). I don't actually ask them at all I don't even look at that box normally*

*VL: The box is on the booking form?*

*ML: It says length of stay and I don't ask them at all really*

*VL: Are you supposed to?*

*ML: Yes - Mr XX (Consultant) came along and he said you don't ask them how long they are staying in. I said 'Well, why do you put how long?' and he said the community midwives will want to know and I said 'Well, they will know when the women go out, anyway it is phoned through that they have gone home so they do not need to know'.*

*VL: Were you one of the first to stop asking?*



*ML: I might well have been. I have said I am not asking that, it is a stupid question and perhaps someone else has said 'Yes, I don't either'*

*VL: You would not be sort of bound by ...*

*ML: Oh no I am not*

*VL: You have worked here for quite a while haven't you?*

*ML: I have worked in the building for about 7 or 8 years*

*VL: So you know your way around? (laugh)*

*ML: I do*

This however concerned a relatively minor issue, which probably did not directly affect the obstetrician. Morriss (1987: 32 -34) differentiates between 'power to' effect outcomes and 'power over' other individuals to persuade or coerce them to take a certain course of action. It is hypothesised that the midwife was accorded the 'power to' adapt the procedure since she was not assuming 'power over' the more dominant individual, that is, the obstetrician. The same midwife wanted to change the policy regarding the time of admission during the evening before elective caesarean section, in order to enable the women to come in later:

*ML: ... the woman had said, can I put the children to bed, and I said of course, you can come in a bit later to the ward. There was a big rumpus about it, this woman had missed the anaesthetist and they blamed me ... So there are some things I am bound by till they change and it is the anaesthetist really that we have got to get round now*

*VL: ... you know which things you can change and which things you have got to stick to?*

*ML: Yes!*

Changing this procedure would have needed the midwife to assume 'power over' the anaesthetist, and this was resisted strongly by the more dominant group. The midwife acknowledged she would have to 'get round' the anaesthetist in order to get what she wanted, which implies a more covert, less challenging approach than that originally used. This accords with Stein's (1978) description of the strategies used by nurses when interacting with doctors, and is reflected in the way women may use manipulation to get what they want from men (Tannen 1992). These issues of power, control and dominance are discussed further in Chapter 7.

**5.3.2.2 Midwives' skills and knowledge** Midwives judged their ability to meet women's needs for information in terms of their perceptions of

- the extent of their own knowledge
- their skill in delivering information
- their power to share this knowledge.



Some midwives felt that their knowledge and skills regarding certain issues were at least as good as those of doctors and other professionals, but considered that doctors were nevertheless the more appropriate professionals to deal with these issues:

*MF: I would like us to have more counselling skills so we could talk about the choices more.*

*VL So you feel you'd like more input into helping people to make choices*

*MF Yes, if we're to do this job, then yes.*

*VL Otherwise, who do you think should do it?*

*MF The GP, I should have thought.*

*VL But do you think their counselling skills are -*

*MF Well, there again, no*

Medical cover was seen as a necessity in case abnormalities and emergencies occurred:

*MF: ...I don't really like the idea of working not knowing you've got a doctor somewhere in the background. I know we're practitioners in our own right, but I just like to think if .. if! ... there's the backup.*

*VL How would you put that boundary between your province and the doctor's province?*

*ME Through what knowledge I have - I feel I've trained to a certain level ... but I couldn't go further in depth.*

### 5.3.2.3 Ownership and 'stepping on toes' Midwives often remarked that they felt

constrained when giving advice, if the consequences of that advice had implications for professionals other than themselves. A commonly cited reason for this was that midwives did not feel sufficiently powerful to impose the consequences of their advice upon other professionals. The midwife quoted below did not feel that any midwife would have this power:

*VL: One of the things that I am quite interested in is how midwives perceive they have power to facilitate choice that is probably going to involve other health professionals, either midwife colleagues or GPs, health visitors, or community midwives?*

*MG: That also has got to do with which rung of the ladder you are on, sort of thing, hasn't it?*

*VL: Are we talking about power here?*

*MG: Yes, absolutely, and when you are fairly low towards the bottom of the ladder, if you like, you haven't got a lot of power .... You haven't got a lot of power to help somebody make a decision that somebody else has got to stick by, have you.*

*VL: But you feel a midwife, somebody that is right at the top of the ladder, maybe would have?*

*MG: Yes, but only if she were going to carry it through herself.*

There was a feeling amongst midwives that the professional who attended the woman at delivery possessed the power to influence the information given to, and therefore the choices made by, the woman. 'Stepping on toes' could cause trouble for the midwife. Fragmentation



of care could contribute to this in that if others (in this case, the community midwife) had not given the relevant information, then Midwife A would need to try to provide it. This could cause problems, especially if the information she gave in good faith turned out to be inappropriate, or not what the community midwife would have said. The community midwife would have to take over the care of the woman for the remainder of the pregnancy, and inappropriate information could misinform, or raise unwarranted expectations in the woman that the community midwife would not be able to meet, thus burdening her (the community midwife), or other members of the community team. This could result in trouble for Midwife A if complaints were made about her, and her professional credibility could be compromised:

*MA: I believe, it all should actually have happened before they get here, because otherwise you could be stepping on other peoples toes ... When I was on Community I used to go through all the options, like you can have your baby at home, or go into hospital -*

*VL Do you feel a bit more constrained working in hospital?*

*MA Yes*

*VL Because of all the other people she's seen before?*

*MA And also because of the um - not the animosity so much, although there is some, between hospital and community and GPs, if the hospital is offering home deliveries we know that the GPs don't want them, then you can cause an awful lot of trouble by mentioning it to women when you know that the people who will be looking after them don't want to take that responsibility*

*VL ...You said animosity - well not quite animosity, a sort of rivalry?*

*MA I think rivalry to an extent but also, because that's their domain, and they don't like people to encroach upon their domain and the GPs in this particular area, well like everywhere, are very anti home delivery.*

*VL Are there any at all that will approve of them?*

*MA I don't think so. There's one in XX that will on occasion, but really, no. So because there is a kind of feeling about them and us, in a way, if you start then encroaching upon their domain then you could cause more problems ... And they don't want anyone giving them more responsibility, more work, more professional responsibility that they don't want to undertake, which would be seen - I mean, you can imagine, if a woman said 'I hadn't thought of a home delivery until I went to the hospital and the midwife that booked me suggested that I could have my baby at home, and I thought oh, that's a good idea', it would be like horrendous -*

*VL What would actually happen?*

*MA Um ... I think some would probably write in or phone up the Consultant to say, you know, what do the midwives think they're doing... Some might not do anything but they would probably persuade the women from home birth*

*VL Um, right. Which would then take away from, sort of lessen your professional standing in the woman's eyes, as well?*

*MA Yes.*

*VL: Do you feel that's all the way through booking, or only with regard to home deliveries, or -*

*MA: No, no - only home deliveries.*



This section of the transcript initially appeared to relate to constraints felt by the hospital midwife in giving information about home births, thus enabling a woman to make choices about where she would like to deliver her baby. If the woman chose a home birth the community midwives and perhaps the GP would be committed to the 'work' of caring for her during labour. The midwife appeared to regard the people who will be doing the 'work' as legitimately having the power to give the information which would influence the choice. When the midwife was part of the community team she was able to advise on home births, but not as a hospital midwife. She argued that it was not for her as a hospital midwife to suggest something that, if taken up by the woman, would cause work to the community staff. If this happened, she said, they would be committed to caring for the woman during her home delivery, and would be thereby inconvenienced and possibly annoyed by her (the midwife's) actions. Complaints may be made by more powerful others (GPs) to those in power over the midwife (Consultants), and her power and professionalism would be diminished in the eyes of the woman, and possibly others. Topics other than home birth were not seen as problematic, however, perhaps because they were unlikely to involve 'community' staff in much extra work.

The hospital midwife quoted below appeared to perceive two different professional cultures; community staff and hospital staff, each with potential for power in different circumstances. There was a strongly implied suggestion that since she regards herself as part of the hospital culture, as opposed to community, she could legitimately advise the woman about issues relevant to her hospital care, but not to issues relevant to 'community' care. Further extracts from two interviews with other hospital midwives reinforce this hypothesis.

The following discourse concerns professional groups, and under what circumstances each of these groups legitimately should have the power to facilitate the decisions made by women in pregnancy:

*MD: It's not possible to give total free choice, not in this area anyway, where we don't offer facilities other places do.*

*VL Right .. what do you feel that you don't offer here -*

*MD Home deliveries - we do offer them, but not to the amount they should be, the GPs don't take them on, so that's why, I think.*

*VL And how do you think that affects you trying to give informed choice to the mothers?*



*MD It's a shame really that we don't offer more home births, we do have a lot of normal straightforward third babies that it would be nice to - I wouldn't say we have a great deal of women wanting them, but we have some*

*VL Are there any GPs at all here that will -*

*MD Oh yes, lots of GPs will, but lots of GPs will persuade women not to.*

*VL So when you book a woman, and you know her GP doesn't like home births how do you deal with that, say if she said she wanted a home delivery?*

*MD Well if there's no reason why she shouldn't do, I'd ask her to discuss it with her GP, and community midwife.*

*VL What do you do if a woman comes along and says she'd like a home birth?*

*ME: Generally they have been seen by the GP or community midwife before coming, and the reason they're sent to hospital is to have the baby in hospital, and if they want the baby at home that would have been discussed with the GP or community midwife -I think I've only seen one lady who came, slipped through the system and she said she didn't know why she was here (laughs) - well, I said I'll book you in, and then I'll phone the GP and community midwife which I did, and sorted it out from there.*

On initial analysis it appears that who will be doing the 'work' should have the power to provide the information that may have implications for that work. Further scrutiny of the transcripts suggests this interpretation is simplistic. The following section again concerns the question of when the woman should be transferred home after the birth of her baby.

Midwife A is a hospital midwife, working temporarily in the antenatal clinic but usually in the delivery suite. She used to work as a community midwife:

*MA: I'm very much a believer that if a woman wants to go home after 6 hours or 24 hours - you see, I don't think they should just book, I think they should go when they want - This business of asking them how long they want to stay at the beginning of pregnancy to me is crazy because you don't know, I think we should tell them the options and then once they've delivered and the baby's fine, then they decide and not the community midwife - I don't think it should have anything to do with the community as to whether they accept them back again, because, when people still talk about home conditions - but what are you going to do about it, because when I was in community I wouldn't go and paint their house or put their windows in or anything so the child would have to live in that environment from whether it's 6 hours old or 3 days old. And nothing will change that. So in that case, you might say, well discuss it with your community midwife but I don't think that comes into it, personally.*

This midwife maintained the decision should be made by the woman and not the community staff. She saw no problem in giving the woman the information necessary for her to make up her mind. Although the woman and her family would do some of the work entailed if her transfer home was early, 'community' would be required to undertake a considerable workload. Initial analysis of the first part of the discourse suggested a perception that advice about choices should be given by the professional whose work load would be increased. The midwife was worried about 'stepping on toes' in the first part of the



discourse, but not in the second; this could be seen as contradictory to the first. The apparent paradox may be reconciled, however, in terms of 'hierarchies of work'. Labour, as the culmination of procreation, is the subject of an intense public interest, as evidenced by the number of articles about labour published in newspapers and journals, whereas postnatal care is not accorded the same degree of public attention. Recently an audit of the maternity services (Audit Commission 1997 - see 1.3.3.1) has revealed the low priority placed upon postnatal care by service providers. It is hypothesised that, because of the intensity of this interest, the work of caring for a woman during labour and delivery is considered as being of higher order work than that of postnatal care, which is not subjected to the same degree of public surveillance. It is further hypothesised that, by carrying out this higher order work, the 'hospital' is accorded the right to facilitate - or direct - future decision-making by the woman, even if this results in the allocation of more (lower order) work to 'community staff', despite their 'excuses', or protestations. This issue will be discussed further in Chapter 7, particularly in relation to Foucault's work on surveillance and power.

To summarise, the power of midwives to circumvent policies and procedures was fragile. The midwife was accorded the power to provide information providing that she did not display 'power over' a member of the more dominant group by giving information not approved of by the dominant group, or encroaching upon other's territory. There is some evidence for the existence of hierarchies of midwifery work.

#### **5.4 Raising Awareness**

Evidence abounds that women are dissatisfied with the information provided to them by health care professionals during childbirth (for example, Shapiro, Najman, Change, Keeping, Morrison and Western, 1983, Martin, 1990, Churchill, 1995). The Changing Childbirth Report (DoH 1993) acknowledged this dissatisfaction and urged that women should be provided with sufficient information to enable them to participate fully in decisions regarding their care. Midwives have undertaken to provide this information as part of the move towards woman centered care. The substantive category called Raising Awareness describes how midwives provided information to women.



By Raising Awareness, midwives

- made women aware of issues
- provided information and clarified these issues
- set out the choices available to them.

Raising Awareness was influenced by Orienting (5.3), whereby the midwife sensitised toward the needs of the woman, and her (the midwife's) power to advise her. Raising Awareness interacted extensively with Protective Gatekeeping (5.5), whereby midwives rationed information in order to protect the woman from physical and emotional problems, as well as themselves from professional, ethical and aesthetic problems.

During follow-up interviews, midwives were invited to describe what they meant by 'facilitating informed choice'. Their responses tended to describe activities related to raising awareness:

*MD ... really making them aware of what we have got available and then they can make decisions about what they want to happen ... they can decide, within certain limits, obviously ... I think most people know what they want, they just have to be given the chance to talk about the issues.*

*MG Facilitating choice to me means that I tell them what is available, and I give them as far as I can all sides of each argument and explain. I would not tell them what I thought but I would give them all sides of the argument ... and make sure as far as I can that they understand what I am saying.*

*MI You are actually informing, giving all the information from your own experiences and from the profession to make that the lady is aware of all the choices that are available. Then for them to make the choice, if they want to, or if they don't.*

*MK ... that the woman is aware of the choices that there are, all the information surrounding those choices, and then given the chance to choose them, and get them.*

*M1 Making them aware of what is available, how to get the service and how to help themselves and then listening to them to find out what they want out of this service and if there is part of the service they do not want yet you think it would be an advantage to them then it is to explain to them more deeply about that aspect of the service so that they then can choose.*

Analysis of these and other responses enabled identification of 3 activities which, as categories, were combined to form the substantive category of Raising Awareness, as follows:

- Setting the Agenda



- Elucidating, whereby information was given, and issues clarified
- Offering choice

Constraints of time and limited facilities often influenced these activities (Figure 5.3).

Each of these categories will be discussed in the following sections.

#### 5.4.1 Setting the Agenda

Midwives controlled the agenda of issues to be discussed in order to ensure the inclusion of topics they considered important for the woman to think about at that particular point in pregnancy. Some topics were given priority over others, for example, fetal screening tests, infant feeding and attending parentcraft classes were amongst the topics always mentioned. Whether a topic was raised by the midwife, and the time she spent on it, was strongly influenced by

- the importance accorded to the topic by the midwife
- the time available during the interaction and
- whether the woman needed to make a decision immediately, or whether the decision could be delayed until later in the pregnancy
- the availability or otherwise of a choice related to the topic

Midwives considered some topics essential for the woman to consider, for example, they invariably spent relatively long periods of time raising women's awareness about fetal screening tests (that is, the triple test). It was policy in all the maternity units to distribute written information about the triple test for women to read and consider before the meeting with the midwife. Several women had discussed the tests with another midwife beforehand, or had previous experience of the test and felt they knew enough to make a decision.

Nevertheless, even though the woman said she was sufficiently informed, and had made up her mind whether or not to have the test, the midwife would still include it in her agenda.

Several midwives, during follow up interviews, confirmed the importance they attached to raising women's awareness of what the triple test entailed, and what the implications of having it could be.



Midwives also accorded importance to issues they thought were important to the women:

Stereotyping (5.3.1.1) featured particularly in their judgements. For example:

*MH You are picking out the major points that probably worry most women like pain and the birth*

*MI I think you have to prioritise on what information you want to give them really. You give the important bits of information the lady needs at that time.*

Some issues, although considered important, did not have to be decided at the time, unlike the triple test. In these instances, midwives were content to 'sow the seeds' for later:

*MJ ... it's just sowing the seeds so they can think about it ... just so that they know the options, really.*

*MH Well ordinarily I do feel that this sort of discussion about pain relief, positions, labour and birth is far too early at the booking appointment. For a start the woman may not have all the information she needs to come to those decisions until she has discussed things more with midwives or read more and presenting her with the information in the booking pack but she may not have read it at that point.*

Midwives would also Set the Agenda in terms of problems that might occur later; they raised awareness of topics in order that women would be able to cope if these problems did arise:

*ME I think if you do explain to women that these problems (with breast feeding) do crop up, and it's part of the normal pattern, that it's normal and nothing is wrong and if they know in advance to expect this to happen, then they feel Oh yes, I remember the midwife saying this might happen, I know what it is, I can cope with it.*

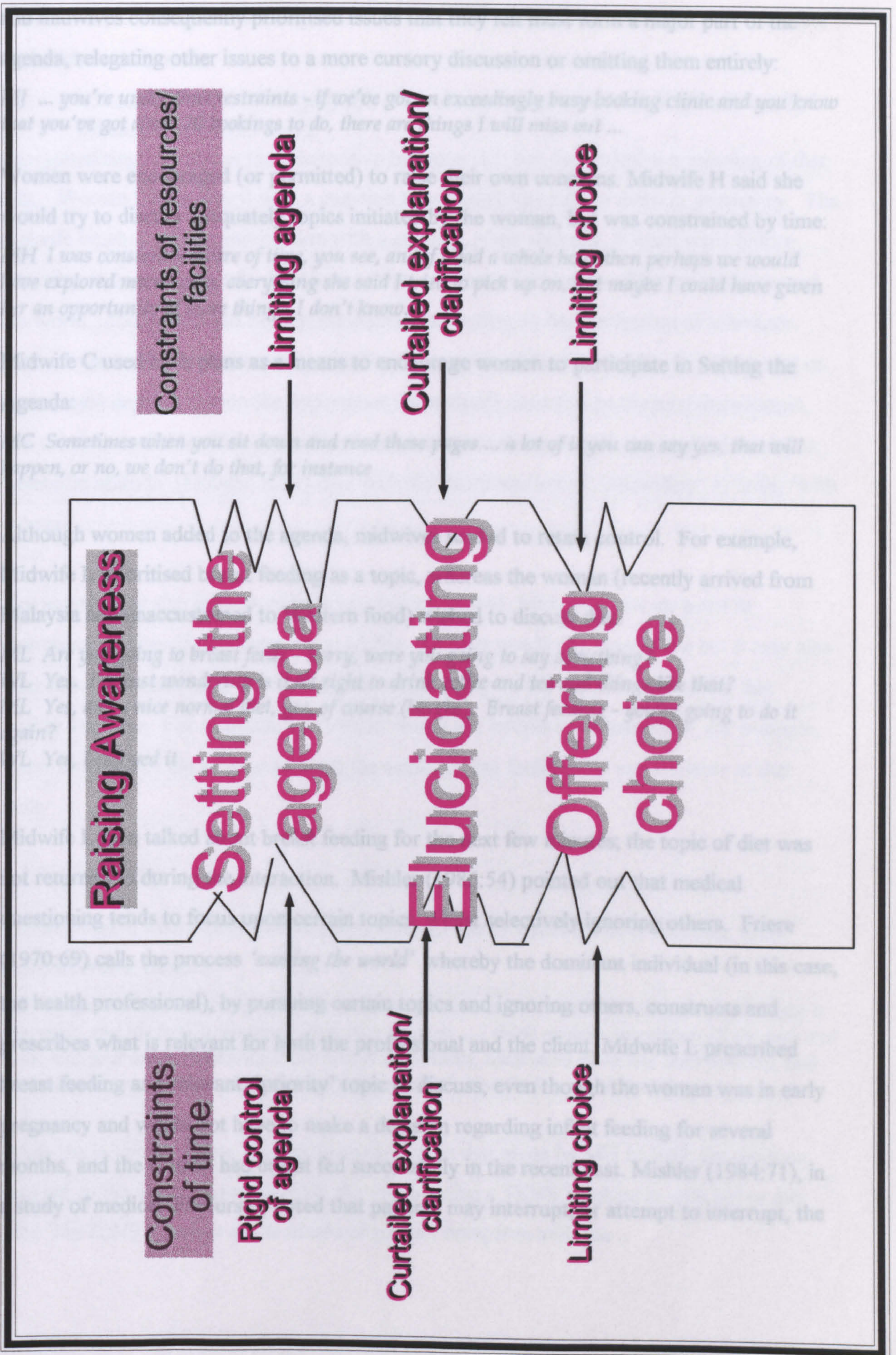
In Setting the Agenda, the midwife would briefly mention topics such as pain relief in labour in order to discover whether the woman was worried about them. In that case, discussion could ensue, aimed at trying to relieve the woman's anxieties. If the woman was not worried about those issues, they could be left until nearer the time a decision needed to be made, by which time the midwife expected the woman would have thought further about them.

Setting the Agenda was influenced by midwives perceptions of constraints (Figure 5.3), that is,

- time
- their own capacity to provide information
- women's capacity to assimilate information



Figure 5:3 Raising Awareness





and midwives consequently prioritised issues that they felt must form a major part of the agenda, relegating other issues to a more cursory discussion or omitting them entirely:

*MJ ... you're under time restraints - if we've got an exceedingly busy booking clinic and you know that you've got about 20 bookings to do, there are things I will miss out ...*

Women were encouraged (or permitted) to raise their own concerns. Midwife H said she would try to discuss adequately topics initiated by the woman, but was constrained by time:

*MH I was constantly aware of time, you see, and if I had a whole hour then perhaps we would have explored more topics, everything she said I tried to pick up on, but maybe I could have given her an opportunity of more things, I don't know.*

Midwife C used birth plans as a means to encourage women to participate in Setting the Agenda:

*MC Sometimes when you sit down and read these pages ... a lot of it you can say yes, that will happen, or no, we don't do that, for instance*

Although women added to the agenda, midwives tended to retain control. For example, Midwife L prioritised breast feeding as a topic, whereas the woman (recently arrived from Malaysia and unaccustomed to Western food) wished to discuss diet:

*ML Are you going to breast feed? - Sorry, were you going to say something?*

*WL Yes. I'm just wondering is it all right to drink coffee and tea and things like that?*

*ML Yes, and a nice normal diet, yes, of course (laughs). Breast feeding - you're going to do it again?*

*WL Yes, I enjoyed it*

Midwife L then talked about breast feeding for the next few minutes; the topic of diet was not returned to during the interaction. Mishler (1986:54) pointed out that medical questioning tends to focus upon certain topics, whilst selectively ignoring others. Friere (1970:69) calls the process '*naming the world*' whereby the dominant individual (in this case, the health professional), by pursuing certain topics and ignoring others, constructs and prescribes what is relevant for both the professional and the client. Midwife L prescribed breast feeding as a relevant, 'priority' topic to discuss, even though the woman was in early pregnancy and would not have to make a decision regarding infant feeding for several months, and the woman had breast fed successfully in the recent past. Mishler (1984:71), in a study of medical discourses, noted that patients may interrupt, or attempt to interrupt, the



‘voice of medicine’ by introducing their own topics or perspectives. He calls this ‘the voice of the lifeworld’, or the

*‘...natural attitude of everyday life; the ordinary commonsense world of social reality’  
(Mishler 1984:14 & 122),*

conceptualising ‘voices’ as the relationship between talk and the underlying meaning of that talk. Woman L interrupted with a question about what was safe to drink in pregnancy. The midwife brushed off the interruption with a cursory, albeit pleasant, 9 word reply before returning to her own agenda. In this and other encounters the voice of the midwife ‘named the world’, controlling and Setting the Agenda according to her perception of relevance. Women were allowed to interrupt; whether their ‘voice of the lifeworld’ was suppressed or encouraged depended upon the importance the midwife accorded to the introduced topic, and the time available. This controlling behaviour accords more with the medical model or ‘scientific attitude’ (Mishler 1984) than with the interpretation of ‘midwifery’ as being ‘with women’.

The agenda was also influenced by what choices existed. Midwives saw no point in discussing options if they were not available; not only would this waste time but it may also raise false expectations in the woman and reflect badly on the Unit for not having that facility available. For example, Midwife D would not inform a woman about, for example, water birth unless the woman initiated the topic, as that facility was not available at that Unit.

#### 5.4.2 Elucidating

Midwives gave information and helped women to clarify issues in order that they could make informed choices:

*ME I think the mother should have the various options made clear to her, when she realises she is pregnant, and the family situation taken into account ... I think explain everything all the pros and cons, and do it on an individual basis to suit their needs, what suits them and their families, and the husband or partner, really what suits them, what’s best for them and the baby.*

Often the information was straightforward such as that given by MH to WH; the decision was left to the woman as to whether she would bring a TENS machine in with her or not:

*MH The TENS machines can be hired and you can bring it in with you ..*



Sometimes the information was not intended to facilitate choice: for example, once women were booked with a Consultant it was not easy to change this and they were merely informed of the name of the Consultant.

Midwives often worked under time constraints and it could be difficult to give the depth and breadth of information they thought women should have. Midwives 2 and 5 constituted negative cases in that they said they had sufficient time to give information and help women make choices:

*M2 I personally have the time with not being very busy at the practice I look after ...*

(Midwife 2 was newly appointed to a GP practice and was building up a caseload of women. She said, however, that this situation was likely to change as the practice expanded).

*M5 I think we need the time to do it and access to the information. To translate it, if you like. We act as translators. Women get bombarded with information ... we can try to pull it all together so they can make choices ... We (the group of midwives within which M5 worked) feel that we can supply them adequate information so they can make those choices. But we're also fortunate in that we have the time!*

Midwife M's group of midwives, practising in an inner city area, worked within a strongly articulated philosophy of offering informed choices to the women in their care and organised their work in order to allow themselves enough time to enable this. For example, they had a policy of visiting all women in their homes at the 36<sup>th</sup> week of pregnancy to discuss labour or any other topics that arose. Two hours were allocated for this visit and more time would be spent if necessary. Other midwives presented a different picture:

*MH ... in the middle of a busy clinic we have got time constraints which will affect the way you offer them choice because constantly at the back of your mind you are aware of the number of people waiting. I do still try to give them as thorough explanation as I can bearing that in mind, but it is difficult.*

*MJ I do feel very strongly that women should be encouraged to breast feed, but we are supposed to get these interviews done in 15 to 20 minutes and I bet I was with this lady longer, I feel I need half an hour, but very often we don't have the time...*

Midwives were, however, reluctant to appear to be short of time. They did not wish to appear to be hurrying the woman along as this could negatively affect the interaction:

*MH If you are aware of time constraints whilst conducting this interview you are going to give off vibes, aren't you ...*



Women were often given printed information regarding topics such as the triple test, infant feeding and other topics which they were expected to read and consider before their appointment with the midwife. This was intended to save time whilst giving the woman an opportunity to consider issues before discussing them with the midwife. Midwives would often reiterate the information, however, as (even if the woman upon enquiry said she had read the information) they were not always convinced the woman had understood it, or because they doubted that she had read it at all.

*M1 (talking about the triple test) I go right the way through from the beginning, I think you have to ... because the Community midwife just says it's a screening test but they don't actually go through it ... the booklet and leaflets that we give ladies, they do read through it but not always.*

Midwife K said in the follow up interview that her offer of answering any questions the woman might have about the triple test was a strategy to avoid 'going through the whole information sheet again', and yet she deflected the woman from asking questions, returning shortly with an offer to summarise the information:

*MK Did you have the triple test last time?*

*WK Yes*

*MK And would you like to have it again?*

*WK Yes*

*MK Would you like to ask me any questions about it? Oh, by the way, the Hepatitis C survey is finished.*

*WK Oh, right. I must admit, with all the problems I've had this pregnancy ... I thought, oh no, not another one*

*MK Would you like me to go over the triple test again?*

The midwife then spent several minutes explaining the triple test and its implications.

Some issues would be discussed at parentcraft classes, but not everyone attended all of them (some women did not attend any), and midwives were aware that these issues would also need to be addressed. Leaflets could be given, but they were seen as 'second best' to an explanation from the midwife:

*MJ If they know nothing about it I'll tell them there is a leaflet about it and tell them to read about bottle and breast feeding ... rather than spend heaps of time talking about it. I wish we had the time, but we don't.*

Midwives would repeat explanations and information rather than risk not 'covering' adequately issues they considered important, even though this meant neglecting other issues.



Midwives had basically the same agenda of issues for each woman, and this resulted in repetition of information which they found tedious.

### 5.4.3 Offering choice

Midwives raised awareness as to what choices were available to the woman. In this, they were constrained by

- resources
- policies (see 5.2.2)
- perceived safety (see 5.4.1 and 5.5.1)

Some choices could be made quite freely. There were no constraints of resources, policies or safety, for example:

*MC And have you thought about how long you'd like to stay in?*

*WC Yes, a few days for a rest!*

*MC It's up to you, you can stay as long as you like!*

(This, of course, was not quite true; women normally would be expected to leave hospital within a few days after delivery, but this was apparent in the context of the exchange).

*MJ I just wanted her to be aware that we did have an obstetric physiotherapist if she needed help.*

*MC The choice is yours, they're there (parentcraft classes) if you want to come ...*

*(To VL) It's entirely her choice, she knows how she feels, so there's no pressure at all. If she decided she didn't want to come that would be fine by me.*

Woman C had other children and the midwife considered it a low priority that she should attend parentcraft classes; she acknowledged that the woman's other commitments may take precedence.

Constraints of resources and policies restricted choice:

*ME I think a lot of women would opt for the Domino scheme but sadly it isn't offered here, and so it's not one of the options ... I think if you say financially it hasn't been possible to set it up they accept it, and then go on to discuss what is available*

*MG The difficulties are giving choices that are realistic. It's no use saying this nurse (sic) will see you every time because this nurse does not come to the clinic every time. It's that kind of thing that is the problem.*



Lack of resources was particularly worrying and frustrating when the woman was severely socio-economically deprived. Midwives knew there were problems, and what needed to be done but felt powerless to offer realistic choices, or to act in other positive ways.

*VL Does it matter at all about housing conditions?*

*MC It could do, but my thought is that the baby is going home to those conditions ... whether it's at 3 days or 6 days, so I don't think there's anything we can do, we can't improve those conditions in that time*

*MF ... we often pick up a social problem ... some of them are living in the most awful conditions, one girl at the moment is with her partner, they're sharing a home with a man who is a known child abuser, and the social security say there's nowhere else to put her, and they've been made aware - told that no way do you leave your baby till we can get you rehoused ... we tend to think that social security can do something, but half the time they can't do anything, they haven't the resources.*

*MF We have mothers going from here into bread and breakfast accommodation - really awful and we can't do anything about it.*

*MF We have had babies in here up to the 28th day because there's nowhere else for them to go and a Court Order has been put on them here ... you see, we felt as midwives that the baby was just not safe going home and the baby was in our care -*

*VL You could end up as a children's home -*

*MF Yes! Every time I go to a social services meeting I have to say 'We are not a mother and baby home' and they say 'We appreciate that, we're so grateful, thank you for all the work you're doing' - but it isn't really our job, is it? (laughs)*

Several midwives noted that some women did not wish to make choices, but reasserted the importance of nevertheless making choices available to women. They regarded as important the woman's right not to choose, non-decision making constituting a choice in itself. A woman may elect not to choose in some instances, whilst choosing in others. For example,

*MD There's some women who know exactly what they want ... but the majority of women don't really bother ... even if they come in labour and you say to them what would you like to happen in this labour they don't mind ... but that's not to say we shouldn't be giving them choice.*

*M2 I feel we have to act as an advocate really ... not forcing things on her, but I still think we have got to tell her about antenatal care and labour, we have got to still tell her because she may well change, she has got to know that she can have different views and opinions about things and she can change her mind at any time.*

To summarise, the category Raising Awareness was concerned with how midwives made women aware of, and clarified, issues to help them make informed choices. Constraints of time and resources influenced these activities.



## **5.5 Protective Gatekeeping**

The previous section has described how midwives gave information to help women make informed choices. Not only did midwives provide information, however, they also guarded it and controlled its release in order to protect women, and themselves. This section will describe the factors influencing midwives when they gatekept information.

Protective Gatekeeping is the name given to the activity carried out by midwives when controlling the release of information. This activity involved protective steering, when the woman was manoeuvred in the direction considered safe by the midwife, by her control of the content and/or the depth and breadth of the information. Protective Gatekeeping was facilitated by Orienting, the midwife needing to sensitise towards the needs and characteristics of the woman, and also to map her own territory in terms of her power and ability to provide information. Protective Gatekeeping constantly influenced, and was influenced by, Raising Awareness. The purposes of Protective Gatekeeping were to protect firstly the interests of the woman, and secondly those of the midwife herself. This section will dimensionalise these two categories of Protecting the Woman and Protecting Self.

### **5.5.1 Protecting the Woman**

Midwives were concerned to protect women from both physical and emotional harm. They provided information on a variety of topics in order to assist women to make informed choices that were perceived as safe, and in doing so steered a course in order to provide the right level of information for a particular woman. If the level of information was not appropriate the woman would either have insufficient or excessive information, both of which were deemed undesirable (for reasons described below). Thus, midwives acted as gatekeepers of information, controlling its release in order to achieve a balance of providing enough information to permit safe informed choices to be made whilst avoiding excessive information that might confuse or frighten the woman (Figure 5.4). Women needed to understand and contextualise (in other words, *assimilate*) information. Assimilation was perceived by midwives as appropriate if women indicated they had

- understood the facts contained within the information.



- contextualised the information, that is, personalised it appropriately to themselves.

Informed choices were enabled by the provision of accurate information, and the successful assimilation of that information. (Figure 5.5). Midwives wanted to offer choice, providing that choice was considered safe:

*MC ... as long as it's not endangering the mother and baby in any way and as long as it's within reason and safe practice, that's fine, and if it's their wish*

In order to protect women against physical and emotional harm midwives took various factors into consideration when making (often fine) judgements regarding the information they gave, and the way in which it was delivered. These factors are discussed in the following sections.

5.5.1.1 Protecting against physical harm Midwives tried to protect women and their fetuses/babies from physical harm, either by trying to guide a woman towards or away from a specific course of action, such as breast feeding the baby, or a home birth, or by trying to influence the woman to adopt a lifestyle which the midwife considered healthy. Much of the information provided by midwives concerned this. For example:

*MI Are you still swimming at the moment?*

*WI Yes, and I also go in the sauna - is that all right?*

*MI Yes, that's fine. I'm sure you won't be going in the sauna a lot towards the end of pregnancy, will you?*

*WI I don't know - it's quite relaxing!*

*ML It's very important now to eat well, and eat more than you would normally eat of green vegetables and meat ...*

*MF We have the birth plan - did you have this before?*

*WF Yes, I didn't put anything on it.*

*MF Are you going to this time?*

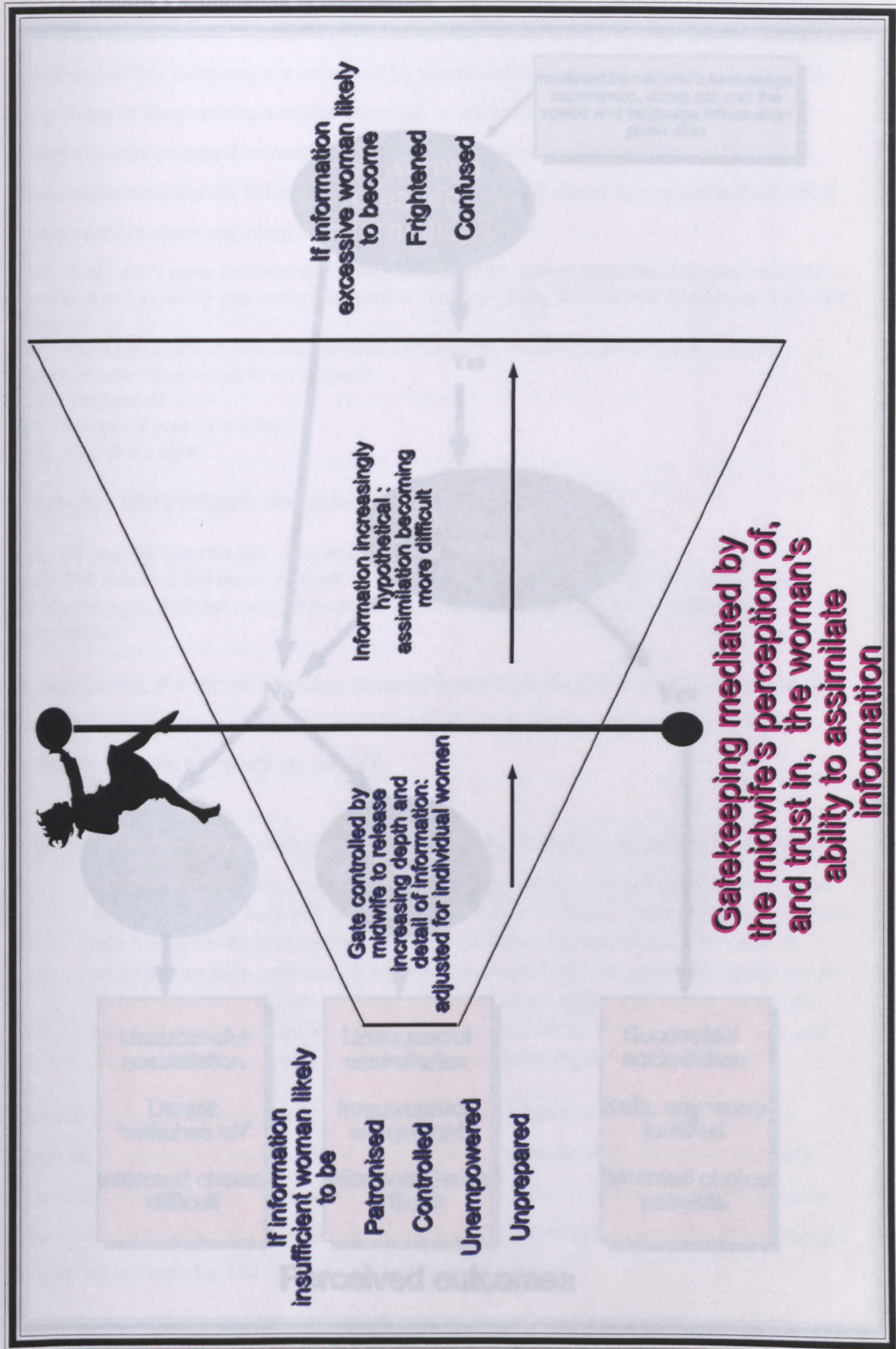
*WF The only thing I can think of, I didn't like the gas and air at all - it sent me flying round the room!*

*MJ Do you plan to breast feed or bottle feed? Or is it rather a long way ahead to think of it? You don't have to decide until you've got the baby in your arms! But it does give the baby a good start if you breast feed.*

Midwives often held strong views on what was safe or potentially dangerous or undesirable, and these views affected the direction in which midwives steered women when helping them

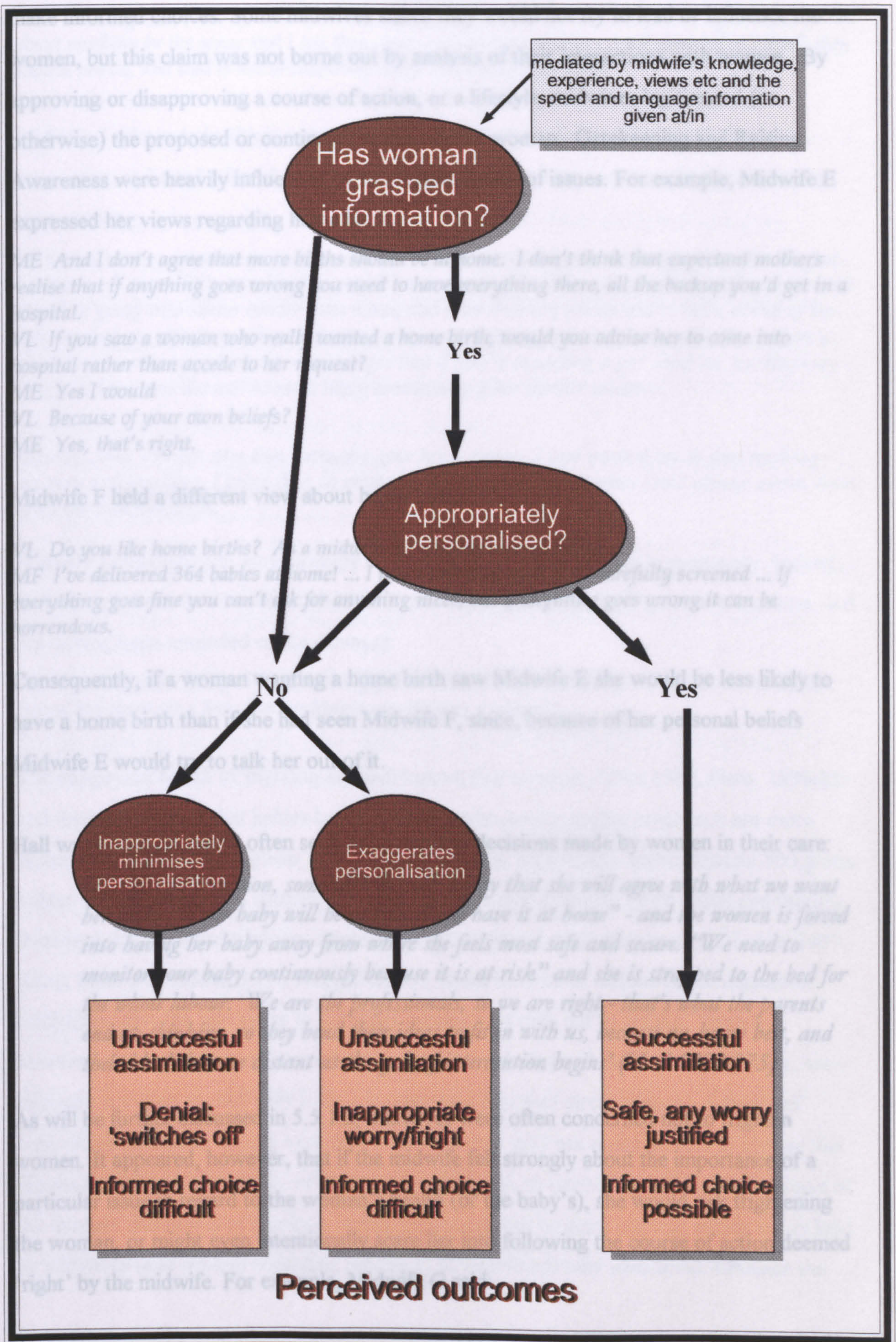


**Figure 5:4 Gatekeeping and assimilation of information**





**Figure 5.5 Midwives perception of outcomes of women's assimilation of information**





make informed choices. Some midwives stated they would not try to lead or influence the women, but this claim was not borne out by analysis of their interactions with women. By approving or disapproving a course of action, or a lifestyle, midwives legitimated (or otherwise) the proposed or continuing actions of the woman. Gatekeeping and Raising Awareness were heavily influenced by this legitimisation of issues. For example, Midwife E expressed her views regarding home birth:

*ME And I don't agree that more births should be at home. I don't think that expectant mothers realise that if anything goes wrong you need to have everything there, all the backup you'd get in a hospital.*

*VL If you saw a woman who really wanted a home birth, would you advise her to come into hospital rather than accede to her request?*

*ME Yes I would*

*VL Because of your own beliefs?*

*ME Yes, that's right.*

Midwife F held a different view about home births:

*VL Do you like home births? As a midwife, do you approve of them?*

*MF I've delivered 364 babies at home! ... I just think they need to be carefully screened ... If everything goes fine you can't ask for anything nicer, but if anything goes wrong it can be horrendous.*

Consequently, if a woman wanting a home birth saw Midwife E she would be less likely to have a home birth than if she had seen Midwife F, since, because of her personal beliefs Midwife E would try to talk her out of it.

Hall wrote that midwives often seek to control the decisions made by women in their care:

*'We offer information, sometimes in such a way that she will agree with what we want her to do. "Your baby will be at risk if you have it at home" - and the woman is forced into having her baby away from where she feels most safe and secure. "We need to monitor your baby continuously because it is at risk" and she is strapped to the bed for the whole labour. We are the professionals, so we are right - that's what the parents end up thinking, so they bend their ideas to fit in with us, because we know best, and their ideals become distant as the cycle of intervention begins' (Hall 1993:375)*

As will be further discussed in 5.5.1.2, midwives were often concerned not to frighten women. It appeared, however, that if the midwife felt strongly about the importance of a particular issue in regard to the woman's health (or the baby's), she would risk frightening the woman, or might even intentionally scare her into following the course of action deemed 'right' by the midwife. For example, Midwife G said:



*MG Smoking is something I always talk about to the ones that smoke, and I don't give them choice about smoking in the sense that I tell them you can do what you like .. I tell them what I think they should not do, and that is not to smoke and why they should not smoke.*

Midwife J acknowledged her own strong feelings against women smoking cigarettes in pregnancy, and cited a list of dangers to the baby in an attempt to persuade the woman to stop smoking:

*MJ (speaking to WJ who admitted to smoking 10 cigarettes a day) It is important, not only for your own health, but you're much more likely to miscarry, you're more at risk of the baby not growing well, you're more at risk of going into labour earlier than usual, and after the baby's born you're more at risk of the baby having ear infections, chest infections, that sort of thing, and also from cot death .... there's also some recent research about miscarriages that if you're expecting a girl child her fertility may be affected too, and she will be more likely to miscarry if her mother smokes.*

*MJ: (to VL, later) I'm not sure that I actually gave her a choice - I just wanted her to stop smoking - I am very anti-smoking, I know that, so anybody I come across who smokes I will always advise them of all the disadvantages.*

Midwife J obviously felt very strongly that women should not smoke in pregnancy. Indeed, in a later conversation between Midwife J and VL, she said (during a general discussion, and not having been reminded of the excerpt):

*MJ There are some things I feel so strongly about that I would probably try to scare women, not many, but there are a few, and smoking's one of them, I admit it.*

The dangers to health of smoking are well known (for example, Gritz 1980, Plant, 1990:82) and there is evidence that babies born to women who smoke during pregnancy are more susceptible to various problems; for example, they are, on average, approximately 300 grams lighter than those born to women who do not smoke (for example, Gritz 1980) and there is increased risk of preterm labour, miscarriage and perinatal death (for example, Lowe, 1959; Kline, Stein and Susser, 1977; Naeye, 1978). There have been various health education campaigns over the past years to persuade pregnant women not to smoke. There is, however, an alternative argument that many women, during and outside of pregnancy, view cigarette smoking as their only luxury in otherwise deprived circumstances, a means of controlling stress and coping with their lives, and they may not easily be able to change this (Graham 1988). The purpose of these comments is not to introduce a detailed discussion of the dangers and merits of smoking during pregnancy, but to point out that strong views held by midwives (and others) regarding the health of individuals may sometimes influence the



verbal force with which the midwife attempts to steer the woman's behaviour. Midwife J made it clear that if the woman continued to smoke her baby would be likely to suffer. Women during pregnancy are often extremely vulnerable to suggestion, particularly regarding the well being of their babies. Midwife J's approach could be considered as a form of moral blackmail; a form of manipulative power (Mills 1958) to influence the woman to stop smoking. Women rarely knowingly carry out actions likely to harm their babies; indeed, they may well be frightened if such a prospect is suggested to them. By gatekeeping the midwife released the information in a way she thought would influence the woman to take the course of action she (the midwife) felt strongly was 'right'. Midwife F considered that midwives could 'go over the top' when influencing women to make certain choices. For example, when talking about breast feeding, she said:

*MF I think there are a lot of people going over the top about it and make people who don't want to or can't breast feed feel guilty about it.*

*VL Why do you think people go over the top?*

*MF Well it's national policy that we must promote breast feeding, and I found that lots of young midwives are not being sensible about it. They've been given this directive, and they're not looking at the person as a whole, all they're seeing is a baby that must be breast fed*

*VL So you think it is possible for the midwife to persuade the mother to breast feed, where she wouldn't have ...*

*MF Oh yes, you can do, yes, you can browbeat them into it, yes.*

Besides smoking, there may be other issues that are known to be potentially damaging to the woman and her child. The midwife may not feel so strongly about them, however, and may not use similar tactics, or may even exclude them from the agenda of what is to be discussed. For example the same midwife (MJ), when asked about the importance of diet in pregnancy, said she had no strong feelings about it but would merely ask the woman if she had read and understood the advice given in the handouts:

*MJ ... it's a personal thing, so I probably don't spend as much time talking about it (diet) as smoking. I can't remember with this particular lady whether we talked about diet ... I always mention it, but I don't go on about it.*

There is extensive evidence that an adequate diet in pregnancy is extremely important for the health of the mother and fetus/baby (for example, Spedding, Wilson, Wright and Jackson 1995:1-23). It could therefore be argued that advice about diet was at least as important as advice against smoking, but the midwife steered the conversation towards the topic about which she felt strongly, largely ignoring an issue in which she had little interest.



To summarise, midwives were concerned to protect the physical well being of women and would direct the agenda towards this end. Unless they deemed it necessary to protect the woman's or baby's physical safety, midwives would try to avoid worrying or frightening women, as discussed in the following section.

5.5.1.2 Protecting against emotional harm. Midwives wanted women to enjoy their pregnancy (or their baby) without worrying unduly about complications that may never arise. Midwife J described a distressing telephone call she had received recently:

*MJ I had a girl phone me up the other day, worried - she had had an amnio and she said she was considering the options and she wanted to know about the termination and whether the baby would be born alive. I hadn't really thought about it, and of course the babies don't survive because they give huge doses of morphine or whatever pain killers they use ... but what a horrible thing to have to think about when you are 20 weeks pregnant. I mean, the baby could be all right, but she is having to think about that baby dying.*

Midwives were aware that women needed enough information to make choices, but in order to protect them against worry or fright midwives limited the depth and breadth of information, and chose their words carefully. Midwife E, who provided an in vivo code for the core category said:

*ME ... you just say to the mothers it's a good idea to stop smoking - but again, you could say, are you going to frighten them (laughs) by saying something awful could happen! But you've got to sort of pick your line ...*

This comment may be contrasted with those made by Midwife J in the previous section. Midwife E, although recognising the dangers of smoking, was concerned not to frighten women by the advice she gave. She wished to avoid scaring the woman into changing her behaviour; preferring an approach that stopped short of that by 'picking her line' and choosing her words carefully. 'Picking your line' was a difficult activity, demanding sensitivity and perception on the part of the midwife. Midwives wanted to be realistic, preparing women for events that might (but would probably not) occur. A balance needed to be struck; sufficient factual information was required to enable choices to be made but if too much information was given there was a danger that the woman would not successfully assimilate it, misunderstanding or inappropriately personalising it with consequent worry or



fright. It is hypothesised that the borderline perceived by midwives between sufficient and excess information lay at the juxtaposition of

- the midwife's assessment of the woman's ability to assimilate information.
- the point at which the midwife considered the information became impersonal and hypothetical (Figure 5.4).

The greater the perceived ability of the woman to assimilate information, the further into detail and hypothetical realms the midwife would be prepared to go. Women who were able to assimilate knowledge were considered to be able to deal with hypothetical information, and not inappropriately personalise it:

*MG ... I know it doesn't sound very nice, but the brighter people are, the easier it is to give them informed choice without frightening them, because they already know something of what you are talking about..*

Midwife J gave a detailed account of fetal screening tests to a woman, and justified this as follows:

*MJ Actually, she was quite an intelligent woman, wasn't she? (Laughs) She did understand, it was a lot of information to give someone, wasn't it, but she did understand...*

Women who were already well informed were thought to be less at risk of being frightened because they could more readily contextualise the information. Although they tended to assimilate information appropriately, however, the way in which they operationalised the information could be perceived by midwives as problematic because their expectations of themselves were so high:

*MF (talking about schoolteachers) They get terribly upset if they do not do so well as they think they ought to be ... we have to be very firm with these ladies ... they write a lot, they want to know a lot, they need a lot of support because their expectations are so high.*

Midwives assessed ability to assimilate information by means of feedback from the woman:

*ME ... I get a response from the mother, that she is interested, she's listening to me and picking up various points or asking questions about them, and you're aware then that she's listened and is aware of what you've said, and can make her own mind up about the choices that are available to her.*

The right balance between giving enough and too much information was sometimes difficult to strike. Some topics (for example, maternity benefits) were fairly straightforward and were



unlikely to worry or frighten women even if explored in depth. Other topics (for example, fetal screening tests) were far more sensitive and needed to be handled with care:

*MG I am always very aware that when I am talking about these things (ie fetal screening tests) and explaining to them, to try and give them all the information they need to make the choice, that I might overdo it, if you see what I mean, I might frighten them, I might put anxieties into their mind that maybe wasn't there initially.... I have on occasions felt that I had frightened somebody ... certainly I realised I had frightened somebody because she said to me afterwards 'Well is there going to be something wrong because you keep talking about what if there is going to be something wrong' and I realised that everything I had said she had not really taken in. She just latched on to this abnormality thing and she hadn't really taken in the explanation, she had not understood it and I find that difficult ...*

The woman referred to above took in the information about screening tests, but inappropriately assimilated it, with consequent distress. It is hypothesised that the woman, alert for cues from the midwife, interpreted the degree of attention the midwife paid to the topic of screening for fetal abnormality as an indication that the midwife thought her fetus was at high risk. A balance also needed to be struck between protection and overprotection.

For example, Midwife G said:

*MG I sometimes think that I must not be patronising or condescending, those again are not entirely the right words, sometimes I cannot find the right words, but do you understand what I am saying? I must make sure that no matter what they are like I must put myself on a level with them, and not sort of be as if they are my chicks if you like, do you see what I mean?*

*VL That you don't take over control of them?*

*MG Yes ... when you get to know them well, especially when you see them often, you sometimes get to feel a little bit like that about them ... I just always want to be a bit careful that they don't see me as a patronising one that is above them, knowing best.*

If a woman was perceived as not having assimilated information, the midwife would provide clarification and further information. There were problems associated with this strategy, however, in that the midwife could stray deeper into hypothetical areas, worrying and frightening the woman further:

*MG ... if I feel that they or she doesn't understand I try and do it again, but at the same time I am always very aware of if you talk about choices about whether you want certain tests done, because you start talking about outcomes, you start talking about abnormalities that you might find.*

*MD A lot of people come in and don't really understand the information. And once you start ... it's very difficult to get off without going all the way to the end ... and women don't want to think about that (fetal abnormality) at 16 weeks.*

An alternative strategy was to refer the woman to 'higher authority', for example, a Consultant Obstetrician:



*MK: ....sometimes you can have conversations with women and it worries me to death. I think we are in a worse confusion, you know, it's not hard to get into that ... I find that women in pregnancy get themselves into a frenzy of worry, hopefully you can talk them out of it .. there are some women that it is very difficult to talk out of it .... the only way I find with women like that is to get them an appointment as soon as possible with the Consultant ... there are some women for whom no one will do but their Consultant.*

Midwives tended to limit information more if they were doubtful of the woman's ability to understand, either because she was perceived as not being bright enough, or as having language difficulties (Figure 5.6):

*VL Would there be any circumstances when you would hold back information from a woman, not wanting to worry her?*

*ME I think, yes, a lot of women we see have a low IQ, and sometimes their partners have a higher IQ, and I'd prefer if he was there, and discuss it with him so if she doesn't fully understand ... and probably if there were language problems ...*

*MG: They only have a certain attention span anyway.*

Some women were thought to be at more risk of 'latching on' to pieces of information taken out of context and personalising it inappropriately to their own situation:

*MG ... but if somebody isn't very well informed generally of what goes on in the world or isn't terribly bright or does not understand the language very well, that's another problem. I find it very difficult speaking to the Asian community who don't always understand very well what I am saying.*

On other occasions, midwives were concerned that women would take actions not thinking of the possible personal consequences. This applied particularly to the triple test, when midwives commented that women often had the test never considering that the test may reveal a potential problem; they had the test to confirm normality, not to suggest abnormality:

*MJ (Triple test) They read the information - or not - they listen, but do not understand sometimes they don't have it in order to find out if something is wrong, they have it thinking it is going to reassure them that everything is all right ... I don't think it really hits home to some these women until the phone rings and they find they are at high risk.*

This view is supported by WI's and WB's comments:

*WI Yes, I think it (the triple test) puts your mind at rest. It makes you a little bit happier to know that everything is OK*

*VL You don't see any problems at all with the screening tests?*

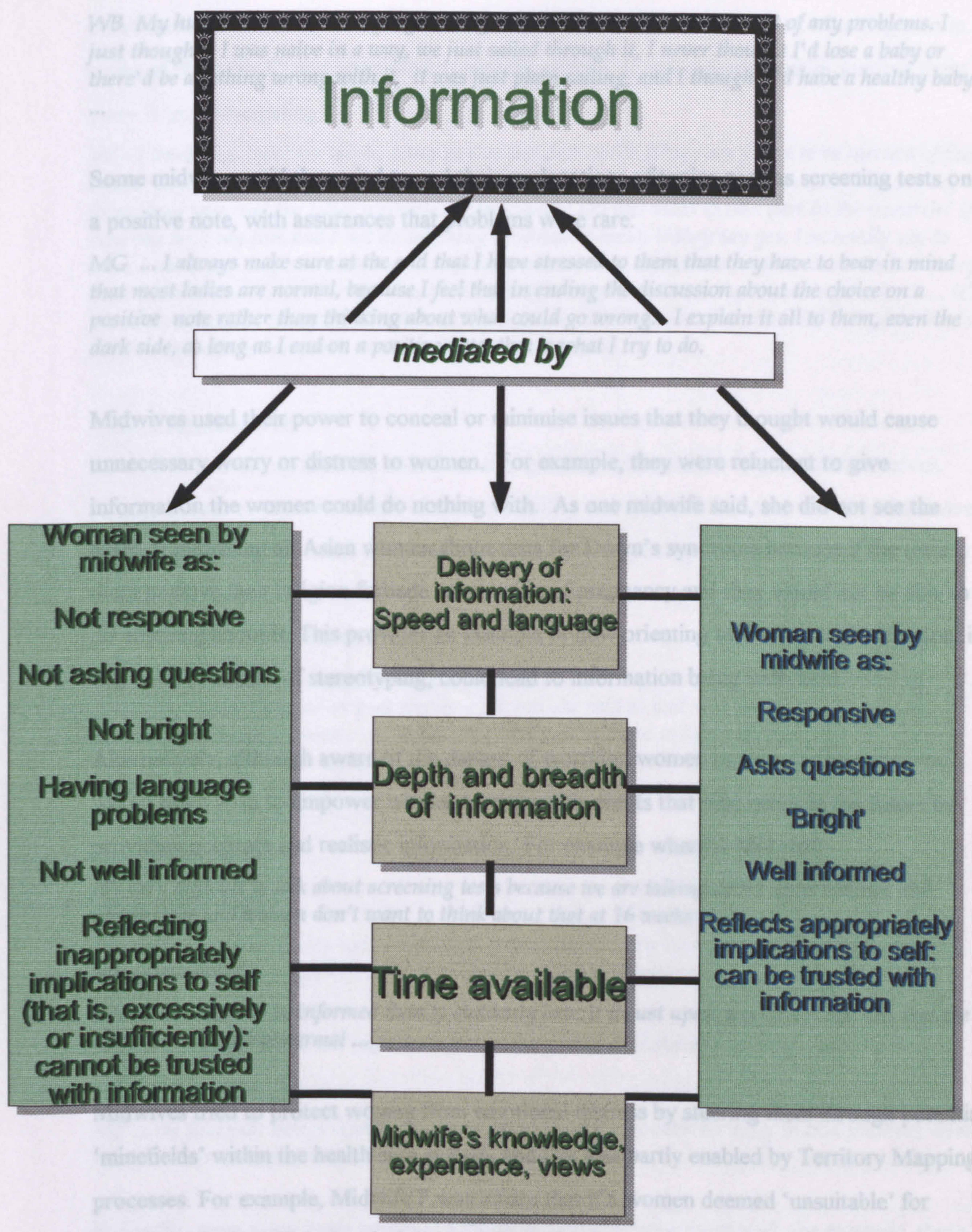
*WI No*

*VL They haven't caused you worry or anything?*

*WI No, it puts your mind at rest when they come back all clear, then you have less to worry about.*



Figure 5.6 Factors influencing the provision of information





*WB My husband and I were saying last night, the first time I never thought of any problems. I just thought - I was naive in a way, we just sailed through it, I never thought I'd lose a baby or there'd be anything wrong with it, it was just plain sailing, and I thought I'd have a healthy baby ...*

Some midwives said they tried to end their explanations of topics such as screening tests on a positive note, with assurances that problems were rare:

*MG ... I always make sure at the end that I have stressed to them that they have to bear in mind that most ladies are normal, because I feel that in ending the discussion about the choice on a positive note rather than thinking about what could go wrong... I explain it all to them, even the dark side, as long as I end on a positive note, that is what I try to do.*

Midwives used their power to conceal or minimise issues that they thought would cause unnecessary worry or distress to women. For example, they were reluctant to give information the women could do nothing with. As one midwife said, she did not see the point of informing all Asian women about tests for Down's syndrome because if the tests were positive their religion forbade termination of pregnancy and they would not be able to do anything about it. This provides an example of how orienting to the woman's situation; in this case, by means of stereotyping, could lead to information being with-held.

Alternatively, although aware of the danger of worrying women unnecessarily, midwives would often wish to empower women to cope with events that may occur in the future by providing accurate and realistic information. For example whereas MD said:

*It's very difficult to talk about screening tests because we are talking about abnormalities and miscarriage and women don't want to think about that at 16 weeks*

ME commented:

*I think it's better to be informed than to suddenly have it thrust upon you by a phone call that the test has come back abnormal ...*

Midwives tried to protect women from emotional distress by steering them through potential 'minefields' within the health care system, and this was partly enabled by Territory Mapping processes. For example, Midwife F was aware that if a woman deemed 'unsuitable' for home birth by her GP insisted on being delivered at home, she was likely to be removed from the GPs list with all the associated unpleasantness that action entailed. Consequently,



she would normally persuade women to have their babies at the GP Unit or in hospital to avoid conflict. Midwife G had concerns about the implications for women of taking part in a study of Hepatitis C, and attempted to protect women by, whenever possible, guiding them away from participating:

*MG I think that there are implications in this for later in life if they are found to be carriers of this virus. Implications for their own health, their own life, when they get older .... what I do is I say to them, have you read the letter (explaining the study)? Do you want to take part in the research? If they say no, I say fine and I not do anything to dissuade them. If they say yes, I normally say to them I think you ought to phone up this person whose name and phone number is on the bottom of your letter if you are not certain about the implications of it .. I know that's passing the buck ... it's got to do with liver cancer, liver sclerosis, liver failure when people reach their 50's. I think that is something I am not prepared to start talking to them about.*

### 5.5.2 Protecting Self

As well as protecting women, midwives also gatekept information to protect themselves. Firstly, midwives protected their clinical credibility and their professional territory. Midwives limited information in order to protect themselves from getting into difficult situations. For example MK was concerned not to predict outcomes that may not materialise; by doing so she would lose credibility in the eyes of the woman:

*MK ... you have to be so careful that you don't say something that is pinned on, and then if something doesn't happen or goes wrong - 'ah, but she said so and so'. So you have got to be careful not to make promises, you know, like 'they will see you at 38 weeks and they will say you have to have a Caesarean section'. You have got to be so careful and say you might have a Caesarean section, but it might be something else, a breech.*

*VL Leaving your options open all the time?*

*MK Oh yes.*

and Midwife F said:

*MF We're up against this body of women, they're quite strong in this area. They're not relying on our professional judgement, and then they're critical afterwards.*

She said she protected her right to make professional decisions regarding, for instance, positions in labour, if

*MF ... we find that things aren't going well, or if we can't monitor the baby in that position, then I think we have to be polite but firm.*

Secondly, there were more personal aspects of practice to be protected, for example, there were certain issues that midwives considered ethically important to address as well as



possible, otherwise they would 'carry it on their conscience'. Midwife K said she always gave a full explanation about fetal screening tests and their implications:

*MK ... because if they had a child with Down's syndrome and then said that no one explained it properly to them I couldn't carry that on my conscience.*

There were some scenarios midwives found unacceptably physically unpleasant; this might lead to the midwife withdrawing choice from the woman. Midwife 1 would not give a woman in her care the opportunity to be delivered in a bath or pool:

*VL If a woman asked you to deliver her in the bath -*

*M1 I would not go along with that. Also, I do not think I should be expected to do that either. I do not like, you will have to excuse me, I cannot cope with faecal matter. As long as I have been a midwife I have to keep the anus clean, I do not harass her to death, but I am very careful what I do, but you will never see me have a delivery where there is BO (bowels open) all over the place.... the anus does dilate a lot and if they are in water I do feel it will circulate round and whatever gauntlet gloves you have got they do not come up to your armpits so it also means it will be flowing round my arms and I do not want that*

*VL Would you advise her to go to another midwife?*

*M1 Yes I would, what she would not have then is my clinical skills!*

In this example, the midwife would not agree to a course of action desired by the woman.

The midwife's wishes were in direct conflict with the woman's, and the midwife had the power to impose her wishes upon the woman, either by refusing to carry out the water birth had the woman requested it, or by with-holding the information that water birth might be available.

To summarise the substantive category called Protective Gatekeeping, midwives released information to guide the woman towards choosing courses of action perceived as safe by the midwife. Midwives prioritised information according to their own perceptions of what the woman required. This was influenced by Orienting to the woman's needs, and also by the personal views held by the midwife regarding what was important, and 'right'.

Midwives gave consideration to the content of the information, its depth, and style of delivery, in order to protect women against undue worry or even fright. On some occasions, however, to protect the woman's or baby's physical safety, it would be seen as justifiable to frighten a woman into following a particular course of action. Midwives also controlled the release of information and choice in order to protect their professional territory and credibility, as well as against ethically or aesthetically undesirable outcomes.



## **5.6 Summary**

This Chapter has described the theoretical framework accounting for how midwives helped women to make informed choices during pregnancy. The core category is Protective Steering, and the contributions to Protective Steering of Orienting, Raising Awareness and Protective Gatekeeping were described.

When engaged in Protective Steering, midwives 'picked their line' in providing sufficient information that could be understood and would not unduly upset or worry women. Midwives tried to protect women from making unsafe decisions (as perceived by the midwife), guiding them towards 'safe' choices. Midwives also protected their own positions in the system within which they worked.

Midwives used various strategies when Orienting, Raising Awareness and Protective Gatekeeping, and these strategies together, with their influencing conditions, have been described. Issues relating to power, dominance, control and trust pervaded the process of Protective Steering. These issues will be discussed in Chapter 7, when the main themes identified in Chapters 5 and 6 will be integrated.

Midwives' clients, that is, pregnant women, also used various strategies when making informed choices, and these will be described in the following Chapter.



## **CHAPTER 6: FINDINGS**

### **THE WOMEN: MAKING INFORMED CHOICES**

#### **6.1 Introduction**

Women require information during pregnancy to guide their actions, and to raise their awareness of issues to be considered and the options open to them (for example, DoH, 1992). Midwives provided much of this information, which is dealt with in a variety of ways by women. The purpose of this Chapter is to describe how women pursued, contextualised and used information given to them by midwives.

#### **6.2 Maintaining Equilibrium**

From analysis of the data pertaining to how women pursued, contextualised and used information, the core category was identified as Maintaining Equilibrium (Figures 6.1 and 6.2). Equilibrium is defined in the Concise Oxford Dictionary as '*a state of balance; balanced state of mind*' (Fowler and Fowler, 1946). When Maintaining Equilibrium, a woman sought and dealt with information in such a way as to protect and keep in balance the interests of herself, her baby, partner, and others, during a period often involving considerable change.

The birth of a baby, whether it is the first or subsequent, inevitably results in change in the woman's life patterns, and those of people around her, especially of course her partner and other children. Such changes may relate to life style, body image, economics, housing, employment and relationships. The changes brought about by the birth of a baby are often anticipated with pleasure and excitement. Even the birth of a severely disabled child can be viewed positively by women and their families. Caring for such a child may not be seen as unduly problematic; the equilibrium of the woman's life is maintained even though considerable changes may be required.

Not all changes are seen as manageable or desirable, however, and women may not feel able to, or may not wish to, cope with or adapt to them. For example, the care of a child born with disabilities is likely to place a heavy burden upon his or her mother which may continue



**Figure 6.1: Women's framework**

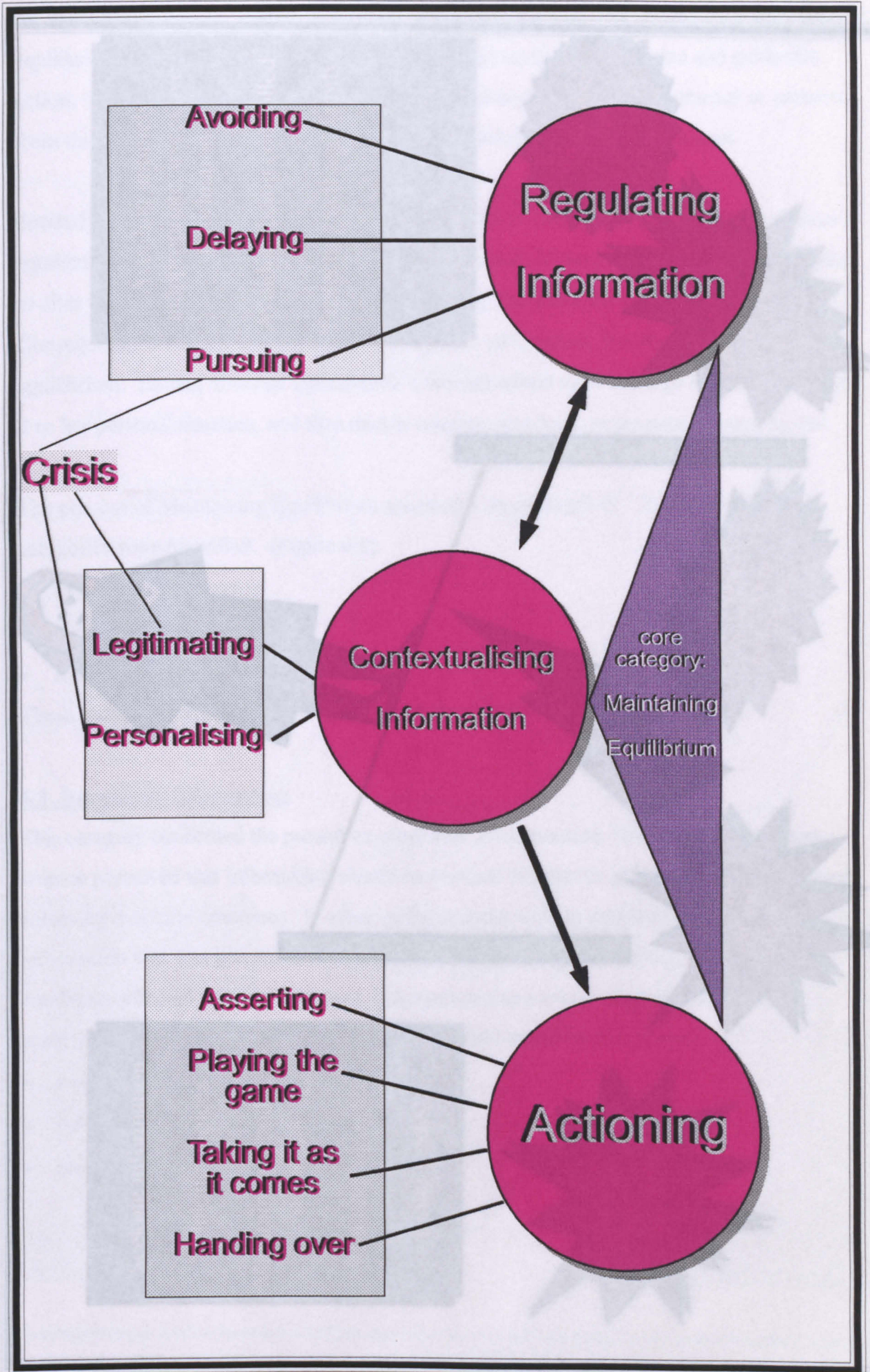
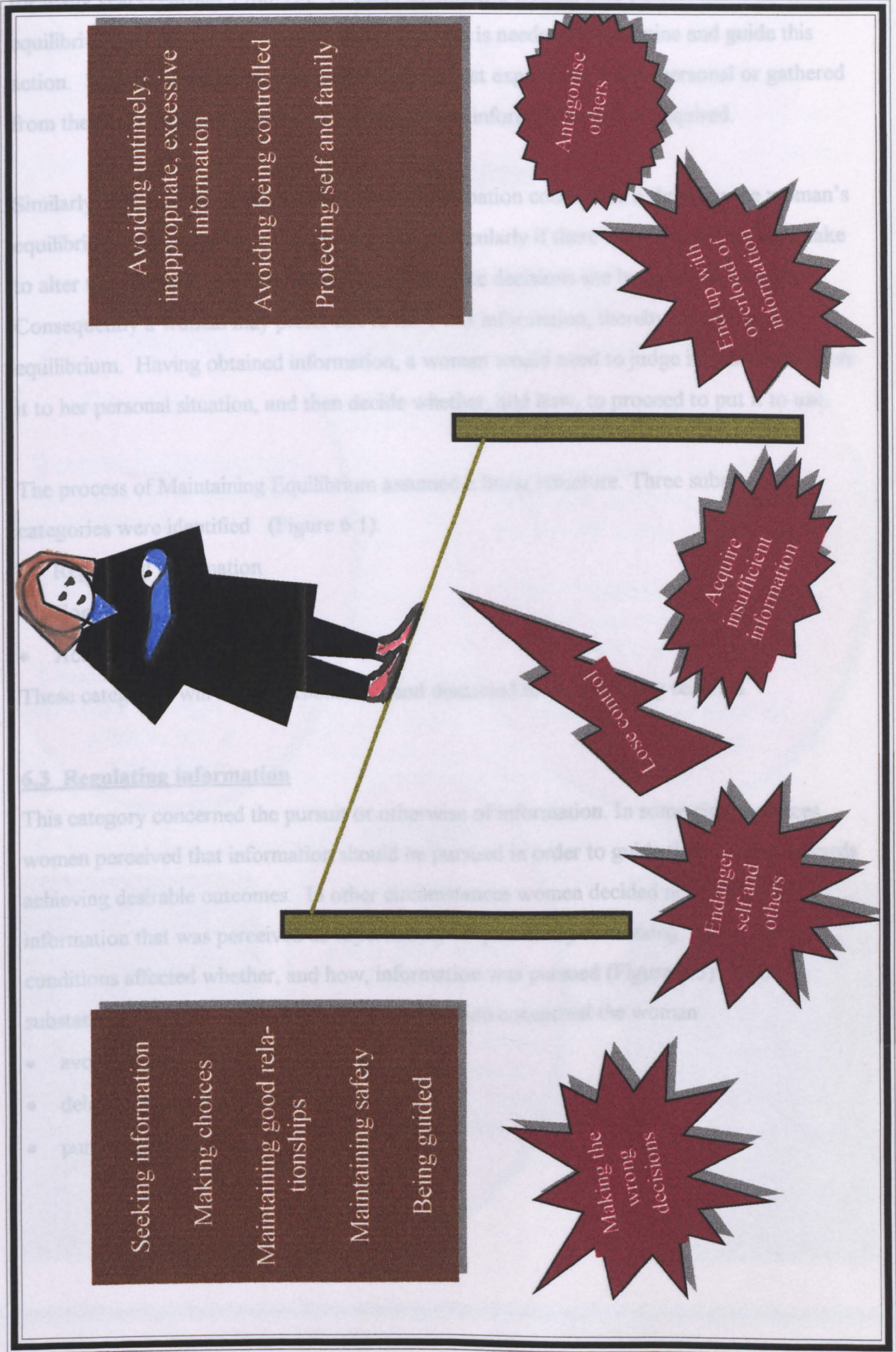


Figure 6.2. Maintaining Equilibrium



Figure 6.2 Maintaining Equilibrium



Seeking information  
 Making choices  
 Maintaining good relationships  
 Maintaining safety  
 Being guided

Avoiding untimely, inappropriate, excessive information  
 Avoiding being controlled  
 Protecting self and family

Making the wrong decisions

Lose control

Acquire insufficient information

Endanger self and others

End up with overload of information

Antagonise others



for many years (Farrant 1980:99). In these situations a woman may perceive a threat to her equilibrium and may act to preserve it. Information is needed to determine and guide this action. Such information may be available from past experience, either personal or gathered from the experiences of friends and others, or new information may be required.

Similarly, and perhaps paradoxically, certain information could pose a threat to the woman's equilibrium by causing worry and/or distress, particularly if there is no action she could take to alter the outcome, or result in her having to make decisions she has no wish to make. Consequently a woman may prefer not to have this information, thereby protecting her equilibrium. Having obtained information, a woman would need to judge its value and relate it to her personal situation, and then decide whether, and how, to proceed to put it to use.

The process of Maintaining Equilibrium assumed a linear structure. Three substantive categories were identified (Figure 6.1).

- Regulating information
- Contextualising information
- Actioning

These categories will be dimensionalised and discussed in the following sections.

### **6.3 Regulating information**

This category concerned the pursuit or otherwise of information. In some circumstances women perceived that information should be pursued in order to guide their actions towards achieving desirable outcomes. In other circumstances women decided not to pursue information that was perceived as superfluous, or potentially distressing. All of these conditions affected whether, and how, information was pursued (Figure 6.3). The substantive category named Regulating Information concerned the woman

- avoiding the pursuit of information
- delaying the pursuit of information
- pursuing information



**Figure 6.3 Regulating Information: Maintaining Equilibrium**



**'Do I want to pursue the information?'**

**Pursuing**

**Conditions:**

- 'I want information so I know what the important issues are'**
- 'I want to know so I can take action'**
- 'I want information so that things don't come as a surprise'**

**Avoiding**

**Conditions:**

- 'I cannot do anything with the information and it would only worry me'**
- 'I have already decided and do not wish to discuss it further'**
- The information is not relevant to me'**

**Strategies:**

- Seeking: reading books, magazines, leaflets etc
- Watching TV etc
- Listening to and discussing with midwife and others
- Asking questions

**Delaying**

**Conditions:**

- 'I do not need the information at the moment but I will need it later. There are more important topics to deal with now'**

**Strategies:**

- Guiding midwife away from topic
- Keeping quiet about intentions



### 6.3.1 Avoiding

Some women avoided potentially distressing information if they could do nothing to influence the situation. For example, WH said she only wanted information on issues that she had choice over; some issues were beyond her control. She wished to proceed with the triple test, but did not want to hear about modes of delivery, and told MH during the booking interview

*WH I scare myself silly with things like that (operative deliveries), so I'd rather wait until the time - the last time I didn't go to parentcraft classes or anything, I thought, well it's going to happen so that's it, really. (Laughs). With the blood tests I'd like to know everything there is to know, but with the other side, I'd rather just wait and see what happens - it's going to happen, so - ! (laughs)*

This was discussed in the follow up interview

*VL What I find interesting is that you did not want to know about these issues (operative deliveries,) and yet regarding the screening tests you really did want to know*

*WH Because I think with the screening tests if there was anything wrong with the baby and you had to make a decision it's going to be a decision that is going to affect you for the rest of your life. Whereas I think with giving birth, although it is obviously a major role it is soon forgotten about... you can't do much about it... I think they are two very separate issues and I think the screening is important and I think that the birth is important and I hope that everything goes all right. I just think that there is nothing I can do about it. It is going to happen, if things go wrong they go wrong I can't do anything about it whereas with the screening if there is anything wrong I have got the opportunity to do something about it if I want to.*

*VL So you are only interested in information that you can do something about?*

*WH Yes. That is exactly right ... I would rather just leave it in the hands of the experts and if anything goes wrong they know what they are going to do at the time, and that's it.*

WH did not wish to receive information that was not relevant to her situation:

*WH ... It's going to happen whatever ... I did go to one class and my husband went as well and it was to watch six different births, and she (the midwife) said yours will probably not be like any of these and so I thought well why are we sitting here watching it.*

If they were able to, women avoided receiving information by not responding with interest to what the midwife was saying, and guiding the conversation into other channels. For example, WH took an early opportunity to express concern about pain relief, which diverted the midwife away from talking about attending parentcraft classes:

*VL Am I right in perceiving that you did guide the conversation away from parentcraft into talking about pain relief in labour?*



WH *Yes ... It just seemed to happen, I thought we had gone as far as I wanted to in that she had told me about it and I had declined to take part, I did not see any point in discussing it further. She respected that and did not pursue it further*

VL *So she went off on the tangent that you wanted?*

WH *That's right, she wasn't set in her ways, she was quite happy to go along with the flow.*

This strategy did not always work, however. If the midwife was determined to give the information she did so, and occasionally the woman did not realise the intention to give information in time to prevent it or to indicate she did not wish to know. WE had experienced a distressing episode when being scanned, although this involved the obstetrician rather than the midwife:

WE *Everything wasn't quite as it should be with the scan, I've got to go back in a fortnight, but we weren't very pleased - it weren't the midwives, there weren't any midwives there, it was the Consultant, he was very abrupt, really upset us, told us he wasn't sure if the baby has both legs or not .... so I've got to go back in a fortnight. A long fortnight.*

VL *(following intervening discussion) ... You're saying that there are some situations where you'd prefer not to know?*

WE *Yes. Yes, if he'd just said to us we needed to go back in a fortnight because the scan weren't clear enough.... in some cases it's best not to know.*

Happily, the baby was normal, but the Woman E reiterated during a later conversation that she wished the obstetrician had not told her of his suspicions.

### 6.3.2 Delaying

Women sometimes delayed pursuing information they required because the time was not right for that topic to be addressed and there were other topics of more immediate concern:

WA *(Regarding labour) ... at the moment I haven't really thought about it ... I will think about it nearer the time*

and, regarding her length of stay in hospital after the birth:

WA *I think that had I not known I was going to see another midwife later on then maybe it should have been talked about a bit more, but at the time I knew I was going to see another midwife anyway so we could talk about that later on ...*

### 6.3.3 Pursuing

Information regarding topics such as maternity benefits was unlikely to result in worry, difficult decisions having to be made, or unpleasant, distressing situations having to be faced as was the case in, for example, screening tests for fetal abnormality. In these more difficult



areas, although on the whole wanting information, women often felt some degree of ambivalence about receiving information that would worry or distress them. For example, WB had been told she was anaemic. This information, although giving her a feeling of some degree of control, nevertheless worried her:

*WB ... Now I know, I'm going to keep an eye on it, and I'll be at the clinic very often and ask for a blood test! But it's taken a lot of the pleasure out of it because instead of feeling positive I'm thinking all the time is the anaemia going to affect the baby?*

She had attended the specialist unit for amniocentesis:

*WB ... sometimes you can just get to know too much - I asked what can go wrong ... and she said 'Oh well, I could go through a blood vessel' and, Oh dear! Some things you think I wish I hadn't asked that, but on the other hand .. you're better to know, I suppose ... it's nice to be treated like an equal ...*

Most women wanted such information, however, and were quite clear on the action they would take if the tests proved abnormal. They wanted to be able to plan their actions. WH's first child had been born with problems with his ureters:

*VL How do feel about the scan?*

*WH I don't mind, I need peace of mind. I just want to know basically what we're in for!*

*VL So that you can plan?*

*WH Yes, that is right, so I know that if the baby is going to need an operation it won't come as such a shock'*

WG was asked by the midwife if she really did want to know whether the fetus was normal, to which she replied that she definitely did:

*WG ... If I found out that I was carrying a child that was in any way not 100% I know - and my husband and I have talked about it, that I would terminate the pregnancy, and that is not being callous, I just feel that I know how I would react and cope, and that would not be good for the child, and my husband would be the same, and I don't think it's very good for the children either, you know, bless them, what sort of a life is it? So I would terminate it, we're very sure about that.*

Several other women gave similar responses that indicated their concern to protect the equilibrium of their lives and that of their families. WF said she would not go ahead with a pregnancy if the fetus had Down's syndrome because

*'it's long term ... Mandy (daughter) would have to look after it, it would be down to her if it were her brother or sister'.*

WH wanted as much information as possible so she could think about making a decision *'that is going to affect me the rest of my life.'* WB's triple test had revealed a high risk of Down's syndrome. She reflected upon how she had felt between receiving the results of the



triple test and learning a few weeks later that her fetus was normal; although she was ambivalent about having a termination of pregnancy she thought she probably would go ahead, especially as her husband had said he would not be able to cope with a Down's syndrome child:

*WB .... I'm not a big believer in abortion, I couldn't have one because it was inconvenient to my lifestyle or I wanted a boy or a girl, but I felt like I would have to. I'm an anxious sort, and riddled with guilt complexes - I'm sure I would feel awful having a termination and I felt I'd be rushed into it whether I wanted it or not, to please everybody, but really being very undecided about it. Obviously you see some children and it would be cruel to bring them up in a life where they're going to suffer and not lead a normal life .... But I didn't realise my husband had such a - that he wouldn't be able to cope with a Down's syndrome child, it surprised me'*

WA was unsure whether she wished to proceed with the triple test. She was having blood taken for other routine tests, however, and thought she '*might as well carry on*' to have the triple test. The results showed a high risk of spina bifida, and WA was referred to a specialist Unit for more investigations which showed the fetus was normal. In the follow up interview (at which her husband was present and participated) they talked about the triple test:

*VL Could you tell me how you felt about having the screening tests?*

*WA Well at the time they were taking blood from me anyway weren't they, so I thought we might as well carry on. But afterwards we talked about it and we said do we want to know or don't we want to know*

*Husband A Because the accuracy of the test is only 65%, it caused us so much worry that we know now wasn't really necessary ... Now it's over and everything's OK it seems like it was a good thing to have - we're probably better off knowing*

*WA Because the worry's past now, but at the time, you know, you wish you hadn't had it done ... Because even when I was sitting there with my little ticket in my hand waiting to go and have my blood taken from me it was a case of do we want to know or don't we?*

*Husband A We said Yes, because it's too late to say No at this point.*

*WA You were still humming and haaing. We're glad we did it now, but at the time we could have done with some more information.*

The Theory of Reasoned Action (Ajzen and Fishbein, 1980) suggests that people's behaviour is influenced largely by their perceptions of the outcomes of that behaviour. WG and WB saw the favourable outcomes as being the knowledge that would guide them to take appropriate action; they were clear on what that action would be (that is, termination of pregnancy, although of course the situation did not arise since further investigations indicated their fetuses were normal; it is not known whether they would in the event have proceeded to abortion). WA knew that she was having a needle prick to have blood taken, and so she '*might as well*' agree to the screening test, as no further needle prick would be



involved. She perceived the benefit as assurance the baby would be normal. At that point, outcomes of her intended behaviour (having the screening test) appeared favourable. The Theory of Reasoned Action suggests that behaviour is also influenced by the perceived attitudes of 'significant others' - in this case, Midwife A, whose approval of her decision to proceed is implied as can be seen in the following excerpt. This is a complete account of the interaction between Midwife A and Woman A regarding the blood screening test:

*MA ... the (blood test) you can have if you want to is one that can show if the baby's at risk of Down's syndrome or spina bifida.*

*WA Is this in the blood test?*

*MA Yes*

*WA OK, if it's in the blood test I might as well take it*

*MA Right, but let me tell you a bit more about it so you know. The actual test is only about 60% accurate as to whether the baby is at risk of having either*

*WA Yes*

*MA And what it does, it comes up with a score and if its below 150 then you're considered to be at high risk of the baby being affected, so what they would then do is give you a ring and get you to come in and then they would go through the whole thing with you again and then offer you an amniocentesis which is where they take fluid from around the baby, with a needle, and then send it to the Lab, and that shows whether the baby is affected or not. And if it is you will be offered a termination, OK?*

*WA Yes*

*MA How far down the line you go is entirely up to you - just because you have this, and if it comes back high risk - if you don't want to go any further then that's your choice.*

*WA Right. Thank you.*

WA and her husband had been given an explanatory leaflet beforehand, but they found the information it contained to be insufficient to make a decision regarding whether to have the screening test. Their decision was influenced by the interaction with the midwife, WA deciding that she 'might as well'. The midwife concurred with this, but on condition that she was allowed to give the woman certain information. In 165 words, information was provided on the following issues. the accuracy of the test, spina bifida, Down's syndrome, the definition of high risk, subsequent action if a high risk was identified, amniocentesis - what is it and how it is done, termination of pregnancy, and the freedom of the woman to choose the outcome. On average, approximately 20 words were used to cover each issue. It is hypothesised that this brevity signalled to the woman and her partner that the midwife did not think it necessary to provide detailed information, and that she thought the risks were low. This supports the pathways suggested by Ajzen and Fishbein's Theory of Reasoned Action (1980) in that



a) the midwife signalled that it was good to have the test, the risks of untoward sequelae, although present, were slight; although the woman should know about them it was not necessary to consider them in any detail.

b) WA's perceptions of the outcomes of the test were positive; she expected to be reassured that the fetus was normal, but knew there was a slight risk this might not be so. In the latter eventuality, however, she still preferred to have the information but acknowledged that there would then be further decisions to be made. Having a child with spina bifida or Down's syndrome could disturb her equilibrium; further information would be needed to make decisions and take actions to preserve equilibrium. These decisions and actions would concern further tests to confirm or exclude abnormality, and to explore its nature and severity. WA would then need to decide whether to continue with the pregnancy, or to terminate it, considering her own feelings and those of her husband regarding termination, as well as the likely influence of a handicapped child upon their life. In other words, she would need to take decisions to protect equilibrium, but these could be extremely difficult to make.

MG wished to pursue information about toxoplasmosis, but felt unable to. The midwife offered her a blood test, but MG interpreted the midwife's reactions as indicating the test was not necessary:

*MG The symptoms of toxoplasmosis, they're a bit like flu symptoms. I think quite a large proportion of the public have antibodies against this - but no, we don't do it routinely. If you want it done, just say, and we'll do it. No problem.*

*WG (To VL in follow up interview)... I turned it down (the test for toxoplasmosis) I do think they ought to do this as a routine thing ...*

*VL You did sound as though you really wanted to have that test.*

*WG Yes. I mean I would have quite liked to, but I felt a bit silly - I thought the nurse - she didn't seem to take it particularly seriously, I didn't think, or didn't seem to think it would be a problem so I thought oh well, I'm being a bit silly here. And just because I've seen it on the TV, I'm being a bit paranoid. But if there was a standard test I'd be more than happy to have it, and once they've taken one lot of blood they might as well take more. So yes, I would have done ... I've been thinking to myself, I've got a greenhouse, and I usually go out and do my seeds in January, but I don't think I'm going to do that, because of the soil, and I can't garden with gloves on. So I'm not going to do my seeds this year, because of this. So I've made that decision, I'm not going to do it, because I don't know how high the risks are, and I don't want to put myself at risk.*

Rather than 'feeling silly' by insisting upon the test, WG preferred to rationalise her decision not to pursue it by claiming a degree of paranoia, and taking action that would reduce the risk of contracting toxoplasmosis in the future. Her claim to paranoia could be seen as self-



deprecating, and this, together with her comment about feeling silly, is revealing. WG is a well educated, confident and articulate woman, with a responsible post in the publishing business. She had several times expressed a strong desire to know in advance of any problem with fetal abnormality and yet was put off easily by the midwife from having this test, which, as she rightly said, could be done with no problem, there and then. Positive reinforcement from the midwife (the significant other) was not forthcoming, and yet WG saw benefits of knowing if the fetus was affected by toxoplasmosis. She compromised by taking avoiding action towards toxoplasmosis.

6.3.3.1 Strategies used to pursue information Women used multiple strategies to seek information, accessing a variety of sources. Many women read books, magazines and leaflets and watched TV programmes they thought would give them information:

*VL ... What influences you most of all when you make choices ...?*

*WE I think it's a bit of everything, really ... I do read a lot, magazines, mainly ... I wouldn't have heard about folic acid otherwise ...*

Women sometimes read books straight through, from cover to cover, but more usually consulted them for specific information:

*WC ... I don't read them cover to cover, but there are bits in them ... my blood pressure was up one time and it was nice to read the things you are supposed to be doing to reduce it ... they're upstairs by my bed and most nights I'll pick one up and just flick through it, and think I've not read that bit, then I'll read it, so by the end of the time I'll probably have read it cover to cover, but not in correct order, it's as when something's happened to me*

WD had obtained most of her information from books:

*VL Where would you get most of your information from?*

*WD From doctors and midwives and books*

*VL Where would you say you got most of it from?*

*WD Books, I think ...*

*VL Would you look up bits in the book as they occur to you, or would you read it from cover to cover?*

*WD Last time I read the whole blooming book! I think that's why I got pre eclampsia! (Laughs)  
Oh dear, I end up reading the lot, but then if something did happen to me I'd look it up*

Women talked to midwives and others at parentcraft classes, clinics and other venues; they listened to and asked questions of midwives:

*WI I have had the pamphlets that the midwife gave me but I feel that if there were anything I really wanted to know then I would ring the midwife - my own midwife at the surgery ... it's just that*



*you can have a conversation about it, whereas in a book it's just written there, whereas you can discuss it when you are with the midwife*

and talked to friends and family:

*VL Where did you get your information about breast feeding from?*

*WA Well this is my first pregnancy, I've read books, magazines and all that, and I've also talked to friends who have tried and failed, and tried and succeeded, so knowledge from there ...*

To summarise, women read written material, watched TV, talked to relatives, friends and midwives and other health professionals to acquire information on a range of issues. They browsed information to raise their awareness of issues that could be important to them, and also accessed specific information when particular issues or problems arose.

6.3.3.2 Information in times of crisis Caplan defined a crisis as occurring when:

*'A person faces an obstacle to important life goals that is, for a time, insurmountable through the utilisation of customary methods of problem solving. A period of disorganisation ensues, a period of upset, during which many abortive attempts at solution are made.'* (Caplan 1961:18)

Stone (1993) pointed out that a crisis occurs as an internal response to an external event, this event being perceived as a threat to an individual's personal wellbeing, or the wellbeing of his or her family, and Murgatroyd and Woolfe write:

*'...it is not the events ... that constitute a crisis, but the way in which the person experiences and thinks about these events which make them crisis-laden.'* (Murgatroyd & Woolfe, 1982:8)

Lazarus (1968) suggests that the perception of crisis or its degree depends upon the appraisal of its significance to the individual experiencing the crisis. He wrote that appraisal consists of two broad types, the first of which assesses the degree of threat and the second appraises possible ways of coping. A person experiencing crisis will perceive significant threat and can find no way of coping with or satisfactorily resolving the situation.

In this study, crisis concerned a personal reaction to an event that seriously threatened the equilibrium of the woman or her family. What constituted a crisis to one woman may not be perceived as such to another (examples of crisis situations are provided below). Caplan (1961) noted that people desire to maintain equilibrium (or, as he termed it, homeostasis) in



their lives and this desire motivates their behaviour. People cope (successfully or unsuccessfully) with crises by using various strategies and resources, both internal (such as problem solving or communication skills) and external (such as enlisting the help of other people) (Stone, 1993).

Caplan (1964) wrote that during a crisis the individual is in a state of high tension and likely to feel helpless until his or her problem-solving strategies prove successful and the crisis is resolved, or conversely the individual adapts to a non-solution. Expanding upon Caplan's work, Aguilera and Messick pointed out that, when customary methods of problem solving cannot be used, equilibrium is upset, and a crisis may result with consequent anxiety and distress:

*'A person in this situation feels helpless - he (sic) is caught in a state of great emotional upset and feels unable to take action on his own to solve the problem ... The outcome is governed by the kind of interaction that takes place during that period between the individual and key figures in his emotional milieu.'* (Aguilera and Messick 1986: 1&6)

Aguilera and Messick considered that crisis may be regarded not only as a threat, but also as an opportunity for intervention. They suggested three forms of therapeutic intervention. assisting the individual to acquire insights into the events leading to the crisis; providing support and advice; and encouraging the individual to continue seeking ways of coping. All of these forms of therapeutic intervention involve the provision of information to the individual. In this study, the common factor in all the observed instances of crisis experienced by women was their need for information. Hall and Weaver pointed out that people

*'... may lack specific information necessary to deal effectively with the problem at an intellectual level. Thus intervention involves raising the level of awareness and supplying helpful facts about the situation. A major task is to assist in the development of a cognitive map of what is happening, as a first step in achieving purposeful problem-solving.'* (Hall & Weaver 1974:5)

This section will focus upon the characteristics of information required during crisis. It is hypothesised that, during a crisis, information needs to be

- Highly personalised to the woman's situation, detailed and comprehensive.



- Accurate; up to date and consistent.
- Quickly provided.
- Provided in a supportive manner.

These characteristics will be further discussed below.

### 1. Information needed to be highly specific to the individual, and sufficiently detailed and comprehensive

The news that her triple test indicated a high risk of spina bifida came as a shock to WA and her husband and constituted a crisis in that the issues involved could seriously upset their equilibrium. Should further tests confirm the abnormality, decisions regarding terminating the pregnancy would need to be made quickly. In order to guide these decisions when the time came they wanted highly specific information about what having a child with spina bifida would mean to them. The midwife broke the news of the abnormal result to them, saying that the test had come back 'reading 160 instead of 140':

*WA ... she said go home and have a look in the books you've got and find out about spina bifida, but there wasn't an awful lot about what it was, you know, the actual information it said the chances of this that and the other happening and the alpha feto protein - but it didn't tell you anything about spina bifida, the information about spina bifida wasn't there, to go and look at ... what it would actually involve should it be housebound, you know what I mean*

*VL What it would actually mean to have a child with spina bifida? How it would affect the child and how it would affect you?*

*WA Yes, everything like that, because there's not really the information - everyone can turn on the TV and there's pictures of children with Down's syndrome but you don't see people with spina bifida. So, you know, there wasn't the information to look up, was there?*

The midwife who told them the test was abnormal did not provide detailed information:

*WA Basically, she just said you are at risk. She was very sympathetic, but we turned round and said how high's the risk, but she couldn't tell us ... She didn't advise us in anything, she gave us 2 choices, she said we could either go for the amniocentesis or go for the scan*

*Husband A She was good at the time, she guided us in the right direction*

The printed material they had, although giving details about the test, did not describe the implications of spina bifida:

*WA Even the leaflet they give you doesn't explain an awful lot, it didn't tell you what it actually was, spina bifida or Down's syndrome, it just said that the risk is there.*

*Husband A ... if you look at the sheet it's skipped through fairly fast by the midwife, and one thing it does it comes up with a score and if its below 150 then you're considered to be at high risk of the baby having something wrong - well, what are we talking about? What sort of scale are we looking at? If its 160 are we so far over it's a big thing? It's very vague.*



WA had to wait two weeks for a scan at the Regional Centre, and during this time she sought information unsuccessfully about what having a child with spina bifida would mean for themselves and the child. This two weeks presented a crisis to WA and her husband. During those weeks, pursuing information was the only action they could take, and it was frustrating and distressing for them not to be able to find the information; without this they were powerless to consider options. They cast their minds back to what had been said to them at the booking clinic, and looked again at the leaflet provided, but that only raised more questions they could not answer:

*Husband A But at the time of asking if you wanted this test, you're asked to make the decision with that small piece of information which is rushed through without -*

*WA Without any information at first*

*Husband A OK, if the test went through and you weren't recalled you aren't going to reflect back on that small piece of information, but having been recalled and then you're asked to reflect back on that, it wasn't enough at the time.*

*VL So you'd like something written - something tangible*

*Husband A Either that, or have it explained in more detail at the time especially these figures - I don't know what these figures mean 150 - 150 mmols or micrograms or what is it, you know?*

*What exactly do they mean, in more detail.*

Breadth and depth of information was needed so that the issues were made clear; until these were known questions could not be asked. WA's husband was a well educated professional man who had enough general knowledge about the issues to formulate the right questions, but this would not be so in all cases:

*Husband A At the initial interview there should be more said about the test and following that there should be information that we had to ask for like the figures what they mean and so on, whereas that should be volunteered without having to ask for it, and questions like the amniocentesis - there is a risk connected with that, that wasn't volunteered to me and I had to ask for that - I'd read in a book there is a risk. All that information should be volunteered, But most concerning is at the initial interview - that wasn't explained in that - this blood test is available, a spiel of information, do you want the test - and it's then you have to make the decision of whether you want the test. Afterwards it was all explained and so on and so on, even if I did have to ask an awful lot of questions to get some information. The follow up treatment was all explained in more detail.*

*WA We were given information, but we had to ask for it, but it wasn't volunteered, was it.*

*VL Right. And you need that information to know what the questions are to ask about it.*

*Husband A Quite.*

WB had also been through a similar experience, and had been unable to gain much information at the local hospital:

*WB ... nobody really talks to you ... no-one really talked to us about Down's syndrome ...*



*- I mean, after I'd seen you, Mr XX (Consultant) said 'You pays your money and takes your choice', and really he didn't tell us much, but when we went to (Regional Centre) he (Consultant there) explained everything to us and really, he told us too much in a way, but it was nice*

A few months after her initial interview with VL, WC had a fall in the doctor's surgery where she worked as a receptionist. Whilst talking to VL several months later (regarding the credibility of data analysis), she recalled that, as she was by then in late pregnancy she was immediately concerned for the baby, but the GP who examined her a few minutes after the fall did not, in WC's view, do enough to ascertain the condition of the baby:

*WC ... she (GP) just looked at me. She did listen to the baby, but she didn't feel. Then they sent me home. And about 10 minutes later Dr XX (own GP) rang and said he was coming to see me ... he was concerned whether I had started contractions, he felt my tummy for a good 15 minutes ... he was much more reassuring ...*

WC's own GP provided the information she needed; it was personalised and concerned what was really worrying WC; that is, the condition of the baby after her fall, and not herself.

## 2. Information needed to be accurate and up to date

WB found leaflets unhelpful and out of date:

*WB ... I came out with a pile of things to read, but I suppose in a way you're better - I mean, you felt like you shouldn't ask because it would all be explained to you in the book. But when I read some of the books they were completely different to how things really are. I mean the CVS scan it said you will find out in 2 weeks, whereas we found out in 24 hours. And then there's other things about the CVS that's different to the books.*

She also found they tended to raise false expectations:

*WB ... in a lot of these books they say you can get counselling and this that and the other, but I don't think you really get counselling - nobody really talks to you, it's just that they said, if you're going to have this scan in a way we hope you will have a termination because it's going to be a waste of money if you don't. But nobody's really - in a lot of these books they say you can get counselling and this that and the other, but I don't think you really get counselling*

## 3. Information needed to be quickly accessible

All women experiencing a crisis wanted information quickly; any waiting resulted in anxiety and distress. WB appreciated obtaining information quickly about tests done at (Regional Centre) for anaemia, although puzzled why she had to wait a few weeks for the results of the amniocentesis:



WB ... at (Regional Centre), everything's so quick, she didn't believe I was anaemic and she said she'd do a blood test and we'd have the results in an hour ... everything was quick and you don't have to wait for a long time. I think it's awful having people waiting, I know with the amnio it's something they can't tell you quickly, but it's not explained to you why. They just say it's a few weeks, but no-one ever explains why.

#### 4. Information needed to be given in a supportive manner

WB was referred to the Regional centre for amniocentesis as her baby was high risk for Down's syndrome. She was reassured by the positive attitude of the staff at the centre, but had not felt well supported prior to the visit:

WB I'm just worried all the time because of my age, and made to feel I shouldn't be having one at my age - it's just a negative attitude really. I felt so much happier when I'd been to (Regional Centre) than when I'd been to (local hospital). I felt at the hospital - maybe not as much with the midwife, as the doctor, they were very pessimistic about a pregnancy at my age and it was all on the downside, and yet when I went to (Regional centre) they were brilliant, I had my CVS scan ... everything's fine ... they're far more optimistic, and things weren't as bad as they'd painted in (local hospital) - and the enthusiasm was there - it was a more positive attitude, and things could be got over.

WA The doctor - he made us feel a bit better because he said ... it's not a diagnosis, it's just a chance of, and so we were a bit more settled.

The examples above have all concerned worries women had about the health or normality of their babies. WG, quoted below, experienced what was to her a crisis during her pregnancy, related to what drugs she could take safely:

WG Yes, I'd only taken one (an iron tablet which caused constipation). It brought everything to a complete halt! ... Yesterday I thought I've got to do something about it, so I phoned the doctor at the surgery, and they've got a doctor off sick, and a doctor on holiday and they couldn't see me till this morning. Well, I couldn't go this morning because I had to go to work, so I thought OK, I'll go to Boots this lunchtime and Boots said there's no way we can give you anything for constipation until we've got the OK from your doctor. So I then went back and rang my doctor, the surgery again, and they said 'you'll need to speak to a doctor, we can't do that for you until after surgery hours, and that will be after 11 o'clock tomorrow morning. And basically, I said, I can't do that either, I'll be in the car, and I can't ring then, so they said they'd get the dispensing lady to speak to me and she said, no, she couldn't do anything till I'd spoken to the doctor. Right, OK. So I put the phone down, and by this time I was getting quite cross, so I phoned the maternity unit, and I spoke to a lady, I was half way through mid sentence when she transferred me, and I got put through, would you believe, to Casualty! (laughs) and they said, oh no, we can't help you here, and I said forget it. And I put the phone down.

Eventually, WG did manage to persuade a pharmacist to advise her on a safe medicine to take.



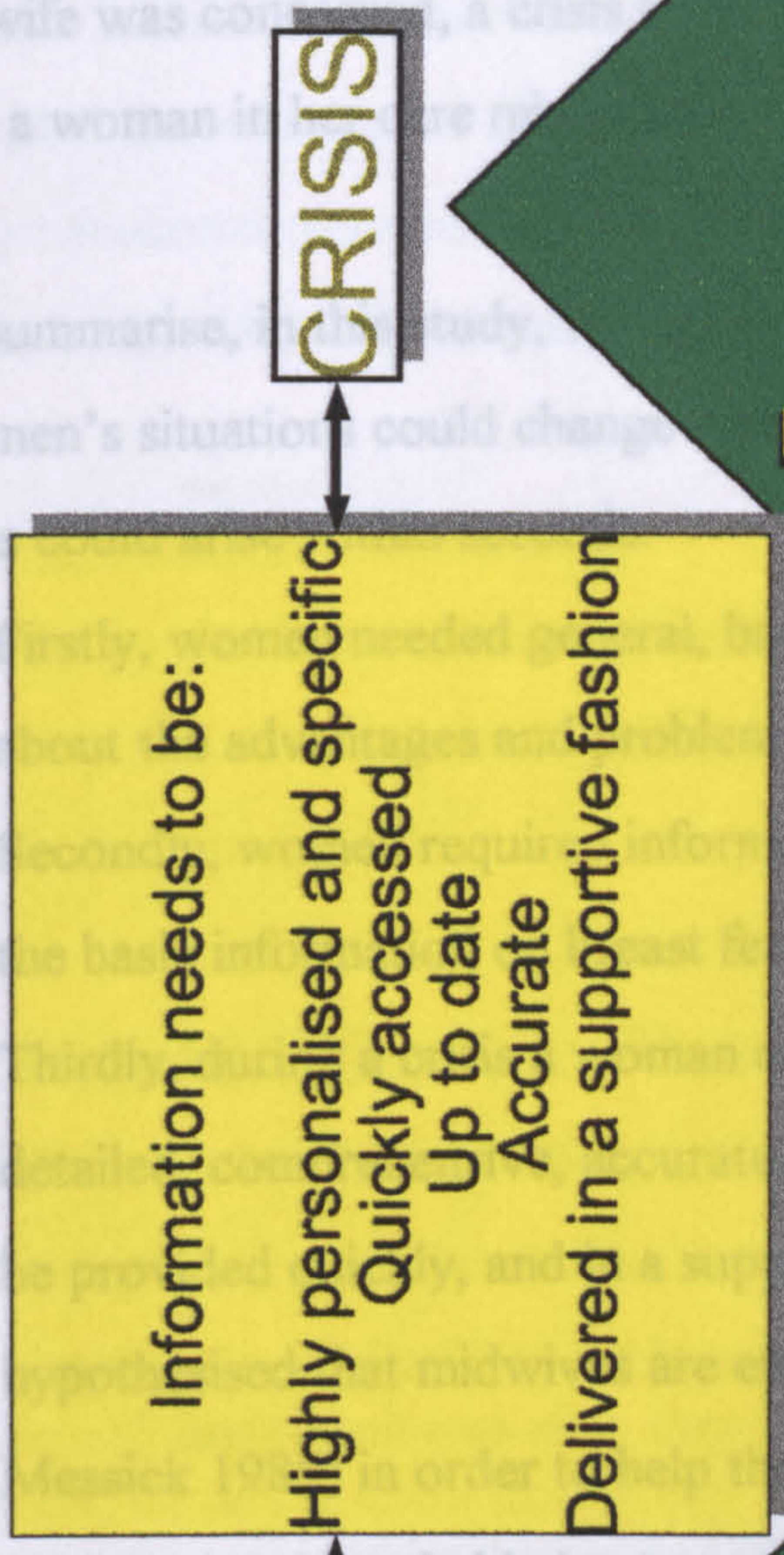
In WG's case, although she had asked for specific information from midwives and others, she was unsuccessful because the health professionals were not available to talk to her, and pharmacists were reluctant to advise her, probably because of legal reasons. In WG's eyes, this was a crisis as she was desperate to know what drugs she could safely take so as not to harm the baby, but she recognised that this was not a crisis to the people from whom she sought help.

What is a crisis to a woman may not be perceived as a crisis to the midwife or others. For example, a midwife would probably regard an abnormal triple test as a legitimate crisis, but not WG's situation. Both share similar characteristics, however. WA's and WB's crises involved possible diagnoses of fetal abnormality that would have many implications. WG's crisis involved a need to take medication that would not lead to a fetal abnormality. WG had the option of not taking any medication but that would have prolonged her physical discomfort and she wanted that resolved. WA had no discomfort but could take no action at that point, but needed information to discover the implication of the possible fetal abnormality so she could determine future action. WG needed information so she could take immediate action. The control to resolve WA's crisis did not rest primarily with her, but upon the outcome of the scan, which turned out to be normal. Resolving WG's crisis, however, turned out to be within her power, given some advice from the professionals.

There is an abundance of evidence that women are poorly informed on issues that may lead to later crisis, in particular, fetal screening tests (for example, Rothman 1986; Smith and Marteau 1995) and that their anxieties regarding these issues are poorly addressed (for example, Green, Statham and Snowdon 1993; Stenberg 1996). Several midwives in this study expressed to me their concern that women should be well informed and should not proceed with screening tests without knowing exactly what the implications were. Even if women (for example, Woman B) were well aware that proceeding with the tests could indicate the likelihood of fetal abnormality, the information they then required was as described above; any preparation or information they had received previously was not likely to be sufficient to guide them through the crisis.



Figure 6.4: Levels of information required, particularly in a crisis



For example, suspected fetal abnormality

For example, fulminating pre-eclampsia

Intermediate: focussed upon the needs of individuals but may be spread over a period of time

Basic information: fundamental knowledge regarding pregnancy and childbirth



Although there are no empirical data to support this observation, it is my experience that the perception of crisis sometimes may be on the part of the midwife and not the woman. For example, a midwife may believe it is vital that the woman with a dangerously high blood pressure is admitted immediately, but the woman may feel quite well and refuse to be admitted; she does not perceive any crisis. In this case, the midwife would normally provide the information that would raise awareness on the part of the woman that, as far as the midwife was concerned, a crisis existed. A midwife would be likely to have the power to do this; a woman in her care might not.

To summarise, in this study, women needed information at various levels (Figure 6.4).

Women's situations could change rapidly; for instance, during the process of fetal screening crisis could arise within seconds.

- Firstly, women needed general, basic information of relevance to most, for example, about the advantages and problems of breast feeding, or the signs of the onset of labour.
  - Secondly, women required information that was more personalised, for example, how the basic information on breast feeding would apply to them.
  - Thirdly, during a crisis a woman required information that was personal to her situation, detailed, comprehensive, accurate, up to date and consistent. This information needed to be provided quickly, and in a supportive manner. By providing this information it is hypothesised that midwives are enabled to intervene therapeutically (Aguilera and Messick 1986) in order to help the woman and her family through the crisis.
- Information is probably best provided during a crisis by one-to-one contact with a knowledgeable, trusted midwife (or other health professional). Books and leaflets are of little use as they tend to become outdated and lack specificity.

#### **6.4. Contextualising information**

Having obtained information, the woman then needed to process, or contextualise, it. When contextualising information, women considered the information provided by midwives in terms of its perceived validity, together with its meaning to themselves as individuals



possessing unique circumstances, attitudes and priorities. Two processes were involved, as follows.

- Legitimizing, that is, checking the information, and the person providing it
- Personalising the information in terms of its value and applicability to the individual woman.

#### 6.4.1. Legitimizing

Women assessed the trustworthiness of the information, and also of the professional who provided the information (Figure 6.5). These two processes of checking the information and the professional were interactive and mutually reinforcing, but will be discussed as separate issues in the following sections. Discussion of trust will be continued in Chapter 7.

##### 6.4.1.1. Checking information

In order to check the trustworthiness of information, women assessed it in terms of its accuracy and completeness. This last was considered to assess whether a full, or selective, picture had been given.

Accuracy of the information The accuracy of information was judged by its perceived up-to-datedness, authoritativeness, specificity, consistency with information from other sources, and congruency with the woman's own experiences and views:

*WB But (the Consultant) told me I'd have to have a spina bifida test, I'd have to have an amnio, but (the specialist unit) don't do amnios now, they do a deep scan and you don't have to go through that, she said 'Oh, we don't believe in that now' which, you know, you feel that you're in more modern, more capable, more technological hands when you're talked to like that*

*WB But it's all probabilities, it wasn't certainties, but they were so positive at (specialist unit), they said this is a conclusive test for the Down's test, and the spina bifida is just a small one, and they were just more positive and up to date - they made me feel that at (Hospital A) they were a little bit behind the times....*

*VL What do you think of the books the GP's given you?*

*WG Pretty good, I must say they're pretty good, as detailed as they can be, you know, I think they're OK. Anything that's concerning me in there, you know, I think I didn't know about that, generally I knew a lot of it, but it's just a sort of official authoritative stamp on it.*

The scope of information WA and her husband were distrustful of the information they were given because recently they had been given information they knew was incomplete:



**Figure 6.5** Assessing truth and developing trust

Husband A And really, we didn't know what it was all about. I mean, I had to ask the question,

wasn't offered, and I had to say there is a chance, isn't there - 'Oh yes, there is' and that should be volunteered because we could have said yes to it prior to knowing that percentage chance.

and:

Husband B I was like the anxious mess - it was a risk connected with the fact that I wasn't

trusting. I had to ask for that, I'd read in a book there is a 10% chance of a complication

to me. I was like, 'There's a 10% chance of a complication' and I was like, 'There's a 10% chance

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**LEGITIMATING:**  
Trust

Context-  
ualising  
information

**INFORMATION:**  
Up to date  
Authoritative  
Comprehensive  
Consistent  
Congruent with  
own views etc  
Specific  
Predictive

**PERSON  
PROVIDING  
INFORMATION:**  
Expert  
Committed  
to woman  
Positive  
approach

**PERSONALISING:**  
Assessing  
costs/benefits  
of possible  
actions  
Maintaining  
equilibrium

Information was also just... woman's past experience... VL What's influenced you... WE I think for the baby... on, and I think it's just... all those bottles and every... When the woman had no... of popular opinion could... removed from her the resp... wrong.



*Husband A And really, we didn't know what it was all about. I mean, I had to ask the question, when we went back, about the amniocentesis, I had to ask if there was a chance of miscarriage - it wasn't offered, and I had to say there is a chance, isn't there - 'Oh yes, there is' and that should be volunteered because we could have said yes to it, someone else could have said yes to it prior to knowing that percentage chance.*

and:

*Husband A ... questions like the amniocentesis - there is a risk connected with that, it wasn't volunteered to me and I had to ask for that, I'd read in a book there is a risk. All that information should be volunteered ... I did have to ask a lot of questions*

*WA We were given information, but we had to ask for it ... to make that particular decision there wasn't enough information*

*VL And you need that information to know what questions to ask?*

*WA Exactly.*

Consistency of information. Information was considered more trustworthy if there was agreement between different sources. For example, WE had previously read about episiotomies, and when the midwife said she needed an episiotomy the explanation the midwife gave coincided with what she had read. WE said she had readily agreed to an episiotomy, and that she had trusted the midwife.

The trustworthiness of the information was confirmed if the outcome it suggested materialised. WB described an occasion when the expected outcome suggested by the books she had been given did not materialise:

*WB ... But when I read some of the books they were completely different to how things really are. I mean the CVS scan it said you will find out in 2 weeks, whereas we found out in 24 hours. And then there's other things about the CVS that's different to the books.*

Information was also judged in relation to its credibility, that is, its congruency with the woman's past experience, beliefs or popular opinion. WE decided to breast feed again:

*VL What's influenced you to make that decision?*

*WE I think for the baby to get that first milk is really important, with all those antibodies and so on, and I think it's just easier, when you first come home you don't want to be messing about with all those bottles and everything.*

When the woman had no previous experience upon which to base a judgement, the weight of popular opinion could influence her. Not only did WK trust popular opinion, it also removed from her the responsibility for having to make a decision that could turn out to be wrong:



WK *I would rather have things the way it is supposed to be with the majority, if you like. It is like all these choices you are given about having the children immunised and that, and then 30 years later they find something wrong with the vaccination. You have got to do what the majority do at the time, haven't you, and risk getting it, in case you might get something else, but what do you do? I think you have to do things when they are available and when the rest of them do if you like. If that makes sense to you?*

VL *Yes. Is there any other sort of reason behind that?*

WK *I suppose it stops you having to make the decision doesn't it? It stops us having to make that decision at the time. Yes I suppose it does, really, of course if you think about it*

VL *What has influenced you to cut it down to one (alcoholic drinks per day)*

WD *Well, everybody says so, don't they?*

Thus, information was assessed in terms of its accuracy and scope. Information was trusted that appeared up to date, specific, authoritative, consistent and congruent with women's experience and views. Their trust in the information was directly influenced by their trust in the person who provided it, and this was assessed in several ways.

6.4.1.2. Checking the individual Women assessed the trustworthiness of the midwives (and other professionals) who provided information, and helped them make choices. As Page wrote:

*'When we give birth we must be able to trust the people who care for us ... to honour our self and our family integrity, and our individual needs..' (Page 1991:9)*

And Pask stated:

*'... only when trust exists between patients and their nurses will information that is necessary for sound caring be communicated..' (Pask 1995: 190)*

Women assessed how far they could trust midwives to provide accurate and complete information, taking into account the perceived expertise of the midwife together with her commitment to the interests of the woman.

Expertise. Recognition of midwives and other health professionals as 'experts' engendered trust:

WI *Oh yes, I tend to have confidence in them, they would not recommend something unless it were for your benefit.*

although WH acknowledged that it would be she who made decisions she would be guided by 'experts':

WH *....I know that at the end of the day it is my decision but obviously they are the experts and I would depend on their advice as to which way I went.*



Woman C provided an example of a negative case in that the midwife did not know certain information, and yet she continued to trust the midwife, rationalising her lack of information. This woman and midwife knew each other well, however, as they worked together in the same Health Centre. It is hypothesised that the trusting relationship already formed was strong enough to withstand the midwife not knowing the information; indeed, the midwife did not hesitate to acknowledge that she did not know, demonstrating a mutual trust wherein she felt sufficiently secure to admit to this:

*WC But I am surprised, although I suppose they can't - that the midwife didn't actually know. I thought she might have more of an idea - that's why I mentioned I didn't know. But then not everyone is the same case are they, everybody's different, there's a lot of information to store up there -*

Commitment and attitude Women trusted professionals (and the information they provided) whom they felt had taken time and trouble, and whose attitude they perceived as positive and caring:

*WA Yes - you could see everything - it didn't look any different to us, but he could see everything. Obviously a lot of time was spent over it, instead of a quick 5 minutes in a normal scan.*

*WB I mean, after I'd seen you, Mr XX (Consultant) said 'You pays your money and takes your choice', and really he didn't tell us much, but when we went to (Specialist unit) he (Consultant there) explained everything to us and really, he told us too much in a way, but it was nice - and the enthusiasm was there, whereas I was told there was a 1 in 64 chance of having a Down's syndrome, whereas (Consultant at specialist unit) said 'Oh well, you've got to think you've got a 70 chance of having a healthy baby' - it was a more positive attitude, and things could be got over ....*

To summarise, when contextualising information, women had first to assess its validity. Trust was a central concept; both trust of the information and trust of the person delivering it. Trusting the information and the person providing it were intertwined and mutually reinforcing phenomena as demonstrated in Figure 6.5.

#### 6.4.2. Personalising

Having legitimated the information, it was then interpreted in the light of the woman's own circumstances and beliefs, according to its congruency with the woman's situation. The more specific the information, the easier it was to personalise. It was often helpful to



discuss issues on a one to one basis with a midwife, since she would help the woman to personalise information:

*VL. Could you tell me why you prefer to go to your midwife rather than read it?*

*WI. It's just that you can have a conversation about it, whereas in a book its just written there, and that's it, you know, whereas you can discuss it when you are with the midwife ... the book can never be for an individual can it? Whereas when I go and see her she can tell me exactly for myself*

The more specific the information, the easier it was to personalise. For example WG was adamant that she would not wish to risk having a baby with Down's syndrome or spina bifida, and she regarded the usual 'cut off' point of a 1 in 250 risk as unduly high and would have considered an amniocentesis at a 1 in 1000 risk if she had been allowed to have done so:

*WG ... So that is something I feel we ought to know a little bit more about ... I would like to know what that risk is, and assess that risk, and even on that I would say that even 1 in 1000 I wouldn't mind having that test ... I mean the more information you have, knowledge is a good thing, and the more information we have the better ...*

Dealing in probabilities rather than certainties could give rise to worry as it was then difficult to make decisions based only upon probabilities:

*Husband A Because the accuracy of the test is only 65%, it caused us so much worry that we know now wasn't really necessary.*

WG was concerned about putting on excess weight and had asked the midwife how much weight women normally gained in pregnancy. She did not find the reply sufficiently specific, and continued to worry:

*WG It was vague, I felt, very vague. There doesn't seem to be any answer to it really, it's 'Oh well, don't worry about that, the doctors won't worry about the weight' and then one nurse did a quick calculation about weight and height and said 'oh well, you're OK, you're within the limits, otherwise we'd give you a blood sugar test, don't worry about that' - but I still am concerned about it ... I would like someone to say to me 'in general, this is how much ladies do put on'.*

Information was needed so that women could assess the implications of various situations to their lifestyle. As mentioned in 6.2, situations that would upset the equilibrium of many women and their families would not affect others, but legitimated information was needed in order to judge the possible effects. A major issue was that of possible fetal abnormality. For example, WA and WB were thought to be at higher than normal risk of having a baby with spina bifida and Down's syndrome respectively. Both wished to learn more about the implications of having children with these problems, but found the information difficult to



come by. The little information they possessed was insufficient for them to personalise this. Consequently, they were unable to come to an informed choice regarding possible courses of action:

*WB ... as I say, no-one really talked to us about Down's syndrome ... I have seen Down's syndrome children but I've never talked to them or had anything to do with them.*

Informed choice could involve making decisions that would fundamentally change the woman's lifestyle in ways that she did not desire, thus upsetting her equilibrium. For example, WJ did not wish to stop smoking, despite the efforts of Midwife J to influence her to stop (see 5.4.1.1). She weighed up the information the midwife provided regarding the dangers of smoking in pregnancy against the difficulties of stopping smoking, and rationalised her decision to reduce smoking and not stop entirely. The reasons she gave for her decision were as follows :

1. Information between sources was inconsistent

*WJ I know it says about cot death, but I had not realised that until I read it on the board in the hospital, because all it says in the books really is that you risk having a smaller baby. It does not really say a lot, it does not say about cot deaths, and it doesn't really say about chest infections or anything like that*

2. Relatives and she had smoked in pregnancy with no apparent adverse effects to the baby

*WJ ... my auntie had a baby last year and she was 37, it was her fourth child and my mum has always smoked, and I think I have gone like them. My mum said she smoked throughout her pregnancy. She said she smoked more in pregnancy than she did before, and I think well there was nothing wrong with me, there was nothing wrong with my brother and there is nothing wrong with (daughter). She was born in August of last year and she has not had anything wrong with her since she has been born. Maybe she has been lucky and maybe I have been lucky and maybe my brother has been lucky I know there is a lot of people that smoke and they don't just give up when they get pregnant.*

3. She did not think her baby would be affected; it did not seem personal to her.

*VL. So the midwife gave you all the information, but you don't really -*

*WJ. No - I could well believe it causes miscarriages and even causes cot deaths but I don't - I don't know, maybe it is you probably think it won't happen to you. I won't say I disbelieve it but it does not really make me think 'Oh God, I have got to stop smoking'.*

*VL. It is not personal for you?*

*WJ. No*

4. Any damage had already been done before she realised she was pregnant.

*WJ ... it says the damage that is going to be done to your baby usually happens within the first month, my first reaction was - well the damage has already been done.*



5. She had reduced her smoking

WJ *As I say I have cut down from about 20 to about 10, I can't seem to get it any lower than that and sometimes it is a bit over that.*

6. If she really thought there was a danger she would stop

WJ *... if someone said to me your baby is going to die say, in a week if you don't stop, then I would*

The Health Belief Model was adapted by Becker (1974) to explain and predict *'health related behaviour, at the level of individual decision making'* (Mikhail, 1981:65). Processes in this model concern the individual's perception of the outcome of a particular behaviour in terms of the outcome's likelihood of occurring and its severity, the strength of the relationship between the behaviour and the outcome, and the perceived costs and benefits of taking action to prevent the outcome. Midwife J was explicit regarding the possible outcomes of WJ's behaviour (that is, smoking cigarettes). The following passage of transcript is repeated from 5.5.1.1:

MJ (speaking to WJ who admitted to smoking 10 cigarettes a day) *It is important, not only for your own health, but you're much more likely to miscarry, you're more at risk of the baby not growing well, you're more at risk of going into labour earlier than usual, and after the baby's born you're more at risk of the baby having ear infections, chest infections, that sort of thing, and also from cot death .... there's also some recent research about miscarriages that if you're expecting a girl child her fertility may be affected too, and she will be more likely to miscarry if her mother smokes.*

Excerpts 1, 2 and 3 indicate that WJ is not convinced of the outcomes, or their severity.

Midwife J felt strongly that women should not smoke during pregnancy, and may be considered to have used 'scare tactics' (as discussed in 5.4.1.1) in order to influence WJ to stop smoking. As Mikhail wrote:

*'The threat can be counterproductive if other negative feelings (such as anger or high anxiety) are aroused or if ways to reduce the threat are not available or are seen as ineffective. Fear arousal does not necessarily lead to belief or behaviour change in the direction intended ... fear messages may motivate avoidance behaviour or denial rather than control of the danger if the person lacks the knowledge of ... coping with the threat or believes that coping may incur a high cost.'* (Mikhail 1981: 74)

WJ indicated that Midwife J's strategy was unsuccessful, saying that she knew smoking cigarettes was not good for her or the baby, but she still intended to smoke, and there was little the midwife could have said that would have altered her decision. She wished the topic



need not be raised as it only served to embarrass her, but realised doctors and midwives had to raise the issue as that was their job:

WJ. ... the dreaded question either when you go to the doctors or like now when they say do you smoke? Because it is something that a lot of people are trying to ban, I feel really awkward about it - I would not say I feel embarrassed, but I feel it is more of a taboo subject. I don't really want to discuss it, you know, because when doctors ask you about smoking and they say you should not be smoking it makes you feel small. I have found that with the doctors and, like my mum has said, you feel as if you are being naughty for smoking because most doctors are anti smokers.

VL. So what did you want from the midwife regarding smoking?

WJ. Nothing really, I would rather have not discussed it, but I know they have got to do their job. I know they have got to ask me, but it is a question that I feel awkward talking about. I knew she would say 'you know you should not smoke, you know this is what is going to happen'

VL. What would you like from her assuming you had to discuss this?

WJ (Pause) Well, there is nothing that she could have said to me that would have made me stop smoking, so there is nothing that I think she could have said to me that would have made any difference.

VL. Is there anything she could have said that would have been better?

WJ. Not really, like I said, I don't think you can feel better about smoking you probably just do it and I know there are a lot of adverts on telly now about stopping smoking. I think in the back of my mind, I think in the back of most people's minds that smoke, it is wrong to smoke, you know that really but you just cannot help doing it. So really, I don't think there is anything that she could have said that would have made me feel better or the other way.

In excerpt 4, WJ noted that if damage is to occur, it would already have happened, so in her view it was not now worth stopping smoking; the costs outweighed the benefits. She compromised, however, by reducing the number of cigarettes she smoked each day, and claimed to be prepared to stop altogether if she thought the baby was in serious danger. As demonstrated by WJ, it is hypothesised that health related behaviours are influenced strongly by the need to maintain equilibrium; behaviours are only likely to change if the outcome of such behaviours is perceived to pose more of a threat to equilibrium than the change of behaviour.

To summarise the category Contextualising, women assessed the truth of, and personalised, the information. Trust was an important issue. During a situation of crisis the availability of trustworthy and highly personalised information was extremely desirable.



## **6.5 Actioning**

One of the tenets of good midwifery practice is that women should be enabled to express their wishes (for example, DoH 1993). Indeed, Woman E emphasised the importance of women stating what they wanted:

*WE I wouldn't like to go into labour without filling one in (a birth plan). Because I think a lot of people don't fill them in and then they complain but they've never said in the first place what they want.*

The substantive category, Actioning, describes the processes women followed when, having obtained and contextualised information, they retained or relinquished control of their decision making. Women did not always find that stating or achieving their wishes was easy; issues related to power affected the strategies women employed when stating and implementing their choices. Women assessed their power to state and implement their wishes in terms of

- **Conferred power.** This related to the power of the woman to make choices, conferred upon her by the professionals (mainly the midwife although others such as obstetricians were also involved). Whether power was conferred upon the woman depended upon the attitudes of the individual midwives and the system within which they worked (5.2.2).
- **Assumed power.** Women would assume power by virtue of their knowledge of the issues they were making decisions about, and their perceptions of their status within the system.

Depending upon their perception of the degree of power conferred upon them, together with the degree of power they assumed (that is, the conditions) women pursued various strategies when actually communicating or implementing their decisions (Table 6.1). The following sections will discuss the strategies women employed.

### **6.5.1. Asserting**

When asserting, women openly expressed their preferences. Women appreciated both being able to express their wishes and feeling that these were genuinely heeded. The attitude of midwives affected women's ability to communicate their wishes. Women appeared to feel more able to assert their opinions to midwives who provided information freely, and



encouraged questions (thus conferring power upon the woman to make and communicate her decisions).

Midwives who encouraged women to choose, and were friendly and personal in their approach were considered to facilitate choice. For example, Woman F felt able to express her decision to bottle feed, as Midwife F did not pressurise her into saying she would breast feed, and remained supportive:

*MF Have you decided yet how you would like to feed this baby? Have you had any thoughts on this?*

*WF It will be bottle again*

*MF We couldn't persuade you the other way?*

*WF No*

*MF That's all right, we'll support you whichever way you feed the baby*

**Table 6.1 Matrix: Strategies for Actioning**

**Strategies.**

	<b>Asserting</b>	<b>Playing the game</b>	<b>Handing over</b>	<b>Taking it as it comes</b>
<b>Conditions.</b>				
<b>Power conferred</b>	√	-	√ or -	√
<b>Power assumed</b>	√	√	-	-

Woman F, in the follow up interview, said she was 'adamant' about bottle feeding:

*WF ... they do try to persuade you to try breast feeding to see how you get on, but if you're absolutely adamant they leave you*

It is hypothesised that it was the supportive attitude of the midwife that enabled WF to insist upon what she wanted, and that if the midwife had been unsupportive, or disapproving, the woman would have been likely to resort to alternative tactics (for example, 'playing the game': 6.5.2). No women in this study overtly challenged or confronted the midwife, but it



is hypothesised that confrontation could be an alternative strategy, used under specific conditions not encountered in this study.

Woman H felt that she had a real choice about what happened to her. The midwife caused her to feel in control by her supportive attitude, and by asking for permission to carry out various examinations:

*WH ... the midwife asked me every step of the way if I minded if they did certain things and even asked my permission to take my blood pressure ... they are asking permission to do something to you rather than just assume that they have a right to do it. It is the same when she explained with all the tests that at the end of the day that it is my decision and that these tests were being offered to me that I was under no obligation whatsoever to have them. It made me feel that she cared about me as a person rather than just another number, do you know what I mean? It was a more personal approach definitely.*

Women often appreciated knowing the midwives caring for them, and felt more able to express their wishes. It is hypothesised that feeling 'at home with' the midwife removed the aura of authority from the midwife that may have inhibited women from expressing their needs:

*WF ... you get the choice ... They are with you there all the time. I can't speak highly enough of them.*

*VL So are you saying because you know the midwives it is easier to say what you would like?*

*WF Yes, I think it is. You feel more at home with them, more at ease with them, you can say what you think and what you want.*

*WE you're not pushed at all ... it was very good ... the people were so friendly, you'd think you'd known them years.*

Women needed to feel they had sufficient information upon which to base a safe choice.

Safety and normality were of the essence:

*WL ... if everything is fine and normal I would want to decide myself*

*WC But if it isn't going to damage you or the baby in any way I think it should be your decision, and not theirs.*

*WL I like to decide unless there is some complication ...*

If safety was threatened, women tended to defer to medical opinion (see 6.4.2 & 3) Women needed to know what choices were available:

*WA There's not much point making my mind up now that I want sky blue pink rooms and things, if I can't have that sort of thing - I have to find out my choices first.*



To summarise, the part played by midwives was crucial; if their attitude was friendly and supportive women felt more able to ask for information, trust that information and the person giving it, and to express their wishes.

### 6.5.2. Playing the game

If the midwife's attitude did not facilitate choice, women were on the whole reluctant to expose themselves to confrontation, or to risk upsetting the midwife. As Woman 4 said, one way to get around this was to 'play the game', which involved keeping quiet about her true intention until she was able to implement it.

*W4 To a large extent you have to play along, play the game, because they are in control. They have means of getting you to do what they want sooner or later, they can wear you down, so you might as well go along with them as far as possible, then make your stand.*

Woman 3 said she liked to make her own decisions. For example, she was adamant about bottle feeding, despite feeling pressurised by midwives telling her about breast feeding and all its advantages. She said she would avoid confrontation though, '*just going her own way and won't do it*'.

Women were quick to pick up cues from the midwife regarding whether she approved or not of their wishes, and decided upon their tactics accordingly:

*WB I felt as if there was censure in her voice when she said 'it is your decision' as if - you know, I think there's a lot of pressure on women to breast feed, and you're made to feel a horrible person if you don't ... But as I say I don't like to upset people so I'll probably say I'll think about it and then do my own thing - the cowards way out! ... I'd probably make half promises - I'm a sort of person that I don't like to upset people and I usually try to be agreeable just to get out of it - I'm not a one to shout my opinions, 'no I'm sticking to that, it's none of your business', I'm just not that sort. I'd probably agree with them, and do my own thing afterwards.*

Although it was a long time ahead, Woman G asked the midwife if the baby could be removed from her the first night after delivery:

*WG ... there's nothing callous in that, I know I will be better with the baby if I can have some sleep, and we're not allowed to do that, I was a bit upset about that. She looked a bit odd at me when I asked that as if to say goodness me, what have we got here, you know, so that's something I'm a bit disappointed about, but nevertheless ...*

WG dropped the issue at that point, but said she intended to pursue it again at a later date, with a different midwife, who would perhaps be more sympathetic.



In a paper concerning patient non-compliance, Donovan and Blake noted that

*'...patients are not, on the whole, passive or powerless ... they are quite capable of making choices about treatments and lifestyles rationally within the contexts of their beliefs, responsibilities and preferences. These choices draw on the information at their disposal which can be quite different from that available to medical staff. (Non-compliance) may thus ... be reasoned decision-making.'* (Donovan and Blake 1992: 508)

In a small grounded theory of the involvement of medical patients in their care, Waterworth and Luker (1990) noted that some patients were more concerned with pleasing the nurse rather than with actively participating in decisions. In this study, women wished to please the midwife but maintaining their equilibrium in many instances took priority. The notion of 'playing the game' accords with my own experience in that, in order to avoid invasive fetal monitoring, women I know have delayed coming to the delivery suite until too advanced in labour for that to happen. These women were not prepared to confront 'the establishment' who supported these policies of monitoring; they assessed the safety or otherwise of their actions and used their power to implement their decisions. Women often appeared reluctant to openly challenge health care professionals (this issue is explored further towards the end of Chapter 7 when the overarching theme of trust is discussed). For example, Woman E simply did not return to a dentist whose treatment she was not happy with:

*WE I had about 6 injections just for 1 tooth, and I thought at the time I wasn't very pleased he was giving me all that.*

*VL Were you able to say anything about it at the time?*

*WE Not really, I'm not the sort to speak up, I just didn't go after that.*

This would cause little problem, however; it is easy to change dentists without having to provide any explanation. It may not be so easy to change midwives, especially if a system of team midwifery or 'named midwife' is in operation, or if the woman is booked with a midwife as the lead professional:

*'A woman with an uncomplicated pregnancy should, if she wishes, be able to book with a midwife as the lead professional for the entire episode of care including delivery in a general hospital.'* (DoH 1993: 2.4)

The woman may not have had the opportunity to get to know the midwife well before choosing her as the lead professional. If she later wished to change her mind, it might not be possible to do without a perceived risk of confronting the midwife.



'Playing the game' could involve risks to the safety of the woman and her baby, however. Women needed to feel sufficiently knowledgeable to make a safe decision. If women perceived a threat to safety, they were more likely to listen to, and accept the advice of, midwives and doctors, as discussed in the next section.

### 6.5.3. Taking it as it comes

Where safety was at risk, women preferred to discuss with, listen to, be guided by and negotiate with midwives and other professionals whom they trusted. Even if power was conferred upon them, if they did not feel they had sufficient knowledge to make a safe decision they did not assume power, preferring to be guided by midwives and others, although retaining ultimate control over the decision making:

*WC I mean obviously you've got to listen - they are the experts, aren't they, and you're really in their hands a little bit, aren't you, I mean they are - but they're really only looking after your welfare-*

*WK I have learned an awful lot through what I have gone through, obviously, but - yes, so I would rather be one of those that is advised what to do, it does not mean I would stick by them but I would listen and I would ask questions*

*VL But if need be, you'd be happy for the midwife to make the decision?*

*WE Yes.*

*VL Would you expect the midwife to discuss it with you first, or just to go ahead and do it?*

*WE To discuss it first, the midwife discussed it first. She said I was going to tear badly, and she thought it would be best to - do that (episiotomy).*

*VL Yes, was there a lot of time to discuss it?*

*WE Yes, long enough for me to think whether I wanted it or not. They weren't rushing me to think about it.*

*W4 Choice is very important ... I need to feel in control, although I will be guided by professionals, especially those I trust' .... You're in their hands, aren't you, they're the experts.*

### 6.5.4. Handing over

Women tended to hand over decision making to professionals in an emergency during which the safety of themselves or their babies was threatened, and when there was no time to discuss or negotiate. This was easier if the women trusted those caring for her; indeed it is hypothesised that handing over would be difficult if the woman did not trust her attendants:



*WH. Like I say no one knows what is going to happen when they give birth whether things are going to go right or not. I would rather just leave it in the hands of the experts and if anything goes wrong they know what they are going to do at the time and that's it.*

Woman 1 rejected the option of assuming power under certain conditions, saying that she would prefer decisions related to emergencies and problems in labour to be made by doctors and midwives:

*W1 ....as they have the knowledge. Not everyone is capable of making their own decisions, if the doctor has to judge whether a person is capable of deciding that puts another burden on him or her.*

Woman D took a somewhat fatalistic view that 'what would be, would be' and that decisions regarding labour should be left in the hands of 'the experts' as they had the knowledge:

*VL What about this baby - you say you don't mind having a Cesarean - would you actually choose to have one?*

*WD If I had the choice, I think I would (laughs). I'm not one for pain. And I've been through that experience, you know.*

*VL Would you actually consider asking for one?*

*WD No, no I'd do what I'm told really.*

*VL Why would that be?*

*WD I think it's because I think what will be, will be.*

In non-emergency situations women were sometimes reluctant to make a stand for what they wanted, and accepted the midwife's views, particularly if the attitude of the midwife was not supportive and power was not conferred upon the woman. Sometimes the general stress of labour disconcerted the woman, with the consequence that any assumed power was relinquished:

*WB ... you're given all these choices but at the same time if something goes different it will all be different from what you wanted at the time. I had a preconceived idea that I'd be able to walk up and down labour ward or squat and do whatever I liked, but I felt I had to lie on that bed and not move and they'd see to me when the time was right ...*

*WJ as soon as you go into labour it just goes out the window because you don't really care what they do, you just want to get it over with*

Non-conferment of power could be a very subtle process, perhaps involving only minimal verbal or non-verbal clues. For example Woman G, a farmer's wife, had tentatively requested a screening test for toxoplasmosis. Although Midwife G offered the test to WG,



she indicated (fairly subtly) that she probably did not need it done - only if she was worried about it:

*MG Toxoplasmosis screening is something we do on request, if someone has cats, handling cat litter daily, or is worried about it, we could certainly do the test, but we don't do it routinely.*

*WG Right*

*MG Do you have a cat?*

*WG I do, but it doesn't have litter, we live on a farm - I wouldn't know if I'd got it, would I? I wouldn't have any symptoms?*

*MG The symptoms of toxoplasmosis, they're a bit like 'flu symptoms. I think quite a large proportion of the public have antibodies against this - but no, we don't do it routinely. If you want it done, just say, and we'll do it.*

Woman G said later that she felt she could not proceed with the test as she had been made to feel rather silly worrying about toxoplasmosis. (She and I did, however, have a lengthy discussion about toxoplasmosis and how to avoid it, after the follow up interview):

*VL You did sound as though you really wanted to have that test.*

*WG Yes. I mean I would have quite liked to, but I felt a bit silly -*

*VL And that put you off?*

*WG I thought the nurse (sic) - she didn't seem to take it particularly seriously, I didn't think, or didn't seem to think it would be a problem so I thought oh well, I'm being a bit silly here. And just because I've seen it on the TV, I'm being a bit paranoid.*

Woman B was reluctant to confront 'authority figures', and would either 'play the game' (as described above, or would hand over control of her decision making:

*WB I tend to think they know best and you should really go along with what they say. I imagine them to like the old matron type in hospital, you know, their word is law and you go along with whatever they say, even though you want something different you go along with them.*

Handing over in this way was perceived to have various outcomes. Woman B took a rather cynical view of opportunities for true choice and saw 'handing over' as a consequence of manipulation by professionals:

*WB I suppose you can be a bit sceptical now thinking that all these modern things you can do, but once you get down to it you're in their power and if you don't want something they'll say it's dangerous for the baby if you don't do what we say, so you'll get all your choices taken away. I suppose in a way you think it sounds good but wait until the actual time and it will probably be different.*

whereas handing over (that is, compliance) was seen by Woman C as a strategy for influencing midwives and doctors to like her, and grant 'favours':



WC ... a lot of it has got to do with attitude from the mother, you know. ... Well I'm pretty easy going I think. ... they still left us pretty much on our own until the last few minutes, which was nice, I mean we didn't actually request that although it was nice, and then when I was being stitched up the doctor said 'Well at least I'm doing you and not the one up the road' because she'd screamed and screamed, ... there was no rushing (partner) away, he was there and they made us a cup of tea,

VL And you feel that might not have happened if you'd been more pushy?

WC Probably, yes, I think they'd have thought 'well lets get this one out', you know ... if you tend to be a bit boisterous, or a bit pushy, they think 'well I'm not going to bother with her'. And I wouldn't want that, and I'm not like that

VL And do you feel that that sort of attitude during pregnancy can also help develop a relationship with the midwives?

WC Yes, I do. Yes. The way Dr X introduced me to midwife X - he said to her 'This is the other nice lady I was meaning to tell you about'. And I thought 'That's nice, they introduce you as a nice lady' (laughs).

To summarise, the category Actioning concerned the strategies women used to convey and implement the choices they made. The attitudes of professionals, together with issues of power, were important here, and these will be discussed further in the following Chapter.

## **6.6 Summary**

When making informed choices during pregnancy, women were concerned with Maintaining the Equilibrium of themselves and their families. Maintaining Equilibrium was identified as the core category to which all the other categories in the framework contributed. Women required information to make the choices that would best preserve their equilibrium and employed a variety of strategies to acquire, process and operationalise this information. Information at different levels of personalisation and detail was required depending upon the situation. For example, during a crisis the quality of information and its provision was particularly important.

A major source of information was the midwife and mutual trust facilitated the provision and acceptance of information. Midwives and the women they cared for were located within power hierarchies which influenced the way in which information was provided and used. These overarching issues of power and trust are explored in the following Chapter.



## **Part 3**

### **Discussion of the study and its findings**

In this final section the findings of the study and their implications for practice are discussed in Chapter 7. Chapter 8 describes my experience and evaluation of the study.



## **CHAPTER 7**

### **DISCUSSION AND SUMMARY OF FINDINGS**

#### **7:1 Introduction**

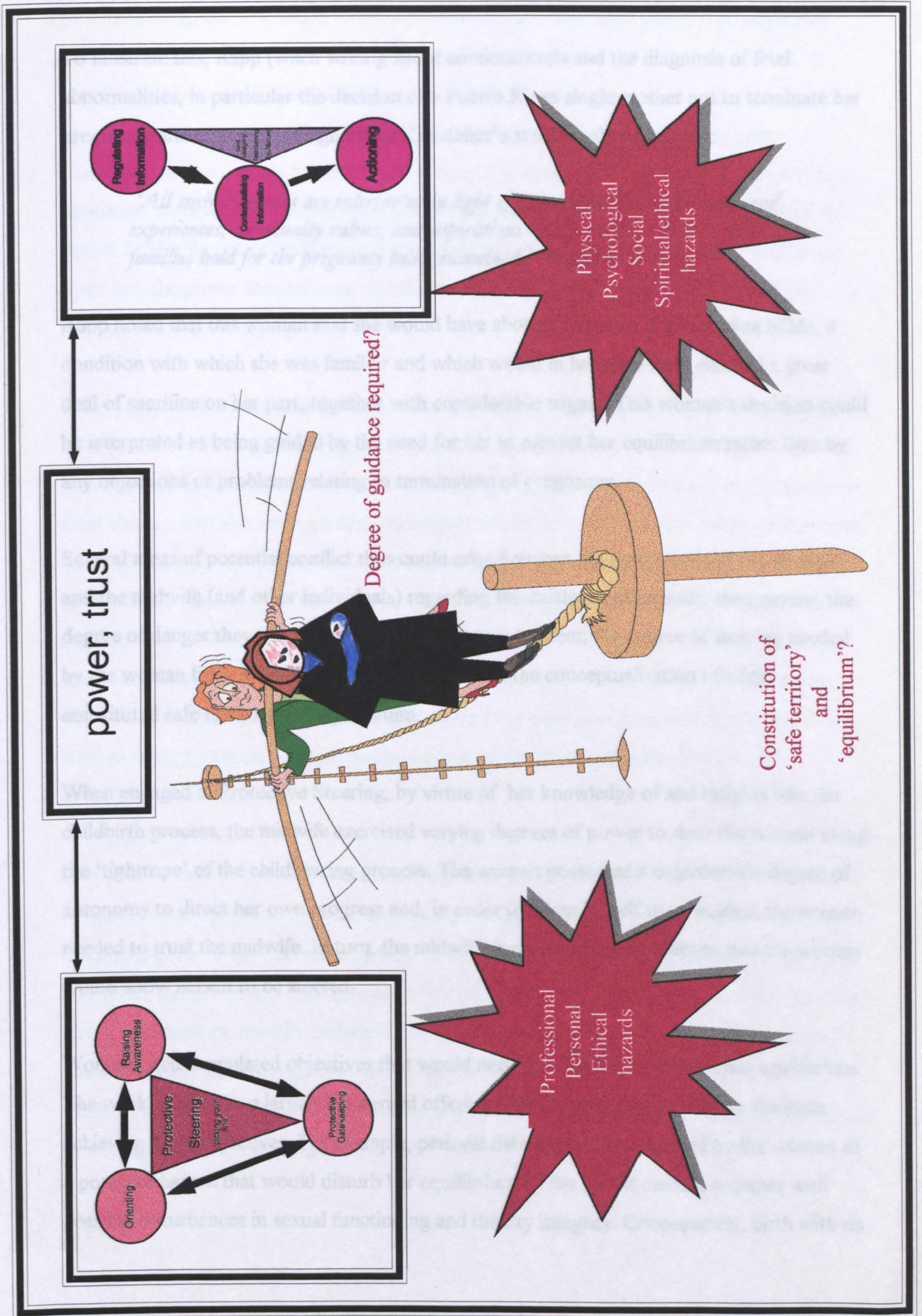
The intention of this Chapter is to integrate Chapters 5 and 6, which have described the theoretical frameworks arising from data provided by midwives and the women in their care when facilitating and making informed choices during pregnancy. Issues pertaining to the individual frameworks have been discussed in these Chapters. The overarching issues common to the midwives' and the women's frameworks will be discussed in this Chapter, together with implications for midwifery practice.

The core categories in the midwives and women's frameworks were, respectively, Protective Steering and Maintaining Equilibrium. The overarching core category was identified as 'Balancing: Walking a Tightrope' (Figure 7:1). In making informed choices, women's purpose was to maintain the equilibrium of their lives, and the lives of those close to them. The metaphorical tightrope (that is, the childbirth process) that women walked spanned potential physical, psychological, social and spiritual and ethical hazards, and women utilised midwives' knowledge and skills to help them avoid or minimise these dangers. When engaged in Protective Steering, midwives attempted to guide women along the 'tightrope', steering them away from hazards. There was no guarantee, however, that the midwives and women would perceive the same hazards, or the same degree of danger. Midwives could lose balance themselves and fall prey to problems concerning professional, personal and ethical issues, and so took measures to protect themselves as well as the women in their care. Some women were perceived by the midwife as needing considerable steering and guidance; they were seen as negotiating the 'tightrope' blindfolded with little appreciation of what lay ahead. Other women were perceived as needing less guidance. It was not assured that the midwife's perception of the degree of guidance required would agree with that of the woman.

Successful negotiation of the 'tightrope' resulted in the woman landing on safe territory, her equilibrium intact; the midwife guiding her to this destiny whilst preserving her own integrity. Notions of what comprised 'safe territory' and 'equilibrium' could however differ.



Figure 7.1 **Balancing: Walking a Tightrope**





To illustrate this, Rapp (when writing about amniocentesis and the diagnosis of fetal abnormalities, in particular the decision of a Puerto Rican single mother not to terminate her pregnancy after a prenatal diagnosis of Klinefelter's syndrome) pointed out:

*'All such diagnoses are interpreted in light of prior reproductive histories and experiences, community values, and aspirations that particular women and their families hold for the pregnancy being examined.'* Rapp 1993: 69).

Rapp noted that this woman said she would have aborted the fetus if it had spina bifida, a condition with which she was familiar and which would in her view have entailed a great deal of sacrifice on her part, together with considerable stigma. This woman's decision could be interpreted as being guided by the need for her to protect her equilibrium rather than by any objections or problems relating to termination of pregnancy.

Several areas of potential conflict thus could arise between the perceptions of the woman and the midwife (and other individuals) regarding the existence of hazards; their nature; the degree of danger they posed; the risk of falling prey to them; the degree of steering needed by the woman from the midwife to avoid them; and the conceptualisation of what constituted safe territory and equilibrium.

When engaged in Protective Steering, by virtue of her knowledge of and insights into the childbirth process, the midwife exercised varying degrees of power to steer the woman along the 'tightrope' of the childbearing process. The woman possessed a considerable degree of autonomy to direct her own progress and, in order to allow herself to be guided, the woman needed to trust the midwife. In turn, the midwife needed to have confidence that the woman would allow herself to be steered.

Women often formulated objectives that would need to be achieved to maintain equilibrium. The work of midwives largely concerned offering their knowledge and skills to facilitate achieving these objectives. For example, perineal damage may be regarded by the woman as a potential hazard that would disturb her equilibrium by the pain it caused, together with possible disturbances in sexual functioning and urinary integrity. Consequently, birth with no



perineal damage may be aimed for, and the midwife may teach the woman techniques of perineal massage with various oils to try to achieve this. Beisecker (1990) wrote that by supplying services others demand a person establishes power over them, and a way to attain power is to provide needed benefits that others cannot easily do without. By virtue of possessing the knowledge needed by the woman a midwife is in a position of power, able to choose to share or withhold her knowledge. As demonstrated in Chapter 5, the midwife's choice of sharing or withholding information depended largely upon the power conferred upon her, the power she assumed, and the degree of control she imposed (for whatever reason) when 'gatekeeping' information.

Unless they are in a powerful position socio-economically or cognitively, women may not be able to carry through their plans for pregnancy and birth if these plans are in conflict with those of their attendants or with institutional policies. Similarly, midwives may be unable to meet the needs of women regarding knowledge of certain policies if they are in conflict with those of more powerful individuals and organisations. Hence, issues of power are central in the facilitation and making of informed choices. Midwives possessed power to help, support and educate women, and consequently possessed power over women. The organisations and dominant groups with which many midwives worked possessed power over midwives, and power to affect the interests of midwives and the women in their care. Midwives and women were, however, by no means powerless within these hierarchies and in their interactions with each other.

This Chapter will discuss the overarching issues of power, and trust between midwife and woman. Wright (1986:136) noted that '*Power, to many nurses, is almost a dirty word*'. This Chapter argues for the acknowledgement of power structures in maternity care situations as inevitable, and potentially desirable and enabling. In previous Chapters, strategies have been described which are used by midwives and the women in their care that may circumvent (or collude with) more powerful or even oppressive behaviour of individuals and institutions. These strategies are considered in relation to theories of power, especially those propounded by Foucault and, to a lesser extent, Lukes.



Much of the recent literature advocates 'woman (or client) centered care' (for example, Fraser 1995). Satisfactory definitions of 'woman centered care' are sparse, but imply a sharing of power between the midwife and woman whereby women are empowered as partners in their care. The term may be considered to belong to the language of consumerism, and patient participation in care. Concepts related to empowerment will be considered in relation to the power structures identified within the midwives' and women's frameworks. The findings of this study will be discussed in relation to existing theories in order to support the findings; apart from this there is no intention to use existing theories as data.

## **7.2 Conceptualisations of Power**

Over the past several decades many different definitions and concepts of power have been offered. Only the most relevant will be cited here, in order to illustrate the move from conceptualisations of 'power over' towards ideas regarding the emancipatory possibilities of power. Tawney (1931) stated that power is the capacity of individuals to modify the conduct of others in the manner desired and to prevent their own conduct from being modified in an undesirable manner. Weber (1947) defined power as the probability that persons within a social relationship will be able to carry out their will despite resistance. These older definitions imply conflict in getting one's own way by the imposition of personal power and will. From the 1950's onwards, definitions tended to conceptualise power as less involved with direct conflict but as being more collaborative (and possibly manipulative). For example, French and Raven (1959) differentiated between reward, coercive, legitimate, referent and expert power. Reward and coercive power implied that the dominant person exerted some form of influence over another person and was thus able to impose his or her will, whereas legitimate, referent and expert power implied that the dominant person was accorded that position voluntarily by the other person, who wished to conform to, learn from, or otherwise benefit from the knowledge or power of the dominant individual.

Mills (1958) differentiated between three forms of power:

*'Authority (power that is justified by the beliefs of the voluntarily obedient), and manipulation (power that is wielded unbeknown to the powerless) ... along with coercion...'* (Mills, 1958 29-41).



Parsons (1960) pointed out that definitions of power were limited by failure to express the social necessity of power, and regarded the use of medical power as conferred by society to reflect society's notions of what constituted proper behaviour (Parsons 1967). He criticised Mills' conceptualisation of power as follows:

*'To Mills power is not a facility for the performance of a function in, and on behalf of, the society as a system, but is interpreted exclusively as a facility for getting what one group, the holders of power, wants by preventing another group, the 'outs' from getting what it wants.'* (Parsons, 1960: 220)

Parsons introduced the term 'zero sum power' to reflect situations where, in using power, one individual gained at another's expense. He considered that this view restricted the conceptualisation of power as serving exclusively sectional interests and suggested instead power relationships from which both sides might gain. As Flammang wrote:

*'... power denotes a zero-sum game of domination, control and denial; ... suggest reformulations, where power means interpersonal relations of reciprocity, ability and energy.'* (Flammang 1994: 178)

In the 1970s conceptualisations of power placed more emphasis on possibilities for shared power. For example, May (1972) identified five categories of power; exploitive, a destructive form of power exemplified by slavery; manipulative, enabled by another person's anxiety or desperation; competitive, the use of power against that of another person; nutrient, such as the power of a parent that protects the child; and integrative, or co-operative power, which could be interpreted as a forerunner to ideas of emancipatory empowerment.

Lukes (1974) pointed out that current definitions of power were two-dimensional, focusing upon power as always involving conflict. The first of these dimensions concerned the power of a dominant group (or individual) to impose its own wishes and views upon another less dominant group. The second dimension related to control of what could and could not be discussed, and the decisions that were able to be made, or not made. He suggested a third dimension to account for the avoidance of conflict, that is, the power to manipulate the less dominant group into believing that the interests of the dominant group were also their



interests, even though they may have been actually harmful. These three dimensions of power have some relevance to this present study and will be referred to below.

During the 1970s and 80s Michel Foucault published his work on the nature of power and its relationship to knowledge and truth. The work of Foucault will be drawn upon heavily in the following sections of the Chapter.

Claus and Bailey (1977) wrote that whatever the definition of power, it involves three major elements; strength (or ability) involving a strong sense of self; energy - that of oneself and the ability to harness the energy of others; and action (Young and Haynes, 1988).

Conceptualisations of power as a positive force that could be enabling and shared continued to be developed during the 1970s and 1980s. Morriss (1987) classified power as 'power over' or 'power to', and in the early 1980s Rappaport coined the term 'empowerment' (Rappaport 1981). The concept of empowerment has been written about extensively in the nursing literature, for example, Hokanson Hawks, in an analysis of the concept of power within a nursing context provided an interpretation of power based upon 'power to', as

*'... the actual or potential ability or capacity to achieve objectives through an interpersonal process in which the goals and means to achieve the goals are mutually established and worked toward.'* (Hokanson Hawks 1991:760)

Issues relating to empowerment identified in this study will be addressed later in this Chapter.

### 7.2.1. Power as a normalising influence: surveillance

Writers, notably Foucault, have discussed the power of various bodies and individuals to exert power to influence, and 'normalise' social behaviour. For example, Foucault (1977) wrote that individuals scrutinise other individuals in a constant appraisal of what others are doing. This scrutiny, which Foucault (1977) termed the 'gaze', is directed particularly upon matters of societal concern (such as procreation). Foucault described the recognition during the Industrial Revolution of the importance of the individual 'docile' body. Biopower (a term coined by Hewitt in 1982) came to be focused upon individual 'bodies', surveilling and disciplining individuals and groups in order that they may be organised to contribute to social production and social service:



*'The human body was entering a machinery of power that explores it, breaks it down and rearranges it. A 'political anatomy' which was also a 'mechanics of power' was being born; it defined how one may have a hold over others' bodies, not only so that they may do what one wishes, but so that they may operate as one wishes, with the techniques, the speed and the efficiency that one determines. Thus discipline produces subjected and practised bodies, 'docile' bodies.'* (Foucault 1977:138)

Sawicki pointed out that biopower is a highly effective as well as invasive form of social control and succinctly describes the first major form of biopower, disciplinary power:

*'...as a knowledge of and power over the individual body - its capacities, gestures, movements, location and behaviours. Disciplinary practices represent the body as a machine. They aim to render the individual both more powerful, productive, useful and docile. They are located within institutions such as hospitals ... also at the microlevel of society in the everyday activities and habits of individuals. They secure their hold not through the threat of violence ... but by creating desires, attaching individuals to specific identities and establishing norms against which ... behaviours and bodies are judged and against which they police themselves.'* (Sawicki 1991:67&8)

Singer applied the concept of disciplinary power to women's bodies:

*'The well managed (woman's) body of the 80's is constructed so as to be even more multifunctional than its predecessors. It is a body that can be used for wage, labour, sex, reproduction, mothering, spectacle, exercise, or even invisibility as the situation demands.'* (Singer 1990:138&9)

An example of a manifestation of the 'docile body' may be found in studies by Kirkham (1989) and Hunt and Symonds (1995). Kirkham studied how information was given by midwives to women in labour. Information giving was impeded by an oppressive, 'high-tech' environment in which the midwife perceived a need to exert control and thus provided only limited information, and the woman felt controlled and consequently felt inhibited in requesting information. It may be interpreted that the woman and the midwife were thus rendered 'docile' by investing them with identities prescribed by the institution and society; that is, of compliant patient and subservient employee. Kirkham found that information-giving was facilitated by the woman and midwife being from similar social backgrounds, and an environment that was unoppressive and conducive to information exchange, in which the woman felt able to ask for information, and the midwife able to supply it. In these situations women felt more able to make choices.



Seligman's theory of learned helplessness could be relevant here (Seligman 1975); midwives and women may learn from experience that there is very little they can do to avoid giving or receiving an undesired intervention and so, believing that any action they may take is futile, may passively acquiesce to giving or receiving the intervention. For example, in a study of 'routine' artificial rupture of membranes during labour, Henderson (1990) found that midwives were often required by labour ward policy to rupture membranes at a certain degree of cervical dilatation (although there was no good evidence to suggest this was of any benefit). Henderson (1990:53) noted that midwives mostly acquiesced with this requirement, as did women in labour who demonstrated *a 'passive acceptance which probably served to reinforce the practices'*. Seligman's theory of learned helplessness is resonant with Foucault's notion of 'disciplinary power' whereby the 'body' is made 'docile'. Seligman also noted that helplessness often could be unlearned by encouraging responses in the 'helpless' individual (Seligman 1990: 28). During my interviews with women during pregnancy I did not encounter any who appeared to be acting in the 'helpless' manner described by Seligman, that is, apathetic, passive and acquiescent. This is not to suggest that women exhibiting the features of 'learned helplessness' do not exist, but rather it was my experience in this study that women in pregnancy would appear to be acquiescent for reasons more to do with their preferred style of non-confrontation than with feelings of helplessness. The climate of consumerism currently prevailing would certainly encourage responses from women regarding their care (Richardson and Bray 1987) and this observation could provide a partial explanation why 'helplessness' did not seem to be an issue during pregnancy. That women were far from helpless is demonstrated by the strategies they used to circumvent unwanted interventions; but they could only use these strategies if they felt they had the information to guide their actions (see Table 6.1). The purpose of this study, however, was to focus upon making and facilitating informed choices during pregnancy and data related to labour was only gathered if it was offered by the participants. During labour the situation regarding helplessness may have been different, although it appeared that acquiescence to unwanted interventions (for example, having to stay in bed, as reported by Woman B) was related more to temporary feelings of loss of power and disorientation, due to



- being in a strange, 'high-tech' environment
- subjected to a highly specialised body of knowledge not shared by the woman
- dominance of medical staff and midwives
- the importance of the outcome (that is, not risking the health of the baby, or the woman herself).
- acknowledgement by the woman of the commitment and investment already made in terms of her trust of the midwives and medical staff
- demonstration of this trust, by compliance with the protocols of the labour ward.

These suggestions are very tentative, however, and more study of the processes of informed decision making specifically in various labour settings is required.

Hunt and Symonds noted in their ethnographic study of a hospital labour ward that few women were given choice by the midwives but appeared rather as

*'... compliant passengers in the birth process ... they had little knowledge in order to make choices and few opportunities existed to increase their knowledge ... the midwives were kind but were part of a system which for much of the time controlled their actions. It would be easy to assume that these women were content with their care. There were apparently few complaints and clearly limited knowledge of what could have been. Realistic choice depends on having sufficient information on the alternatives that are actually available.'* (Hunt and Symonds 1995:147).

Disciplinary power thus renders individuals compliant and their bodies 'docile' and productive; they do not cause trouble to those in power. Instead of force, compliance is achieved by creating desires and norms, which guide behaviour towards their attainment.

Regulatory power is the second form of biopower, imposed by the government to scrutinise the demographics of, for example, birth, death and health. Foucault maintains that certain functions of the 'body' have been considered to be of too much social importance to be left to chance and that consequently the procreation, health, and education of the population is subjected to intense central (that is, government) scrutiny and control. Foucault uses the concept of Bentham's 'panopticon' as facilitating this scrutiny by illuminating the actions of all individuals and groups involved. (Foucault 1980:146-165). The panopticon was a central tower from which individuals, imprisoned and segregated in illuminated compartments, could be surveilled by someone in authority. This was a one-way surveillance; the authority



figure could not be seen by the others but would have knowledge of those others. Only the person in authority would be able to see the whole picture, and could choose which aspects of the picture to reveal.

The metaphor of the panopticon may be applied to many situations, including that of maternity care. For example, enabled by their professional knowledge and experience, midwives were able to perceive a more or less complete picture of the probable course of the pregnancy and childbirth, once they had sensitised to the woman and her needs during the process of Orienting. Thus, the midwives framework assumed a circular structure. Women could normally see only one part of the picture, however, unless they were unusually well informed, and it is hypothesised that even then it would be difficult for them to perceive the whole course of likely events. Although there is little published evidence to support this observation, childbearing midwives, obstetricians and paediatricians are frequently heard to comment that most of their knowledge seems to disappear when they, themselves, are in labour. Even if the women had personal experience of childbirth, situations new to them could arise. It appeared that certain information had to be assimilated before they could see the next part of the process, or picture, with any degree of clarity. Thus, their framework assumed a longitudinal structure. It may be argued that individual women were situated within their own panopticon which oversaw their personal life and this view was not available to anyone else. In this case, the 'panopticon' would exist across dimensions of time, the woman having exclusive views of her past life and experience and also a view of what her future would (or could) hold. Possibly (and this is suggested extremely tentatively) the apparent loss, or disorientation, related to knowledge experienced by childbearing health professionals is influenced by difficulties in switching between two panopticons, both possessing a normalising function, but one of which is static in time, whereas the other extends over time.

In addition to this central scrutiny, individuals were held by Foucault to be involved in continuous scrutiny of each other. This is termed the 'normalising gaze', whereby the actions of individuals, and 'bodies', are continually reappraised. Thus, by the 'gaze', individuals have power over others by, to some extent, controlling and normalising others'



behaviour. The 'gaze' may take the form of direct observation, examination of the body, examination of knowledge and the keeping of documentary evidence:

*'The examination that places individuals in a field of surveillance also situates them in a network of writing; it engages them in a whole mass of documents that capture and fix them. The procedures of examination were accompanied at the same time by a system of intense registration and of documentary accumulation.'* (Foucault 1977:189)

By means of the panopticon and the 'gaze', the actions of individuals thereby became visible to those in authority. It is this visibility, and consequent vulnerability, of the individual that enables power to be exercised. Foucault noted that certain societal functions were crucial in nurturing the health, education and above all, the procreation of the population. For example, one of these concerns sexual functioning:

*'I believe that the political significance of the problem of sex is due to the fact that sex is located at the point of intersection of the discipline of the body and the control of the population.'* (Foucault 1980:125)

If one substitutes 'childbirth' for 'sex', then issues of power and the control of childbirth take a central position in the Foucaultian view of politico-social power. Women during pregnancy and labour - together with their attendants - are subjected to an intense 'gaze'. Arney wrote:

*'...obstetrics located childbirth in a wider social order and subjected it to the power of a structure that creates birth in a field of visibility.'* (Arney 1982:88)

Women's bodies and their functions are examined at predetermined, frequent intervals during the childbearing process by, for example, abdominal palpation, urine and blood pressure testing; the fetus is examined by ultrasound, amniocentesis and fetal monitors. As Arney (1982) describes, these 'bodies' are subjected to the 'normalising gaze', and deviations from the 'normal' are corrected back onto the pathway of the 'normal' trajectory. The 'gaze' is self-perpetuating; surveillance leads to more surveillance. Oliver, Rajan, Turner and Oakley quote a letter from a consultant obstetrician regarding the importance of routine ultrasound in diagnosing a twin pregnancy:

*'They (MIDIRS leaflets on routine ultrasound) also quote there is no known health advantages (sic) to the babies or their mothers in knowing about twins and I would dispute this as this allows us to give higher doses of Folic Acid for better placental development and*



*also increases surveillance and monitoring for the rest of the pregnancy.’ (Oliver et al 1996: 34)*

Midwives and other attendants are not exempted from ‘the gaze’; they are required to demonstrate by examination the adequacy of their professional knowledge and skills, and are required to keep extensive records of their care. Although no evidence can be cited, it is suggested that power may be manifested by not keeping records. For example, anecdotal evidence points to junior medical staff, midwives and nurses being required to maintain detailed records of the care they provide and yet senior medical staff who exert considerable power often appear to keep minimal records of their care; the Consultant may write a line whereas more junior staff write pages.

The ubiquity of ‘the gaze’ may also be demonstrated by the way many hospital labour and other wards are organised to allow little privacy for the woman and her midwife. For example, medical and other staff often enter the room where the woman is labouring with no more than a cursory knock on the door (and frequently not even that). Or medical and midwifery staff may, without giving warning or being granted permission, enter drawn curtains around a bed where the woman may be breast feeding or engaged in some other activity for which she requires privacy. Whether or not an intimate procedure such as a vaginal examination or perineal examination is interrupted, this intrusive action asserts dominance by relegating the woman and her midwife as subject to ‘the gaze’ of the more powerful individual.

Although the topic of self assessment and monitoring is an extensive one and its exploration is outside the scope of this study, it is worth noting the growing awareness of the effect of individual’s gaze upon themselves. For example, the UKCC’s recent requirements for evidence of professional updating (implying competence to continue practice) take the form of portfolios and reflective journals rather than written and oral examinations overseen directly by those in authority (ENB 1991; UKCC 1995).

By constant examination and surveillance, deviation by childbearing women or their attendants from accepted, rule-governed behaviour (Hayes 1989) is thereby made visible to



the 'gaze'. For example, the case of Wendy Savage, a feminist obstetrician suspended from practice following accusations of malpractice by her (male) peers, attracted much publicity in the mid 1980's. These accusations of malpractice related to Ms Savage's non-interventionist approach to obstetric practice, which was contrary to the interventionist approaches adopted by her obstetrician colleagues (Pratten 1990). Following a long public enquiry during which evidence to support Ms Savage's practice was given by patients, midwives and other (particularly feminist) groups, Ms Savage was eventually exonerated and reinstated. This enquiry represented an occasion when the 'the gaze' was directed upon the practice of obstetrics and, to some extent, 'renormalised' in that an alternative 'normal' trajectory of non-interventionist practice was adopted in addition to that concerning interventionist practice. Over the past several years considerable effort has been expended by feminist and other groups including consumer groups (for example, the Association for Improvements in Maternity Services), professional groups (for example, the Association of Radical Midwives) as well as individuals to strengthen this 'alternative' trajectory and to redefine childbirth in terms of normality instead of potential pathology.

The relevance of the 'gaze' to midwifery practice may be demonstrated in this study by an example from a situation described in 5:2:2:4. Midwife A said that she would not 'tread upon toes' (that is, of the community staff) by suggesting to a woman that she should consider a home birth, but would not hesitate to transfer the woman home early to be cared for by community staff. It is hypothesised that there is a hierarchy of work in midwifery, influenced, or perhaps reinforced, by the intensity of the public perception of the relative importance of, for instance, the intrapartum and postpartum periods. It is hypothesised that the attention accorded to labour by the media confers, by the intensity of the media 'gaze', an importance that exceeds other aspects of care in childbirth, such as postnatal care. These hypotheses arose from Midwife A's comments that if a woman was delivered in hospital, the hospital staff (together with the woman) could specify to the community staff when she would be returning home for postnatal care, and yet Midwife A felt unable to commit the community staff to the 'work' of caring for the woman in labour. It appeared that whoever did the 'higher order work' - that is, delivering the woman, had the right to prescribe where the 'lower order work' of post natal care should take place. (5.2.2.4). This perception may be influenced by the preponderance of technology surrounding intrapartum care, compared



with that in postnatal care, or - and more likely - it is the 'gaze' that reflects the interest in intrapartum events that has led to the technological control.

### 7.2.2. Power as a positive force

Power is sometimes assumed to be a negative, destructive force (for example, Wright 1986). The notion of power as a benevolent and necessary force is emphasised by scholars such as Lukes, Zola, Maseide and Starr, whose views will be outlined below. Lukes (1978) wrote of the social benefit of power, and described it as a potentially collective achievement whereby all may gain. Foucault (1980:125) also wrote that power structures are necessary for social functioning. He described the nature of power as having changed from mediaeval to modern times, becoming focused upon production by individuals for service to society, rather than to a sovereign or feudal overlords. He noted that power is exercised in order to obtain productive service from people in their everyday lives, and should be viewed as a positive force, producing rather than excluding and repressing:

*'We must cease once and for all to describe the effects of power in negative terms ... In fact, power produces; it produces reality; it produces domains of objects and rituals of truth. The individual and the knowledge that may be gained of him belong to this production ...'* (Foucault 1977:194)

Maseide (1991), a medical sociologist, argued for the status quo by supporting the concept and practice of power within medical hierarchies as a positive force, writing that without power medical practitioners cannot function adequately. Maseide deplored the neglect of consideration of the structural necessity for power in medical practice, pointing out that arguments that patients are victims of medical sovereignty tend to be influenced by (in his view) unhelpful Marxist or Weberian ideologies. He suggested instead that a Foucaultian, poststructuralist approach might provide useful insights, in which power is considered as a positive force that assists proper medical functioning. Maseide acknowledged the power of medical practitioners, referring to Zola (1972), who considered medical power to be more effective in 'normalising' social behaviour than religion or the legal system. Turner described how the medical profession has taken over from the clergy the role of regulating normal social relationships:

*'Through preventive medical regimens, we are encouraged to jog, to diet, to rest, to avoid stress and to manage our sexuality in the interests of social normality.'* (Turner 1987:219)



Power structures and influences change over time. For example, Starr (1982) pointed out that medical power, conferred by society, is being to some extent replaced by other forms of power, notably corporate power. (Starr was writing about medicine in North America, but it is suggested that the same trends may be seen in the United Kingdom). In other words, social behaviour is more likely to be influenced by advertising and other manifestations of corporate presence than by the power of the medical profession which he considered to be diminishing. Under the influence of consumerism, the delivery of health services is viewed by many individuals as a service for which they pay (directly or indirectly) and for which they demand value for money. The fallibility of health service professionals is widely recognised and in this study was often expressed by women in terms of trust and distrust of midwives and doctors (which will be discussed further in 7.3). Women rarely appeared to accept with blind faith the information and recommendations of midwives and doctors, as can be seen within the framework (Figure 6.1). For example, women adopted various strategies to circumvent midwifery (and medical) power; their compliance with the advice or wishes of the midwife (or doctor) was by no means inevitable. At the same time women were reluctant to overtly challenge the power of the midwife and it is suggested that this may represent reflections of what was accepted behaviour some years ago when medical advice was perhaps heeded more than today and the power of paternalistic, dominant groups more apparent. Scambler (1987) noted that the terms 'patient compliance' reveals a medical bias in that, although physicians (and presumably other health professionals) may fail to fulfil the expectations of patients and clients, they are not described as 'non-compliant'; this term is reserved exclusively for the less powerful, client group who are expected to comply with the directions of the more powerful group; failure to comply would possibly result in confrontation. It is well documented that the interactional style of women tends not to be confrontational but conciliatory (for example, Tannen 1992). The category 'Playing the Game' illustrates this phenomenon when, in order to avoid conflict, women appeared to comply with the midwife's advice when in fact they (the women) followed their own choices. It is highly unlikely that this is a new phenomenon, there is evidence to suggest that women have long 'Played the Game', thus enabling themselves to Maintain Equilibrium whilst avoiding confrontation. For example, in the early part of this century in England, women were usually advised to rest following childbirth. This was impossible for many



women who had large families to care for and little money. Whilst promising the midwife they would rest, in order to Maintain the Equilibrium of their family they would quickly return to heavy housework - sometimes within hours of delivery (Llewelyn Davies 1978). Whether this action really did serve the longer term interests of the woman's family is of course questionable, because by acting to Maintain Equilibrium in the short term the woman would often seriously compromise her health and with it, her future family nurturing capabilities.

### 7.2.3. Power, knowledge and truth

The following sections of this Chapter relate the events observed and stories recounted to Lukes' conceptualisation of power, which provides a useful three dimensional framework within which to locate and explain these events and stories. According to the first dimension of power (Lukes 1974) individuals have the power to make decisions against the preferences of others. In this study, dominant groups such as doctors and managers had power to institute policies that midwives were expected to abide by. For example, a powerful Consultant Obstetrician formulated a policy that all the women in her care should be given prophylactic iron tablets and Midwife G felt powerless to directly confront the Consultant, or overtly advise Woman G not to take them, although she believed it to be true (from various research studies) that the routine, prophylactic administration of iron tablets in pregnancy was at best unnecessary, and at worst, harmful. The midwife's 'truth' was suppressed by that of the more powerful individual. Interestingly, the Consultant changed her policy shortly afterwards. Even though the Consultant was probably considering changing the policy at the time Midwife G was advising Woman G, Midwife G felt that it was *'not her place'* to challenge the more powerful figure.

Midwife J used her power to coerce a woman into a specific course of action that would accord with the midwife's perception of 'truth'. Her concern for the physical safety of the woman and her baby took precedence over the possibility of frightening her, when advising the woman about the dangers of smoking cigarettes during pregnancy. The midwife's power as a professional enabled her to impose her own 'truth' upon the woman, reflected by her emphasis upon certain topics and her control of the agenda, the actual information given,



and her style of imparting the information. These events illustrates how the 'truth' of a more powerful group may be imposed upon that of the less powerful group. Such imposition may be extremely subtle, as when midwives influenced women's choices by giving clues to their desired behaviour. For example, Midwife A implied her approval of Woman A proceeding with fetal screening tests by signalling the 'routine' nature of the tests and the likelihood of a normal result (6:3:3).

Many writers have related knowledge to the distribution of power in society, maintaining that it is the dominant, powerful groups who define what can be accepted as knowledge. The values and norms of the dominant group become accepted as the 'right' ones within society, and those of the oppressed group are suppressed. The 'waterbirth' case described in 1.4.2 illustrates this point. As Roberts wrote

*'More important, dominant groups not only define themselves, but situations and other groups as well.'* (Roberts 1995:296)

In discussing the history of the medical subordination of women's bodies and their sexuality, Ehrenreich and English (1973) describe the suppression of village 'wise women' and their knowledge about childbirth. These 'wise women' were persecuted as witches, their knowledge replaced by medical knowledge, and their practice largely taken over by men. As a result of this action, women themselves may come to perceive their knowledge as inferior; midwives may consider their midwifery knowledge as inferior to medical (male-constructed) knowledge; pregnant women may consider their knowledge of their own bodies inferior to the knowledge of the midwife.

Power, knowledge and truth are inextricably linked by Foucault (for example, 1980), who regards knowledge as culturally determined and mediated, cultural structures implying power relationships within which knowledge exists, and is accepted or rejected as 'truth'.

Foucault maintained that power mediates truth:

*'Truth isn't outside power, or lacking in power ... Each society has its regime of truth, its general politics of truth: that is, the types of discourse which it accepts and makes function as true; the mechanisms and instances which enable one to distinguish 'true' and 'false' statements; the means by which each is sanctioned; and the techniques and procedures accorded value in the acquisition of truth; the status of those who are charged with saying what counts as true.'* (Foucault 1980:131)



Relating this to how 'the way' of birth is determined, Jordan wrote:

*'... the physiology of birth is universally the same - yet parturition is accomplished in strikingly different ways by different groups of people ... In most societies, birth and the immediate postpartum period are considered a time of vulnerability ... In order to deal with this danger and the existential uncertainty associated with birth people tend to produce a set of internally consistent and mutually dependent practices and beliefs that are designed to manage the physiologically and socially problematic aspects of parturition in a way that makes sense in that particular cultural context. It is not surprising, therefore, that - whatever the details of a given birthing system - its practitioners will tend to see it as the best way, the right way, indeed the way to bring a child into the world.'* (Jordan 1993: 3-4)

#### 7.2.3.1. Hierarchy and oppression

In addition to her Midwives Rules (UKCC 1993), Code of Practice (UKCC 1994) and Guidelines for Professional Practice (1996) a midwife's practice is, to varying extents, dominated by the hierarchies and policies of the organisation within which she works. Health service organisations are frequently extremely hierarchical (Hugman, 1991: 53), dominated by medical consultants and senior managers. Nurses and midwives are often at the lower end of the hierarchy (Chavasse 1992), the midwifery structure itself possibly exhibiting some, if not all, of the features of an oppressed culture. Roberts argues that nursing may be seen as an oppressed group exhibiting some aspects of typical oppressed group behaviour, pointing out that the traditional values and norms of nursing have been suppressed by the values and norms of the medical model:

*'... warmth, nurturance and sensitivity have been viewed as negative when compared with those of the dominant (medical) culture, that is, intelligence, decisiveness, and lack of emotion.'* (Roberts 1983:27)

Friere (1970) described oppressed groups as being controlled and exploited by others possessing greater prestige, power and status. Gilbert (1995) advocated caution when using Friere's theories, however, pointing out that it is easy to overuse them, applying them to situations that perhaps do not really compare with the original source of Friere's theories, that is, uneducated, unenfranchised and exploited South American peasants. When considering midwives and pregnant women in the UK, although it is perhaps easy to



overstate the case for oppression, it is nevertheless useful to consider midwives and women within this framework, whilst bearing Gilbert's advice in mind.

In this study, midwives sometimes exhibited typical oppressed group behaviour as described by Roberts (1983). That is, midwives sometimes assumed that their skills were deficient when compared with those of medical staff, and felt unable to make decisions which would affect the more dominant group. For example, Midwife F's first reaction was that her knowledge and skills regarding counselling were insufficient and counselling would be better done by the GP. On reflection, however, she asserted that her skills in this respect were almost certainly superior to those of the GP, and that she was, after all, the right person to be counselling the women in her care.

Midwife L had been reprimanded in the past when making a decision that benefited the woman in her care but caused a problem to the anaesthetist, and she was consequently wary of repeating the same mistake. It is likely that if the situations were reversed and the anaesthetist had made a decision in the woman's best interests which inconvenienced the midwife, the midwife would have perceived little power to challenge the anaesthetist. Midwives, the less powerful group, avoided conflict with the dominant group, but employed alternative means to try to achieve their aims. Similarly, women tended to avoid direct conflict with midwives when making the choices they wanted, but instead used various tactics to get their way.

#### 7.2.3.2 Control of the agenda

Lukes' second dimension of power concerns the power to prevent certain issues being discussed and decisions made, by controlling the agenda of what may be discussed. Similarly to the first dimension of power, this second form of power was also considered by Lukes to involve conflict.

Mander (1993b) asked '*Who chooses the choices?*' Mander referred to the Winterton Report (DoH 1992: Paragraph 51), using their observation that '*choices available are often more illusory than real*' to argue that women may be offered certain choices freely, in order to try



to disguise the fact that other, possibly more important, choices are not available. The reasons for unavailability of choices (for example, place of delivery, choice of Consultant) may be logistical, due to lack of resources, or associated with maintaining the status quo, particularly of power relationships. Whether certain options are available depends thus less upon the wishes of women and more upon the needs and convenience of those controlling the maternity service. For example, Midwife 1 used her power to withhold information about water births (which were available within the unit in which she worked) because of her aesthetic objections towards delivering women in water. Lukes' second dimension of power was evident here whereby the agenda is controlled by the person in power, in order that the other person is not made aware of the possibilities open to them. There were many examples of this second dimension of power in the midwives data, when midwives controlled the agenda, and gatekept information. The substantive category named 'Protective Gatekeeping' exemplifies this second dimension of power. The use of power in these contexts could be benevolent, intended to protect the woman. When engaged in Protective Gatekeeping, midwives used their power to conceal or minimise issues that they thought would cause unnecessary worry or distress to women. For example, they were reluctant to give information the women could do nothing with. As one midwife said, she did not see the point of informing all Asian women about tests for Down's syndrome because if the tests were positive their religion forbade termination of pregnancy and they would not be able to do anything about it. This provides an example of the role of orienting to the woman's situation; in this case, by means of stereotyping, which was likely to lead to information being with-held. Alternatively, the use of Gatekeeping could be self-serving on the part of the midwife or the institution for which she worked. Water births were not available in one of the units and this issue was not raised, partly because, as the midwife remarked, it was pointless to talk about facilities which were not available, and also because she considered that raising awareness of a lack of facilities available in other hospitals would not be welcomed by the powerful hospital authorities. Whether her perception was correct is not known, but this illustrates the potential power of a dominant group to control the agenda by implicitly encouraging various sets of values and beliefs within the workforce which regulate and control their actions, thus (in this study) rendering the midwife as a guardian of the status quo. This is further exemplified by Midwife E's decision not to provide information about neonatal konakion because she believed that to do so would contravene



the values reflected in the policies of the antenatal clinic within which she worked. In their survey that evaluated the MIDIRS leaflets ('Informed choice leaflets on positions in labour, and routine ultrasound'), Oliver et al (1996) reported that midwives hoped the findings from the research would highlight the lack of facilities enabling women to deliver in a variety of positions. It is not made clear whether the midwives had asked previously for more facilities but had been refused, but they obviously felt that the published research findings would be more effective in producing more facilities than any request from themselves.

### 7.2.3.3 Power and manipulation

Lukes third dimension of power is a far more subtle/insidious form of exerting power. Three factors are involved. Firstly, there are the objective interests of the dominant group; secondly, the possibility of latent conflict as these are not likely to coincide with the interests of the other, subservient group, and thirdly the awareness that the collective forces of this other group could be harnessed to overturn the interests of the dominant group. Lukes pointed out that the first two dimensions of power were likely to concern conflict, the first dimension accounting for the direct imposition of the wishes of the more powerful group over the less powerful; the second dimension concerning controlling the agenda of what may be discussed and what decisions may be made. Lukes argued for this third dimension of power which accounts for the circumvention of conflict; instead, groups of people are manipulated into accepting policies as beneficial that may in fact be harmful to them. Alternatives to these policies are not suggested by the dominant group, instead the manipulated situation is presented as the natural way, the only way that should be considered (Gilbert 1995).

*'... he (sic) also exercises power over him by influencing, shaping or determining his very wants. Indeed, is it not the supreme exercise of power to get another or others to have the desires you want them to have?' (Lukes 1974: 23)*

As Cleland (1971) wrote, dominance is most complete when it is not even recognised. An example of this could be cited as the medicalisation of childbirth. Turner (1987) describes the subordination and control of women's bodies and sexuality by the medical profession. In the UK, and indeed throughout the developed world, obstetricians, usually male, have assumed control of childbirth. This has led to the suppression of women's (that is,



childbearing women together with their - usually female- midwives) knowledge, and power and control over their own childbirth and fertility (for example, Oakley 1984). A recent example of an attempt to suppress the dissemination of knowledge aimed at enabling women to make informed choices is provided by Oliver et al (1996). They reported considerable difficulties in piloting informed choice leaflets concerning routine ultrasound in pregnancy. Opposition to distributing the leaflets to pregnant women was encountered from health professionals (particularly ultrasonographers and obstetricians) when it was realised that the evidence-based information contained within the leaflet pointed out the risks and uncertainties of ultrasound. Oliver et al comment

*'It is clear from their responses that many issues are involved; the threat to non-evidence based practice posed by the systematising and dissemination of evidence; concern that women themselves will be upset to find out how little scientific medicine knows, and the thin relationship between knowledge and practice; opposition to moving the power base for decision-making from professionals to users; the argument that the social and psychological functions of a technology such as routine ultrasound offer more than 'simply' problem diagnosis and treatment, and that these covert functions need to be respected.'* (Oliver et al 1996: 59)

Turner noted that

*'..the medical profession and medical knowledge constitute women as patients whilst also subordinating those occupations which are dominated by women and rendering these paramedical groups into subordinate associations.'* (Turner 1987:132)

During the decades from the 1950s to the 1980s childbirth was almost completely taken over by the medical profession. As Wagner (1986) wrote this take-over was accomplished by several strategies, as follows: redefining childbirth in terms of medical problems to which only the medical profession had solutions, hospitalising birth, dominating and prescribing the limits of midwifery practice, retaining control over the prescription of drugs and the use of most technological instruments, controlling the distribution of research funds (and therefore the development and dissemination of knowledge), heavily influencing government policy on maternity care and, finally, convincing the government (and the general population) that only the medical profession were able to police their own activities.

During these years several medical myths (Old Men's Tales? - see Chapter 1) arose. One such myth was that hospital 'confinements' were safer than home births, even when



childbirth was normal (for example, Standing Maternity and Midwifery Advisory Committee: Peel Report 1970). This policy was enforced by a government heavily influenced by the medical profession, whose personal interests were served by the resultant considerable increase in the numbers of women seeking hospital confinements, in the belief that they were safer than home birth (Wagner 1986). This myth has only recently been challenged, and the safety and popularity of home births is (very slowly) reasserting itself. Examples of the exposure of many other medical myths may be cited, especially regarding certain procedures in childbirth, for instance unnecessary inductions of labour; invasive methods of fetal monitoring; high incidences of operative deliveries and episiotomies; all of which have been largely discredited in recent years. (for example, Campbell and Macfarlane 1986; Enkin, Kierse and Chalmers 1989; Tew 1990). Furthermore, it has been suggested by a number of writers, particularly feminist writers, that procedures such as screening tests for fetal abnormality may be manoeuvring women into positions as agents of fetal quality control, especially if choices are lost to refuse screening tests or to refuse termination of pregnancy if tests show the fetus to be abnormal (Sawicki 1995). There is a danger that consenting to fetal screening tests, or termination of pregnancy, may come to be regarded as confirming to rule governed behaviour, whereby it is seen as socially and morally unacceptable and deviant to bring a physically or mentally compromised child into the world. Such patterns of expected behaviour would seriously reduce genuine choice for the woman and her family.

#### 7.2.3.4 Counterbalances

It may be argued that Lukes' conceptualisation of power provides a rather pessimistic view of the use (or misuse) of power. Lukes does not address the counterbalances available which can at least partially redress situations of oppression: midwives and the women in their care were by no means powerless and adopted various strategies to circumvent situations. Foucault (1979) regarded power as ubiquitous, operating not only in a top-down but a multidirectional manner.

*'Power is everywhere: not because it embraces everything, but because it comes from everywhere ... power is not an institution, nor a structure, nor a possession. It is the name we give to a complex strategic situation in a particular society.'* (Foucault 1979:93)



The multidirectional characteristics of power were visible within the frameworks. As a group often subservient to hierarchical control and policies, midwives sometimes used covert tactics to subvert the power of more influential others. For example, Midwife G, who did not consider herself sufficiently powerful to challenge directly the Consultant's policy that all women should take iron tablets, did in fact influence the woman against taking the tablets, by implying rather than stating her opinions. Although all was communicated by inference, Woman G perfectly understood Midwife G's tactics. Even though the Consultant possessed the power to impose certain courses of action upon the midwife, the midwife had the power to subvert this. In turn, the woman had the ultimate power of deciding whether or not she would take the tablets. It is hypothesised that strategies to circumvent policies and procedures are a feature of advanced or expert practice; that when practitioners develop experience and confidence in their skills they more readily exert power to influence and direct their own practice, possibly in contravention of policies and procedures. This accords with Benner's description of expert practice when she cites Dreyfus and Dreyfus' (1977) study of air force instructors (expert practitioners) which found

*'... that the instructors weren't using the rules that they were instructing the trainees in at all! Furthermore, their deviation from the rules allowed the instructors to perform faster and better.'* (Benner 1984:38)

Midwife G's actions avoided direct confrontation with the Consultant Obstetrician, but she nevertheless achieved her purpose of making the woman aware that she did not need to take the iron tablets. Woman G, however, was of the same cultural group as Midwife G and spoke the same language (that is, English), and understood the unspoken message from the midwife. At one level this could be considered as a satisfactory interaction and outcome for both midwife and woman. There are two major problems within this situation, however.

Firstly, if the woman had been of a different cultural group and not fluent in English it is unlikely that she would have understood the inferred message. Oliver et al (1996) noted that non-English speaking women in their study were less likely to be well informed as they could not make use of the English language media although in some hospitals (but not all) linkworkers were available to relate information given by health professionals. In advocating a more extensive use of linkworkers and interpreters, Hayes (1995) stressed the problems



women of ethnic minority groups face when trying to overcome language barriers in order to make informed choices in pregnancy. It is suggested from this study, however, that such interpreters should ideally be versed in the nuances of communication illustrated above for the intended messages to be conveyed. Even then, whether it would in fact be possible to convey such unspoken, culturally bound, messages is highly questionable.

Secondly, the need for the midwife to convey the message without words serves to underline to the woman the relative powerlessness of the midwife (and indeed the woman) in the face of obstetric policy, and to reinforce the hierarchical structures between obstetrician and midwife. Midwife G was really saying to the woman words to this effect:

*'I do not believe in this policy of giving iron tablets routinely during pregnancy, but I must appear to adhere to it and not to question the obstetrician's policy as my professional power and knowledge is inferior to that of the obstetrician. If I openly disagree with the policy I will be harmed in some way. You have a right to choose not to follow the policy. If that is your decision you must take responsibility for it, not I'.* This raises issues of advocacy in that a midwife is required by the UKCC to act to defend the rights and wellbeing of women in their care (UKCC 1996:13); such advocacy may well put the midwife into a confrontational position against more powerful others. If confrontation with the more powerful obstetricians did occur, it is not guaranteed that the midwife would find support amongst her colleagues, particularly the more senior ones. Even the UKCC has been bitterly accused of failing to support nurses and midwives when they do take assertive action to protect the interests of their clients (for example, Pink 1993,1994), which reinforces the feelings of powerlessness that many midwives and nurses experience in such situations, together with a lack of trust in colleagues and managers or leaders of the profession. (Issues of trust between a midwife and her managers will be returned to later in this Chapter: 7.3.3).

Midwife L did directly refuse to complete various aspects of documentation stipulated by hospital policy and was challenged regarding this by a Consultant Obstetrician. There was a perceived limit to how far this particular strategy of direct confrontation could be employed, however. In this instance the issue was a minor one, appearing neither to cause inconvenience to the Obstetrician nor to affect the woman's care. As outlined above the consequences of more serious confrontation could be damaging for the midwife and



midwives in this study generally tended to circumvent rather than to directly challenge the power displayed by more dominant groups. This observation has been well documented in other studies. For example, Kitzinger, Green and Coupland named as 'hierarchy maintenance work' the actions of midwives when advising junior doctors regarding the care of pregnant women:

*'(midwives) sought to advise the (doctor) without challenging the hierarchy or negating the (doctor's) medical training, and they emphasised the need for gentleness and diplomacy ...'* (Kitzinger et al 1990:156)

The pregnant women, as well as midwives, in this study employed various strategies to circumvent the power of the dominant group, avoiding open conflict. For example, by the simple expedient of not returning for further appointments, Woman E used her power to decline further attention from a dentist whose treatment she was not happy with. One of the categories was identified as 'Playing the Game' (6:5:2), in which the woman appeared to follow the advice of the midwife in order not to provoke conflict, but quietly took alternative action. Woman B said she would consider breast feeding, whereas she stated later that she had no intention of breast feeding the baby, but had only said that to please the midwife and to prevent further discussion on the topic. The substantive category of Regulating Information accounts for the strategies women used to avoid, delay or pursue information. So, although the power of certain dominant groups was evident, women and midwives used a variety of strategies to circumvent power.

Emmens (1993) categorised midwives in terms of their approach to midwifery and their perceptions of the environment within which they worked. The first group she termed 'crusaders' who saw midwifery as a profession separate from nursing and in need of rescue from medical domination. They regarded clients as partners in care, and themselves as independent, autonomous practitioners who are deeply committed to midwifery and to the need for midwifery practice to become research based. The second group were identified as 'survivors' who, although sharing some of the beliefs of the 'crusaders', do not always practice them, mainly because of a fear of censure or litigation. They often experienced conflict between their professional ideals and the way they actually practised. They saw themselves as powerless to resolve this conflict and were generally pessimistic regarding the



future of midwifery, predicting a move towards obstetric nursing. Emmens named the third group 'nurse-midwives', a minority who regarded obstetricians as superior and deferred to them even during a normal birth. The nurse-midwives saw themselves and other health care professionals as experts whose directions the client should follow. They preferred to work within a hierarchy with a clear division of power, and tended to regard research as a waste of time. Their approach to practice was task oriented. Emmens noted sadly that 'nurse midwives' tend to hold positions of power, often as senior managers. Emmen's study is a recent one, but nevertheless many changes have swept through the maternity services during the past few years, many influenced by the Winterton and Changing Childbirth Reports. As noted in Chapter 1, Trusts have been required to implement at least some of the changes identified in the Changing Childbirth Report. Most midwives could probably name at least one senior midwife of the 'nurse midwife' genre who has recently taken forced early retirement or has otherwise been required to make way for more a progressive midwife manager to bring about change. Another influence upon change in the maternity services and midwives is that programmes of midwifery education have undergone considerable development in recent years and are largely centered in Universities where midwives have greater access to wider bodies of knowledge and ways of thinking than perhaps was available to them when midwifery education took place in small, often comparatively isolated, hospital schools of midwifery.

Although not as clear-cut as Emmens describes, some features of these groups were reflected by individual midwives. Many midwives in this study appeared to be 'survivors' who expressed anxiety about maintaining their role within a hierarchy, and not falling foul of it. They seemed to have negotiated a role in the hierarchy within which they felt reasonably secure. No 'nurse midwives' were encountered. At least one midwife was a 'crusader'; one very much wanted to be but felt too inexperienced, isolated and powerless to act as such and was considering leaving midwifery.

Sawicki (1995) suggests that medicine has not simply imposed itself upon childbirth over the past century; many factors have operated to bring this about and these factors are still operating; the dominance of medicine is constantly challenged and power structures are constantly renegotiated and realigned. Overly pessimistic views of the medical dominance of



childbirth may be tempered by considerations of the benefits technological advances may bring as well as the dangers of increased dominance and reduced control by women. For example, many women in this study were in no doubt that they wanted fetal screening tests, and would terminate the pregnancy if abnormalities were found. This is an example of how a medical/technological advance may be exploited by women to maintain their equilibrium.

It is well documented that consumer participation in the health services has become progressively more widespread in recent years (for example, Brearley 1990). The consumer movement continues to be informed by the media; 'the gaze' focuses by means of television and radio programmes as well as newspapers, magazines and other means upon a wide range of consumer issues, and health issues - especially maternity care - are popular topics for discussion. In discussing the influences upon the lives of the carers of children with Down's syndrome Rapp comments that television is by no means merely a neutral presence in the lives of consumers, but is possibly

*'... the most powerful panopticon through which the information revolution is constructed, represented, and enforced.'* (Rapp 1993: 72)

Consumers are encouraged to be critical of their care this is reflected by the observation that complaints regarding care have escalated 8-fold since the 1970s (Brearley 1990). Brearley further pointed out that:

*'... nurses ... engaged in their own struggles against hegemony ... have championed ideas of patient autonomy and have developed (various strategies) to facilitate greater patient involvement.'* (Brearley 1990: 8)

Kennedy (1981) noted that consumerism implies an interest in protecting the consumer against the interests of more powerful groups, and the rebalancing of power in order that the powerful group cannot harm or exploit the consumer. This certainly applies to consumers of maternity services. Midwives in this study were generally anxious to protect the 'consumers' but often perceived themselves as lacking in power to do so adequately. This perceived protective function may be at odds with the ideals of empowerment, however; the interface and tension between the concepts of protection and empowerment require further exploration. Such detailed investigation is outside the scope of this study, but there nevertheless follows a brief outline of empowerment and its relevance in this study.



#### 7.2.4 Empowerment

Concepts of power have altered since the early part of this century towards a view of empowerment whereby power may be used for the mutual benefit of all participants. Issues relating to power and empowerment will affect the ability of women to make decisions regarding their pregnancy, labour and postnatal period. By recognising the forms that power may take in its benevolent and less benevolent manifestations, midwives and the women in their care may be in turn empowered to control their professional and personal lives. It is, however, difficult to define empowerment, as Rappaport, who coined the term, acknowledged. He nevertheless attempted a definition as follows:

*'...the mechanism by which people, organisations and communities to gain mastery over their lives.'* (Rappaport 1984:3)

He stated that empowerment was more visible by its absence, which is characterised by powerlessness, helplessness, alienation, victimisation, subordination and oppression (terms which Farmer (1993) pointed out are often used by nurses to describe their position), and impossible to define in any detail because of the infinite variety of situations which could concern the process of empowerment, each needing a different approach.

Gibson defined empowerment as:

*'... a social process of recognising, promoting and enhancing people's abilities to meet their own needs, solve their own problems and mobilise the necessary resources in order to feel in control of their own lives. Even more simply defined, empowerment is a process of helping people to assert control over the factors which affect their health.'* (Gibson 1991:359 )

This definition contextualises 'empowerment' as integral to informed decision making in maternity care situations, from both the midwife's point of view when facilitating decision making and the woman's when making decisions. Empowerment in this context would strengthen the woman's position in relation to her attendants and/ or policy making authorities to enable her to carry through her plans. Definitions of empowerment, however, retain the notion of 'giving' information' or 'giving' power, rather than individuals enabling themselves to take power. Rissel wrote:



*'Some critics question whether empowerment is possible in situations where power is bestowed to those without power without addressing the structural inequality of power represented in this interaction.'* (Rissel 1994:40)

The ability of individuals to assume power is perhaps the ultimate manifestation of empowerment, the individual (or organisations or communities) requiring strength of self-identity and self-concept, energy and action (Young and Hayne, 1988). Processes of mutual empowerment are visible, when groups of midwives, for example, The Association of Radical Midwives (ARM), and groups of women concerned with childbearing, for example, the Association for Improvements in Maternity Services (AIMS), or various feminist groups, facilitate individual empowerment through group activities.

Gibson (1991) conceptualises empowerment as associated with coping skills, mutual support, community organisation, self esteem, and connectedness, and sees it as involving both the taking and giving of power. In her analysis of the concept of empowerment Gibson concludes that empowerment can be conceptualised as a composite of attributes that relate to the client, attributes that relate to the nurse and attributes that belong to both the client and the nurse. Gibson's analysis is incomplete, however, particularly when applied to midwives and women during childbirth as it lacks any sense of contextual attributes, that is, those relating to the situations in which the midwives and women find themselves, particularly those relating to power structures within which they work.

Sheilds (1995), in a grounded theory of empowerment in a group of women, described the emergence of three themes. These themes are very similar to those cited by Young and Haynes (1988). Firstly, an internal sense of self was developed which concerned the development of a sense of identity, self value, self acceptance and trust in the form of self knowledge. One of the intentions of groups such as ARM and AIMS is to further these values by developing, for example, a strong sense of professional identity in midwives and a clear sense of purpose in women regarding the choices they wish to make during childbirth. It may be argued however that the concept of 'professional identity' is a double edged sword, implying an allegiance to a particular worldview of what midwifery is about, especially if this worldview is at odds with the woman's. Furthermore, the term 'professional identity' may also imply allegiance to other professional groups and organisations



demanding codes of behaviour that may not be in the interests of childbearing women. For example, Midwife L said she would hesitate to act in the best interests of a woman if this brought her into conflict with a more powerful professional - in the instance she cited this was an anaesthetist whose perception of the professional role of a midwife was seen to be someone whose priorities concerned the smooth running of the department and not necessarily the convenience of the woman. Secondly, according to Sheilds, women moved towards taking action, speaking out and participating in life; taking risks, and developing skills. These actions are also reflected within the organisations cited above. Midwives and women are increasingly vocal in their views about childbirth and the fruits of this action are visible in initiatives related to the Changing Childbirth report (DoH 1993). Sheild's third theme was that of connectedness, between all parts of the individual person, and between people. Midwives and childbearing women have collaborated to stimulate many initiatives to improve the experience of childbirth and to empower midwives and childbearing women as, for example, described in the Changing Childbirth Report.

In this study, midwives often stated their commitment to 'empowering' women in terms of giving them the necessary information and power to make decisions. It must be pointed out, however, that it was the midwife who decided what information, and how much power, to give to the woman. Rafael (1995) wrote that the concept of empowerment is open to abuse. The findings from this study appear to illustrate this danger in that, although midwives generally wished to provide information that would empower women, their control of the situation did not necessarily lead to empowerment - rather the opposite. There was evidence that information-giving could become a strategy for behaviour modification rather than empowerment, as Rafael pointed out, being '*simply a facade for old control strategies*'.

Patterson, Freese and Goldenberg (1990) conducted a grounded theory study to investigate how women utilised health care in pregnancy, and identified the core category as 'Seeking safe passage'. (This study focused upon the general use of health care, and not upon how choices are made in pregnancy). Patterson et al pointed out that women wanted choice of health care during pregnancy, and were willing to assume personal responsibility for seeking



it out. Noon however expressed disquiet that, in being offered choices pregnant women have

*'... expressed anguish at being given too much information and too many choices without adequate, if any, explanation ... the women were completely mesmerised, and some even frightened, by their new status (of pregnancy) and what was in store for them later on in their pregnancies. With so many options, and never before having experienced pregnancy, one woman was terrified of having to make a decision which she feared might be the wrong one, putting her baby at risk of an adverse event.'* (Noon 1995:361)

In her study of information-giving during labour, however, Kirkham (1989) found that every woman wanted information, and wrote that without it they were unable to make decisions. With the few exceptions noted in 6.3.1 this observation was supported in this present study; women wanted choice, but difficulty could arise when they were faced with too many choices, or with making difficult decisions that could significantly upset their equilibrium. Noon's observation serves to reinforce the importance of personalising information, thereby providing explanation (as Midwife M termed it, *'interpreting the information for the woman'*). In this study there was much evidence of midwives providing and interpreting information, particularly within the substantive category of Raising Awareness. For example, Midwife M went to considerable lengths and some personal inconvenience to supply Woman M with sufficient information to make a decision about a specific aspect of her care in labour. This is an example of information that could be read in books or pamphlets being personalised by a midwife for a particular woman's needs, so that she could see how the information could be interpreted by herself and the midwife in a way that would enhance her labour. The information was thus made usable by the woman and she was thereby empowered in its use. Alternatively, some midwives were observed to control interactions in order to provide the information they considered the woman needed, largely ignoring the woman's expressions of need for information in other areas; in these instances the midwife assumed the power to 'name the world' (Friere 1970). When Midwife L (5.3.1) imposed her own wish to discuss breast feeding over the woman's desire to talk about what she should be eating during pregnancy the midwife was doubtless acting in what she perceived as the best interests of the woman, but she defined what these 'best interests' were. Rafael (1995) described behaviour as paternalistic when it is done without the individual's consent on the premise that it is for the individual's own good. Hearn (1982:193) described as 'patriarchal femininity' the



control exerted by women in, as he expressed it, '*nursing, teaching and similar semiprofessions*' by which nurses (sic) can wield authority in '*the areas left for them by the medical men*'. Rafael proceeds to note that paternalism is guided by principles of beneficence and non-maleficance. She points out, however, that these principles are judged from the perspective of the person carrying out the paternalistic action and individuals are thereby deprived of self-determination. Noted throughout the data is tension between the desire by midwives on one hand to empower women and on the other to protect them from harm and from making decisions perceived by midwives as 'wrong'; this tension is captured within the core category of Protective Steering.

#### 7.2.5 Summary

This section has outlined the changing conceptualisations of power over the past several decades, tracing notions of power from that of control over subordinates to that of a mutual utilisation of power that can benefit all participants. Midwifery and childbearing are activities carried out in environments influenced by differing concepts and operationalisations of power; some of these involving traditional, Weberian ideals. Power, however, works in many directions and groups often considered as subordinate have various strategies they can use to circumvent situations.

Although power structures are vital and potentially beneficial, they need to be deconstructed frequently in order that gross abuses of power may be identified. At one level, it may be argued that relationships and directions of power are constantly re-negotiated and justified in order to provide a workable structure in which different groups of varying status may locate and identify themselves. It was strikingly apparent, however, that the fundamental power structures and the status quo were constantly reinforced by the actions and strategies of the midwives participating in this study.

### 7.3 Trust

It has been argued that power is potentially benevolent, and necessary for adequate medical or midwifery functioning, and that empowerment involves the giving and taking of power. Lukes (1974) in his theory of 'radical power' distinguishes between force and manipulation



as forms of power. Midwives were not in a position - and indeed were most unlikely to have wished - to use force, but they could manipulate women into courses of action. This raises issues of trust which will be discussed in the following sections.

### 7.3.1 Trust by women of midwives

Hugman pointed out that:

*'The power of nursing can be seen in the general acceptance by patients of treatments administered by nurses ....' (Hugman 1991:32)*

By accepting 'treatment', patients or clients demonstrate trust that nurses and midwives will act in their (the patients) best interests. Trust is placed that power will be used in a benevolent way, and not (exclusively) to further the ends of those in power; that the level of midwifery (or medical) functioning is (at least) adequate; and that power will be given as well as taken. The benevolent use of power therefore assumes the existence of trusting relationships. The categories 'Taking it as it comes' and 'Handing over' concern the trust placed in midwives by women when they feel (or indeed are) unable to make choices regarding their care. This section addresses the concept of trust, particularly as evoked within the study data and resultant frameworks.

Several authors have emphasised the importance of trust in any therapeutic relationship (Gibson 1991, Pask 1995). For example, Lupton stressed the need for consumers of health care to have trust in their doctors:

*'Many patients do not want occasion to lack trust in their doctor, to doubt his or her motives, to wonder whether they are getting a good service of a fair deal ... at both the conscious and unconscious levels there is a deep-seated need to invest trust in a responsible other ... they were reluctant to place themselves in a position in which they would be forced to view their doctor as potentially incompetent.'* (Lupton 1995:159)

It may be reasonable to assume that women would comment similarly on the desired relationship of trust between themselves and their midwives. Various definitions of trust in nursing settings have been provided. Meize-Grochowski undertook an analysis of the concept of trust in a nursing context and developed the following definition:



*'Trust is an attitude bound to time and space in which one relies with confidence on someone or something. Trust is further characterised by fragility.'* (Meize-Grochowski 1984:567)

Meize-Grochowski (1984) pointed out that although trust occurs in the present there will be a history of past experience with the person who is trusted that has led to the present trust. Johns (1996) describes trust not only as an outcome, but also as a process involving assimilating information regarding the person to be trusted and the risks inherent in trusting that person, making decisions regarding the degree of trust to be invested, the forming of the relationship and, finally, dealing with the consequences of the trusting relationship. Bissett (1995) noted that trust between woman and midwife is facilitated by forming a personal relationship, when promises are less likely to be forgotten. Trust usually must be earned (Travelbee 1971), although Mitchell and Loustau (1981) pointed out that the trust patients often place in nurses may be based completely upon their stereotype of the nurse's role. This may well have been the case in several interactions observed in this study, whereby the woman trusted the stereotype of the midwife as a person worthy of trust (if, indeed, this was the woman's stereotypification of a midwife). In this study, women were often required to place trust in individuals they had not met before; in most cases they were meeting the midwife for the first time. Whether the woman trusted the midwife depended on how the woman judged her expertise, her perceived commitment to the woman as an individual and whether the midwife appeared to have a positive, optimistic attitude towards the outcome of the pregnancy. It is probably often difficult for a trusting relationship to develop in the relatively short time span of a single interview. Indeed, it may not always have been necessary if the interview was regarded by the woman as a formality with little intrinsic value; several women said they trusted their 'own' midwife (that is, the community midwife) with whom they had started to build up a relationship, and would go to her for advice rather than to a hospital clinic midwife they were only likely to see once. Trust between these women and the midwives studied could have been important, however, if further meetings proved to be necessary. For example, if screening tests indicated a high risk of fetal abnormality requiring further investigations, the woman and the midwife might well meet again. Even if the woman subsequently did not meet the same midwife, a feeling of trust in individual members of staff may lead to confidence in the Unit as a whole, which would be



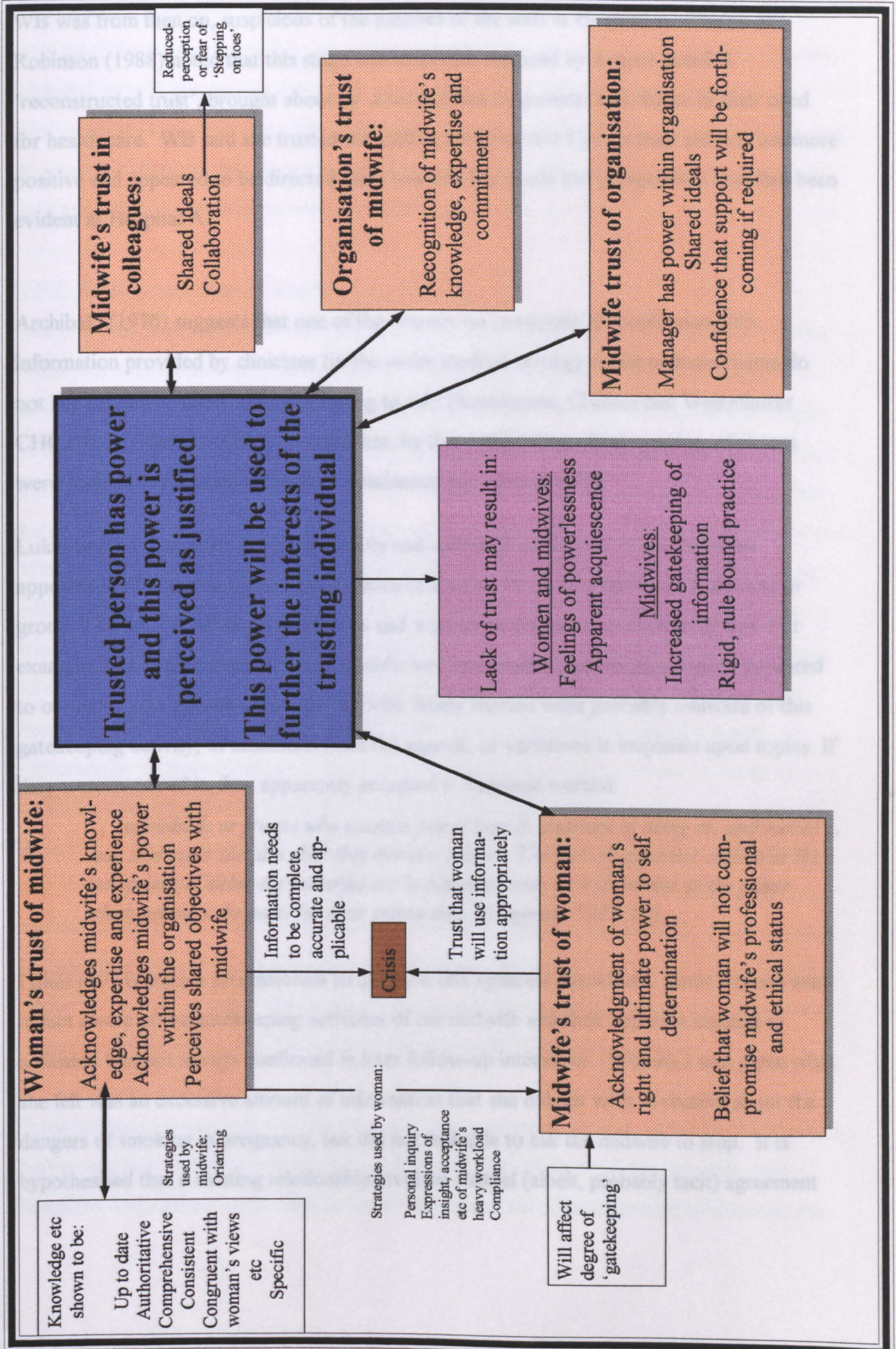
desirable when future visits took place to the clinic, or the delivery suite. Stewart (1995) pointed out that it may be logistically difficult for an individual midwife to continue care throughout pregnancy, labour and the postnatal period, and trust is likely to be required between the woman and a team of several midwives caring for her. This study showed that trust was likely to develop if the information the midwife provided was trustworthy, that is correct, credible, consistent and complete, and the midwife appeared to be professionally capable, and committed to the woman's goals (Figure 7.2). Gibson (1990) studied how nurses caring for clients with spinal cord injuries and their patients perceived trust behaviours. She found the first important behaviour identified by patients was credibility, which could be affected by perceptions about the nurse's personal appearance, prestige, status, voice quality, competence or skill. Patients needed to believe they could depend upon the nurse, and also needed to perceive congruence of values and goals between themselves and the nurse. The findings of the present study appear to agree with those of Gibson's study.

Mitchell and Loustau (1981) stress that, even when trust has developed, it can be lost. Trust is a fragile state (Mieze-Growchoski 1984) in that a negative experience with someone previously trusted will lead to loss of trust that may be difficult or impossible to regain. For example, WA and her husband lost trust when the scope of the information was found to be lacking; they had to probe for information which they felt should have been more freely given. Thorne and Robinson (1988) observed that although patients and clients often entered into a relationship with health care professionals from a position of naive trust, the perspectives and interests of health care professionals were sometimes soon perceived to differ from those of the woman. Initial trust was then replaced by '*distress ... anger, suspicion and intense vulnerability*' (Thorne and Robinson 1988:783). At Hospital A, WB was offered screening tests for Down's syndrome because of her age. She would have liked specific information regarding what having a child with Down's syndrome would mean to her husband and herself, but instead, according to WB, was told:

*WB ... if you're going to have this scan in a way we hope you will have a termination because it's going to be a waste of money if you don't ... I felt I'd been rushed into thinking about an abortion, whereas I might have changed my mind at the time. It shouldn't be down to cost and wasting their time ...*



Figure 7.2: Outline of conditions and consequences of trust between individuals (and organisations)





and negotiation of the topic and depth of discussion, and that if these parameters are exceeded (or indeed not reached) then trust is damaged or lost. As pointed out above, it may be difficult to arrive at this tacit agreement within the short space of a single encounter, although as with any human interaction, immediate mutual understanding may be sensed very quickly. If power is unequally distributed it may be difficult for the less powerful person to explicitly stipulate the parameters of the interaction, and the individual may be coerced into areas they do not wish to enter, as happened with Woman J.

### 7.3.2 Trust by midwives of women

The previous section has discussed the trust of women towards midwives. It was apparent within the study, however, that the degree of trust the midwives placed in the women affected their gatekeeping activities. Midwife M said that she went to considerable lengths to facilitate women making informed choices, and gave as much information as she could, but she trusted the woman in her care to act sensibly if things went wrong, and to trust her judgement. This was borne out by the observation of the interaction between Midwife M and Woman M, which lasted well over an hour in the woman's own home. Issues such as the administration of syntometrine and konakion were discussed and the midwife went to some trouble to ensure the woman was informed of and understood the issues involved. Woman M decided not to have syntometrine during her home birth, unless the midwife thought it necessary. In the follow-up interview Midwife M remarked that she would not give syntometrine if the third stage of labour was normal, but trusted the woman to agree to the administration of syntometrine if she, the midwife, thought it necessary. In other words, she trusted the woman to trust her, and trusted the woman not to take a foolish course of action that would harm the woman and perhaps the midwife. It should be emphasised, however, that although mutual trust and congruent values were apparent, Midwife M wished to retain the power to make ultimate decisions regarding care. Although, legally, the woman could refuse to have this possibly life-saving drug, the midwife trusted her not to do this, and not to put her, the midwife, in a professionally and ethically dangerous situation.

Trust between woman and midwife was particularly important during a crisis (6.3.3.2) when the woman required information quickly. She needed to trust that the information was complete, accurate and applicable to her situation, and the midwife needed to trust that the



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woman made appropriate use of that information; that is, there would be no unpleasant surprises for the midwife.

Midwife M and Woman M knew each other well. There was a system of team midwifery in place and they had built up a relationship over the past months. Woman M said that she knew and trusted all the midwives in the team and was happy for any of them to attend her. Conversely Midwife G, working in a hospital antenatal clinic, seldom saw women more than once or twice during pregnancy, and those interactions tended to be brief perhaps lasting fifteen to twenty minutes. She commented that she felt unable to trust the women in her care; she would not rely upon them to follow sensible courses of action. Indeed, she felt it likely that without a lot of advice and guidance that they would act unwisely compromising themselves, and possibly herself; she might be blamed for their actions. During the interaction observed between MJ and WJ, Midwife J provided more detail than she said she would normally because she perceived the woman as able to assimilate the information and therefore able to be trusted with the information (5:4:1). Meize-Grochowski cites Byrne and Thompson's (1978) definition of trust as:

*'...a feeling of safety in sharing one's own thoughts and feelings with another ... an individual will limit his (sic) information sharing in order to protect the integrity of his self-concept; he will be willing to share information about his thoughts and feelings only to the extent that he determines what is relevant and safe.'* (Meize-Grochowski 1984: 565&6).

Although the intention was to describe the trust of patients for health care professionals, this also applies in reverse; it is hypothesised that the midwife needs to feel assured that the woman is able to assimilate information before she will trust her with it.

Thorne and Robinson studied trusting relationships between health care professionals and their chronically sick clients. They noted that

*'... trust from health care professionals was specially meaningful and powerful ... described as an affirming and validating phenomenon, one which promoted self-esteem and fortified the health care relationship.'* (Thorne and Robinson 1988:784).

Thorne and Robinson described the strategies clients adopted to encourage health care professionals to trust them, such as gift giving, enquiring about the health, working and



personal life of the professional, joking and generally promoting a relationship in which the client was regarded as a likeable, trustworthy person who appreciated the circumstances of the professional. Woman C provided an example of this when she presented herself as compliant and understanding of the pressures upon the staff attending her in labour, saying she believed this had resulted in the staff trusting her, as demonstrated by the comments they made to her comparing her behaviour favourably with that of other women. In many encounters, there were examples of women asking midwives about their personal lives, and showing sympathy when midwives appeared to be busy or disorganised. It is hypothesised that these were primarily strategies used to explore possibilities for, and to encourage the development of, mutually trusting relationships between women and their midwives.

The woman, by virtue of the midwife being a member of a profession which is generally considered as trustworthy, has a stereotype upon which to base initial trust. Several studies of trust in health care relationships emphasise the importance of this trust by the patient/client towards the nurse. As argued above, it is probably equally important for the midwife (or nurse) to trust the woman (or patient). The midwife has a limited range of stereotypes (such as social class, ethnicity) upon which to judge how far she can trust a woman she does not know with information. Until the relationship, and trust, develops beyond that based upon stereotype, it is hypothesised that it is difficult for the midwife to relinquish power, or to 'open the gates' for fear of what the woman might do with that power, and information. It is further suggested that continuity of care, either by means of care by an individual or, more probably, care by a group of known midwives, facilitates the growth of mutual trust.

The way midwifery care is organised in many areas may militate against the development of trust between midwife and woman. For example, if care is fragmented between many midwives the woman and a particular midwife may be unable to get to know each other well enough to form a trusting relationship, as stated by Midwife G. It should also be pointed out that, when using computers to guide their interactions with women, midwives said they felt constrained and unable to orient to the woman's situation to their satisfaction; 'fishing' for information was difficult (5.3.1.3). If the midwife is unable to orient to the woman's situation she is unlikely to trust the woman with information. Furthermore, if the midwife



feels unable (as did Midwife G) to state clearly what the woman's options were, then this may convey messages to the woman regarding the midwife's perceptions of her own powerlessness, which may not be conducive to the development of trust.

### 7.3.3 Trust by and of midwives of the working environment/organisation

Johns (1996) pointed out the importance of health care professionals trusting the environment within which they work. It appeared that midwives went through similar processes of developing trust regarding the organisations within which they worked as outlined above, that is, a reconstituted trust could develop when the parameters were known. Midwife L knew by experience how far she could extend the parameters of her practice and autonomy, but was nevertheless wary of going too far. Midwife M worked within a system where she said she felt well supported by her manager. She felt that her manager shared her ideals about midwifery practice, and trusted her to come to her rescue if conflicts arose with other powerful figures who did not share those ideals. Woman M also trusted the midwifery organisation; she had chosen to be cared for within that environment where midwives were regarded as independent practitioners, although working within the National Health Service. She knew she was trusted by the midwife and in turn trusted 'the system' to provide the type of care she wanted.

When working in a team, members of that team needed to trust each other and to be secure within their roles. Midwife A appeared to be insecure in her role in feeling unable to suggest home birth to the women she saw. This was reflected in her comments about being wary of 'stepping on toes'(5:2:2:4).

Finally, in order to function adequately, the midwife needs to feel trusted by the organisation within which she works. Pask wrote:

*'... the question of 'will I be covered?' is a major preoccupation. This may be the result of nurses experiencing heavy handed policy which has not given the benefit of the doubt to nurses (that is trusting in their good will) and without careful assessment of the situation of concern. The result seems to be that nurses who feel untrusted may practice*



*in ways that they believe will safeguard themselves. Rather than operate for the good of their clients - practice that might have dangerous implications.’ (Pask 1995:192).*

#### 7.3.4 Summary

This Chapter has used data obtained in this study to illustrate how power and trust are manifested. Power and trust may operate in several directions and it has been argued that both are integral to the processes of facilitating and making informed choices in pregnancy.

#### 7.4 Summary of the main findings

A grounded theory approach has been used to construct frameworks to account for the processes involved when midwives facilitate, and women make, informed choices during pregnancy. The study is descriptive and has attempted to shed light upon complicated processes that (certainly in the midwifery context) do not appear to have been studied in depth before.

The core category, or central process, underpinning the midwives’ facilitation of informed choice was identified as Protective Steering, during which the midwife attempted to guide the woman towards the options available to her, whilst at the same time protecting both the woman and herself from harm, which could arise in many forms. This category demonstrates a tension between enabling/empowering and protective/paternalistic modes of practice. The framework took a circular structure, with the substantive categories of Orienting, Protective Gatekeeping and Raising Awareness.

When engaged in the process of making informed choices, women’s central concern (and thus the core category) was identified as Maintaining Equilibrium. This meant different things to different women; what would upset one woman’s equilibrium would not necessarily affect another. The women’s framework assumed a longitudinal structure, comprising the substantive categories of Regulating and Contextualising information, and Operationalising.

Issues of power permeated the data and strategies implemented by midwives and women to wield, counterbalance or circumvent power were identified. Trust was integral to the



processes involved in facilitating and making informed choices. Trust, like power, was shown to operate in many directions.

I named the category that linked the midwives and women's framework 'Balancing: Walking a Tightrope'. 'Balancing' describes the process of facilitating and making choices from both the midwives' and women's points of view to indicate that equilibrium was involved, and that loss of balance could occur which may be harmful. Consequently, a protective element is implied. 'Walking a Tightrope' is a metaphor to indicate the decision processes during childbirth as a journey with potential hazards that need to be avoided, but also with the goal of arriving upon safe terrain; that is, equilibrium. In the journey along the tightrope of making choices the woman and the midwife are both travellers, each with her goals; her safe terrain. The goals may or may not be similar, the goals may be known to each other or only assumed. The degree of steering required may differ between individuals, or at different times in an individual's journey.

Several interpretations of the metaphor 'Walking a Tightrope' are possible, all of which testify both to the individuality of the midwife and the woman, and their commonalities of interest, in the way Protective Steering and Maintaining Equilibrium are conceptualised and operationalised.

### **7.5 Implications for midwifery practice**

This study has identified a number of strategies employed when midwives facilitate and women make informed choices during pregnancy. These strategies were linked in the form of descriptive, middle range theoretical frameworks from which practice theories may be formulated and tested in order to guide midwifery practice (Bryar 1995). Strategies used by the midwives and the women in their care concerned seeking and controlling the flow of information in various situations, and were shown to be mediated by issues related to power and trust.

Almost invariably the midwives exerted considerable control over interactions (particularly when they occurred within the hospital environment) and were able to direct the information exchange in the direction they wished. Brain (1990) pointed out that as a primarily female



profession midwives have a legitimate interest in women's issues. This observation was confirmed within the data. As women (and often mothers) themselves, the midwives felt strongly about certain issues, for example about the dangers of smoking cigarettes in pregnancy and desirability of breast feeding, amongst several other issues. These views, on several occasions, were seen to influence the focus of interactions between midwife and women. Jackson pointed out some of the difficulties midwives face when trying to help a woman choose, for example, the problem of bias:

*'The difficulty of presenting an unbiased opinion should not be underestimated. It is hard to believe that any woman would seek professional advice and not want to know the professional's personal views on a given method of treatment.'* (Jackson 1993:226)

Richards (1997) emphasises the importance of using professional judgement to help women make choices and not as a vehicle to impose the midwife's personal values upon the woman. It is important that we midwives, who are often in powerful, controlling positions as far as the women in our care are concerned, are aware of our views, prejudices and biases. It is highly desirable that we clarify our own perceptions of what midwifery is, and what it means to us, and how we put midwifery into practice. Bryar (1995) noted that considerable unpublished work has gone into constructing models of midwifery care and urges that these should be published. In many midwifery programmes of study (particularly post-registration programmes) consideration is given to explicating personal and group models of midwifery and the concepts appearing therein. I believe, from personal experience, that such exercises are helpful in assisting us to reflect upon, and clarify, our attitudes towards aspects of midwifery practice, especially when approached from a critical theory paradigm. Particular attention should continue to be paid to the development of this aspect of the curriculum in post-registration courses, in order to raise awareness of midwives of our own personal paradigms of practice. The Changing Childbirth and other publications recently have stimulated such discussion, but there is still some way to go towards developing between midwives shared ideals of midwifery practice in order that a sense of collegiality develops within which midwives feel supported and secure, and can trust colleagues (especially those more senior) to come to their defence when confronting more powerful individuals and organisations, in the interests of the women in their care.



It is also desirable that midwives should be aware of the assumptions we are making about women; that is, assumptions regarding what individual women want, and what their needs are. Otherwise, it is inevitable that our assumptions, if wrong, will lead to inappropriate information being given. If time is limited it is all the more important that information should be appropriate, that time should not be wasted in conveying information to the woman that is not required or inappropriate. Midwives should be particularly aware of the danger of making assumptions convenient to ourselves. For example, Fraser wrote:

*'Are we really committed to changing our practices if it is in the interests of our clients or do we suppress our consciences if the change would make life uncomfortable for us? It is easy to pay lip-service to current ideologies, but still to do our own thing. By suppressing our consciences we can convince ourselves that our motives are altruistic when really personal self-interest prevails.'* (Fraser 1995:174)

The reasons for unavailability of choices (for example, place of delivery, choice of Consultant) may be logistical, due to lack of resources, or associated with maintaining the status quo, particularly of power relationships. Whether certain options are available may depend less upon the wishes of women and more upon the needs and convenience of those controlling the maternity service.

In the process of reflection about our practice it is also important to acknowledge and appraise honestly our own needs as midwives. What do we want from our practice? How do we go about getting it? What are our needs as women (or men), as people with family, social, financial and other commitments, and how do we reconcile these with the demands of midwifery practice as we believe it should be practised? Are any 'trade-offs' necessary, and if so, what are they? Do they matter? These and other questions can serve to clarify our individual identity as midwives and the way in which we practice, or would like to practice.

No midwife specifically mentioned the lack of research based knowledge upon which to base the information she provided to women, which was surprising. Many authors have expressed the need for midwives and nurses to develop skills in locating, evaluating and putting into practice research findings and this argument will not be pursued here as its truth is evident. The only point that may be added is that concerning the fair use of research findings. They should not be used selectively to enforce a particular viewpoint espoused by



the midwife. The selective, biased representation (and probable distortion) of research findings in order to coerce a woman into following a particular course of action is highly unethical, no matter what good intentions on the part of the midwife guide her action.

#### 7.5.1 The relationship of this study to published midwifery and nursing theories

This Chapter has discussed theories of power and trust in relation to the components of the theoretical frameworks that explain how informed choices are facilitated and made during pregnancy. It is outside the scope of this discussion to consider in depth the relationship of the theory developed in this study to the body of literature on midwifery and nursing theory, but some of the most relevant related theories will be briefly considered here.

Over a period of many years, Rubin, a nurse/midwife from the United States of America studied the tasks women carry out to acquire the maternal role (for example, Rubin 1967, 1984). She found that these involve the woman ensuring her own and her baby's safety, ensuring social acceptance by those important to her of herself and child, attachment to the baby; and understanding of the implications and tasks of mothering (Bryar 1995). There is some resonance between these tasks Rubin has identified and the core category in the women's framework of 'Maintaining Equilibrium' in that during this process the woman is defining her conception of 'safety'. As the Changing Childbirth report notes:

*'Safety is not an absolute concept. It is part of a greater picture encompassing all aspects of health and wellbeing.'* (DoH 1993: 2.1.6)

As already discussed, what is safe and acceptable to one woman will be unsafe and unacceptable to another; these perceptions will guide the choices she makes. An example of the operationalisation of 'ensuring social acceptance' in Rubin's theory can be seen in this present study when women underwent screening tests to investigate fetal normality saying their families would find it difficult to accept a baby who had Down's syndrome or other abnormalities. Rubin also investigated maternal role identity in terms of self-image. Her writing on the role of fantasy in relation to self-image is particularly interesting in the context of the informed choice frameworks since many of the choices women made during this present study were apparently influenced by their fantasies of how their pregnancies, labour



and postnatal periods would progress. For example, women had ideas about what they wanted to happen in labour; the sort of pain relief they wished for; and the way they would feed their babies. All of these ideas and many others appeared to be guided by their fantasies about how their labours would be, how their babies would behave, and how they would feel following delivery. Of necessity, these are superficial comments but a detailed exploration of Rubin's work in relation to the findings of this present study would be likely to be a fascinating and revealing exercise.

Other theorists who have produced work relevant to this study include Mercer, another American nurse theorist, who further developed the work of Rubin, and also developed a model (Mercer, May, Ferketich and DeJoseph, 1986; reproduced in Bryar 1995:139) to explicate the effects of antenatal stress upon family functioning. Lehrman (1981) identified the components of antenatal care provided by certified nurse-midwives which included concepts such as education and counselling, participative care, consumer advocacy and time (Bryar 1995:147). Ball, a British midwife, developed a theory of maternal emotional well-being that used the metaphor of a deckchair to illustrate the support systems and other factors that influenced the well-being of postnatal women (Ball 1987). Recently, Crichton (1997) reported the development of a 'Needs Assessment' model, specifically related to midwifery practice. Evaluation of this model has not yet been completed, however. All of these theories contain a strong midwifery component. There are many other nursing theories which do not address midwifery and maternity care specifically, but would nevertheless be of some interest. It would be worthwhile to consider these (and other) theories in relation to the frameworks developed in this study.

#### 7.5.2 Summary and emergent hypotheses

To summarise, over the past several years much attention has been paid to explicating the philosophies and patterns of practice available to the profession of midwifery, and consideration has been given to the place of midwifery in society (for example, the Changing Childbirth Report, DoH 1993). In order to facilitate enabling and emancipatory systems of care it is recommended that individual midwives are themselves enabled to reflect upon their own philosophies and paradigms of midwifery practice, in order to facilitate genuine choices for the women in their care.



This study sought to explore the processes midwives and the women in their care engaged in when facilitating and making informed choices during pregnancy. A critique and limitations of the study are discussed more fully in Chapter 8, however it is noted at this point that the study was necessarily limited by the research question. Processes operating during labour and the postnatal period were not specifically addressed; further studies are required to map these processes. Such studies may test the frameworks developed in this study, as it is possible that the frameworks may (at least in part) be transferable to labour and postnatal situations. Several major hypotheses arose from this study which also require further investigation, as follows:

1. Members of less powerful groups (in this case, midwives), may be accorded the 'power to' act as long as they do not appear to be assuming 'power over' the members of the more dominant group (in this case, medical practitioners).
2. There is a hierarchy of work in midwifery, influenced by the intensity of the public perception of the relative importance of aspects of childbearing.
3. Intrapartum care is perceived by the public as the most important part of the childbearing process and thus assumes primary position in the hierarchy of midwifery work.
4. Those who carry out this higher order intrapartum work are accorded the right to direct the allocation of more (lower order) work to other staff.
5. Health related behaviours are influenced strongly by the need to maintain equilibrium; behaviours are only likely to change if the outcome of such behaviours is perceived to pose more of a threat to equilibrium than the change of behaviour.
6. 'Fishing' for information is an activity associated with advanced or expert practice.
7. Strategies to circumvent policies and procedures are a feature of advanced or expert practice.



8. Continuity of care, either by means of care by an individual or by a group of known midwives, facilitates the development of the relationship beyond that of stereotype, and consequently the growth of mutual trust and relinquishing of power and gatekeeping of information on the part of the midwife.
9. Women employ various strategies to explore and develop possibilities for the development of trusting relationships between themselves and their midwives.
10. A trusting relationship between midwife and woman involves mutual and tacit agreement and negotiation of the topic and depth of discussion. If these parameters are exceeded or not reached then trust is damaged or lost.
11. Until the relationship between midwife and woman develops beyond that based upon stereotype it is difficult for the midwife to relinquish power and her gatekeeping activity, because of concerns regarding what the woman might do with that power, and information.
12. The borderline perceived by midwives between sufficient and excess information lies at the juxtaposition of the midwife's assessment of the woman's ability to assimilate information, and the point at which the midwife considers the information becomes impersonal and hypothetical.
13. The more hypothetical the information provided by the midwife, the higher the likelihood of frightening and /or confusing the woman.
14. The lower the midwife's perception of the woman's ability to assimilate information, the less information the woman will be given.
15. During a crisis, information needs to be highly personalised, detailed and comprehensive; accurate; up to date and consistent; and quickly provided in a supportive manner.



16. If information is provided as in (15) midwives are enabled to intervene therapeutically: information is ideally provided during a crisis by one-to-one contact with a knowledgeable, trusted midwife (or other health professional).
17. The process of 'handing over' is easier if the women trusts those caring for her.

To conclude, a probably highly worthwhile direction in which to take the findings of this study will be to consider them in the light of the work of published midwifery/nursing theorists, notably Rubin.



## **CHAPTER 8**

### **REFLECTIONS UPON THE STUDY**

#### **8.1 Introduction**

The purpose of this concluding Chapter is twofold: firstly to describe the natural history of the study in terms of the events that influenced its progress, and secondly to evaluate the approaches used to gather and analyse data. The two aspects are inseparable because, in a spirit of dialecticism, one informed and influenced the other. Throughout the Chapter I will attempt to reflect upon the use of self; how my views, beliefs, talents (or lack of them) and life in general impacted upon the study. At the beginning of the study I started to keep a journal, writing notes about its progress, my thoughts and feelings about the research and the situations I encountered. Much of what follows is based upon those notes.

Reflecting upon the research process, I identified 4 groups of tasks:

1. Planning the study: deciding upon the philosophies, approaches and method that would guide it.
2. Organising: communicating my intentions and gaining permission, arranging access and funding, co-ordinating the working, social and family aspects of my life to enable time to be given to the study, and liaising with the University and my supervisor.
3. Managing data: recording, transcribing, storing and retrieving data.
4. Doing the study: collecting and analysing data, and writing up the study.

This Chapter will discuss these various aspects.

#### **8.2 Planning the study**

My original research intentions concerned how women felt, and coped, when labour ended in emergency operative delivery or otherwise did not go according to their plans, together with the role of midwives during and following these labours. This led me to consider what the expectations of women might be regarding their labour, and how they came to form such expectations. These were relatively vague thoughts that I turned around in my mind over a period of several weeks. I have a very clear recollection of returning from a research



conference by train and admiring the passing scenery as I continued my vague cogitations. In an almost epiphanal moment these thoughts coalesced into the theme of informed choice. How did women acquire information in pregnancy? what did they do with it? how did they make decisions? what influenced midwives when giving information? Ideas flooded in, and by the time my journey ended I had a more or less clear idea of what questions I wished to address. My thoughts were no longer vague; the study had a focus, and seemed feasible. Although it was a few years since I had been directly involved in clinical practice, particularly regarding caring for women in labour, I remembered the constraints I felt when trying to offer choice to women during pregnancy. I had wanted to facilitate choice but within the bounds of my and my institution's ideas of safety and what facilities were available. My most recent practice had consisted of antenatal clinic work and I had been aware of the limitations of my role in only delivering a very small part of the overall care women required when trying to facilitate informed choice.

At the beginning of the study (and indeed throughout it) I was teaching research methods as well as midwifery to midwives and nurses. My research background was primarily in quantitative research; my Masters degree involved extensive factor analysis. I was intrigued by the possibilities of qualitative research and felt that in order to teach it I ought to increase my experience of qualitative approaches. Consequently, for this study I considered using either phenomenology or ethnography. Since my research questions concerned process, an ethnographic approach using grounded theory seemed the most suitable and I was interested in this as a research method. The associated philosophies of interpretation and symbolic interactionism were congruent with my feelings about the research questions, midwifery, data collection and analysis. I did not consider that this was a true ethnographic study as the periods of observation were relatively limited, but I believe that I am justified in claiming that some degree of ethnography was involved since so many of the interviews served to clarify what I had observed.

At the beginning of the study I took a liberal feminist stance; it seemed appropriate to do so as I was studying women and how they interacted in what appears to be male dominated situations. My assumption was that all professionals whether female or male, feminist or patriarchal, were working towards a perceived common good, that is the wellbeing of



childbearing women. It seemed likely, however, that issues related to power and control would surface at some point. As described in Chapter 2 I tried to 'bracket out' feminist views in order to allow for more possibilities in the interpretation of data. I realise that during the latter stages of the study my conception of feminism has changed towards a postmodern view of feminism. Recognising that the meaning of feminism, truth, reality and self identity are not fixed but change over time, postmodern feminism is not tied to any particular feminist theory. Being the 'Other', 'Second Sex' is celebrated as an opportunity to stand back and challenge the 'norms' of, for example, situations and language and thus is directed towards freedom from oppressive thought (Tong 1989: 217-223). This view to some extent influenced my analysis of the data, but I think that the reverse action was the stronger; that is, my reading of the literature and the outcomes of my analysis led to my change in approach to feminism. It is possible that this feminist viewpoint may influence any future research with which I become involved.

My experience with grounded theory was limited at the outset of the study and I read whatever I could on the topic. There are various standard books on grounded theory approaches to data collection and analysis which I read voraciously and tried to put into practice. I soon realised, however, that what I was trying to do regarding data analysis was not congruent with my interpretation of what grounded theory analysis should be about. It appeared too formalised and structured, and seemed to me to be more appropriate to research within a positivist paradigm than naturalistic/ interpretive. In fact, at that stage I wrote an early draft of Chapter 2 locating this research within the positivist paradigm. I was unhappy with this and for some time considered changing to an alternative interpretive approach, such as discourse analysis. I then found a recently published book Chapter by Stern (1994) which referred to Glaser's thinking on precisely the same issues; he deplored the direction away from interpretation that Straussian grounded theory was taking and reasserted the interpretative nature of grounded theory analysis. This not only resolved my doubts about the method, but also allowed me to return to grounded theory with renewed confidence that my interpretation of the method was legitimate.



### **8.3 Organisation**

During the course of the study I worked full-time as a lecturer and was thus registered as a part-time PhD student. The study had to be planned very much with what was possible in mind. For example, I had not the time to travel vast distances to collect data. I therefore chose maternity units near my home to collect data. I usually managed to spend one day during the working week upon the study (as well as weekends and annual leave); the units and their catchment areas were within about 35 miles of my home, except for the inner city unit which I accessed towards the end of the study. I felt fortunate in having several maternity units within fairly easy travelling distance, and representing a range of patterns of practice and catchment areas.

#### **8.3.1 Access**

Several months were spent in setting up the study; meeting with my supervisor and other academics; registering the study; writing proposals for funding and ethics committees; attending ethics committees; contacting midwifery and nursing managers to request and organise access; requesting permission to access 'their patients' from consultant obstetricians; and meeting with midwives to explain the study. Consultant Unit A was accessed first and permission from all concerned was obtained, and I was ready to start data collection. Unfortunately, at that point there was a sudden change of midwifery manager. The new manager refused to meet me, but insisted through her deputy that I should be registered under the Data Protection Act before being allowed access. This was arranged, after some time and expense, and I approached the Unit again, to be informed that the manager had withdrawn permission for me to access data and did not see the point of meeting me to discuss her decision. The head of nursing services heard about this decision, intervened and negotiated a compromise whereby I would be allowed access after a year, when the new manager thought she would be sufficiently settled in her role. I well remember my feelings of anger and disappointment regarding the manager's decision; this was probably my lowest point in the study. Fortunately, my supervisor came to my rescue with support and encouragement, and I temporarily 'let go' of Unit A. The midwife in charge of the antenatal clinic at Unit A was also extremely supportive, and asked me not to forget them, saying the midwives were keen to participate in the research; I promised her that I would return in a year's time.



In the meantime, I proceeded with negotiating access with Consultant Unit B and GP Unit C and started data collection there. I returned to Unit A the following year and collected data there. By then, the manager who refused me access had taken early retirement. One of the assumptions of qualitative paradigms is that the research takes place in ever-changing environments, and this was certainly true of Unit A. It seemed that every time I visited the Unit more changes had been or were about to be made in the management structure; even the head of nursing services took sudden early retirement. As Sister X, the midwife in charge of the clinic in Unit A, said *'we just keep our heads down and get on with it - I don't suppose you fancy a head of midwifery services job here?!'* I assured her I did not. These changes did not appear to affect either the process of data collection or the willingness of the midwives to participate; indeed they sometimes seemed to welcome my intrusions as an interesting diversion to the usual working day.

The other low part of my study also occurred in relation to changes in personnel in Unit A. Towards the end of the data collection and analysis, when I had some findings to show the midwives, I contacted Sister X and made arrangements with her to speak about the research at a study day to be held in approximately 4 months time. I duly arrived at the clinic several months later and asked for Sister X, to be told that she had died the previous week, from a particularly sudden and virulent form of motor neurone disease. The midwives and other staff in the Unit were shocked and upset about her death, as was I. A considerable time was spent in that feedback session in reminiscing about Sister X and trying to comfort each other. A feeling of intense sadness and loss pervades me when I think of her and her untimely death.

### 8.3.2 Rejection

When approaching women and midwives to take part in the study I was always very aware that I was intruding upon the relationship between midwife and woman, and also requesting time from both to talk to me about their feelings and reasons for their actions. Consequently, I usually braced myself for rejection, which always discourages me. With the exception of the midwife from GP Unit C, who said from the outset that she would not participate, and 2 women in the GP clinic later in the study, all appeared quite happy to take part which was



enormously encouraging. This high rate of agreement did not surprise me, however, from my own experience and reading of other's experiences (for example, Finch 1984) women are willing and generous in being interviewed, and certainly all the women and midwives in this study appeared to be happy to share with me their thoughts and views. Invariably when visiting their homes I was offered refreshment and made to feel welcome. Many commented that they had enjoyed being interviewed. Several expressed concern that they had not provided helpful data for me, but I was able to assure them that indeed they had.

Despite my anxieties regarding recruitment, thanks to the hospitality of the midwives, I felt quite at home in the maternity units. I did, however, feel acutely uncomfortable when recruiting in the GPs surgery. In the maternity units I was invariably introduced to women by the midwives, usually as a midwife researcher. Such introductions took place in the privacy of the room where the interaction was to take place, and so if the women refused, at least, I felt, it would be in private. In the GP surgery, however, I had to 'hang around' in the waiting room which was crowded with non-pregnant patients, and wait for obviously pregnant women to arrive. Although I tried to speak as quietly as possible and construct some semblance of privacy my request to them to participate was made in public, and I felt acutely aware of many people listening in. Divested of any official identity, I felt vulnerable and in the position of importuning for help which I did not enjoy, particularly when two women declined to take part. Even though their reasons were (to me) quite justifiable their refusal nevertheless embarrassed me. There was nowhere for me to hide whilst awaiting the next woman. I had to stand in the waiting room and I felt that all eyes were on me, curious to see what the outcome of my next encounter would be! This says a lot about me, and my reliance upon the identity and power invested in me as a midwife (or at least my perception of it), but in my favour, despite desperately wanting to escape, I did stay until I had recruited sufficient women. I was also made to feel a lot better towards the end of the clinic when one of the GPs saw me, remembered my purpose there and came over to greet me and chat briefly about the study. I felt 'legitimised' by this action!

### 8.3.3 Data collection

As I have written above, I was aware that my presence during interactions between midwives and women could be viewed as threatening and I was anxious to avoid any degree



of coercion into the study. It is with gratitude and admiration that I acknowledge that all the midwives I approached agreed to participate (except one midwife who refused from the outset).

8.3.3.1 Observation Several midwives told me they felt nervous about my presence, and about being tape recorded but would nevertheless take part. I promised to ‘merge with the wallpaper’ as much as possible and assured them that they would not be required to listen to themselves on the tape afterwards, which was an expressed concern of several midwives. I offered to send them the tape after I had finished with it, but no-one took me up on this. I emphasised to the midwives that I was not seeking to assess their practice; I was not there to evaluate or criticise, and that I too had practised ‘in the real world’. This appeared to reassure them, and I am grateful they trusted me.

It is probable that midwives were ‘on their best behaviour’ when being observed. Indeed, when reminiscing about Sister X, the clinic midwives said that she was known for her rapid booking interviews, and they recounted their amusement that she had spent longer than anyone had ever known in a ‘doing a booking’ when I had sat in! As Kirkham (1987) noted, however, it can be extremely illuminating to observe what people perceive as ‘best practice’.

8.3.3.2 Interviewing Ramhoj and de Oliveira (1991:124) note that although interviews may resemble conversation, they are different because of

- *methodic consciousness of the form of questioning*
- *a dynamic consciousness of interaction*
- *a critical consciousness of what is said, as well as of one’s own interpretations of what is said*

As with all research interviewing, a high degree of concentration was needed to listen to what was being said and at the same time think of the next question that would keep the conversation focused and flowing. In order to acquire rich data, when interacting with midwives and their clients I tried to use my intuition and experience as a midwife to guide the questions asked during interviews. I was aware of the pitfalls of asking leading or closed questions. Interruptions from children and other family members, or the telephone, were



frequent and the television was often on throughout the interview to keep younger children occupied. I examined the transcripts to establish where my questioning techniques could be improved and I believe that this helped to add to the credibility of the data; an unduly large quota of leading questions, or repeated occasions of my 'putting words into the respondent's mouth' would lessen the credibility of the data. Transcripts are included in Appendices 5 and 6 partially in order that this aspect of the data collection may be assessed by readers of this study.

My role during the follow up interviews required careful consideration. It was possible that the midwives' clients would ask me questions regarding their pregnancy. One strategy, common amongst interviewers, is to avoid answering, in an effort to maintain emotional distance and 'over-rapport' (Moser, 1958). Feminist researchers have rejected this approach, for example, Finch (1984) and Oakley (1981) who cites 3 reasons for rejecting the 'traditional', non-participatory role of researchers interviewing women, firstly, to avoid exploiting women, secondly, her awareness of the role of the interviewer interviewing women in developing theories relevant to women, and thirdly, in order to develop 'rapport' and so to acquire rich data. Webb (1993) criticises 'smash and grab' research, where the interviewer takes all, and gives nothing back despite having the knowledge and expertise to do so. I was aware of a tension, however, between 'giving something back', and encroaching upon another midwife's professional territory (my personal manifestation of the category Stepping on Toes!). Perhaps more importantly, any professional advice I may have offered could have conflicted with advice already given, or with unit policies. By influencing a woman's expectations regarding her pregnancy, or by confusing her by offering conflicting advice, there was a possibility of causing harm. It was difficult to decide strategy in advance that would encompass every situation, and consequently I had to decide upon issues concerning this aspect of my role as they arose, reflecting upon them at a later stage. I am not aware that I caused any harm, and certainly had no feedback that I had done so. When asked for information my usual practice was to provide it, often at the end of the interview with the tape recorder switched off. For example, following the booking interaction, Woman G was left with unresolved anxieties regarding toxoplasmosis. After our follow-up interview at Woman G's home we had a fairly lengthy conversation about toxoplasmosis in



relation to her role as a farmer's wife, her cats and her interests in gardening. I was anxious not to provide any advice that would make me unpopular with the institution and lead to my access being withdrawn but at the same time I wished to help Woman G. I think that both objectives were met, since after our conversation Woman G appeared to understand the risk factors to toxoplasmosis and what her options were and I received no ultimatum from the institution!

I was also aware of the possibility noted by many writers (for example, Oakley 1981) of raising potentially distressing issues during interviews. Some of the topics addressed were highly sensitive, such as fetal screening tests. I hoped that my experience of interviewing in previous studies together with my experience of midwifery would enable me to pick up on non-verbal as well as verbal clues to recognise the onset of any distress, and also to provide me with the means to deal with the situation appropriately. The nearest I came to such a situation was with Midwife E, who, towards the end of our interview during which she had talked about various frustrating aspects of her role, confided that she wanted to leave midwifery as it was not as she had hoped it would be. She appeared on the verge of tears, although she did not actually cry. We spent the next several minutes talking about midwifery, its joys and frustrations, and I did not seek to resume the interview. I have no way of knowing whether these issues were waiting to surface and our interview enabled a therapeutic airing of them, or whether my interviewing technique stimulated thoughts that had not been there before. I hope it was the former.

I reflected upon my possible and probable influence upon the participants, the data they gave me, and my treatment of the data, at stages throughout the study. Many of my assumptions and biases only became apparent to me as the study progressed and the reflective circle (Esterson 1972) enabled increased self-realisation. For example, as Wright (1986) suggests, many nurses (sic) associate power with oppression and abuse and I was no exception. My assumptions about power and control were challenged by the data and by the literature, however, and as my theoretical sensitivity developed I came to view power as a necessary and desirable entity. I admit that I had never thought about power in any depth prior to the study; had I done so I would probably have come to the same conclusions, but this study



gave me the impetus to consider the influence of power upon various interactions within the maternity services. Such reflexivity was an ongoing process throughout the study.

#### 8.3.4 Analysis of data

Following grounded theory method, data analysis proceeded at the same time as data collection. My interpretation of data was influenced by a dialectic between my understanding and experience of the wider context of the care midwives seek to provide to their clients, and individual, focused events the midwives and their clients described to me. A hermeneutical approach to data collection and analysis was used to interpret, for example, where decisions are being facilitated or made, in interpreting spoken and body language to guide my questioning during interviews and during data analysis, for example

- In the identification and extraction of 'triggers' from the tapes recording interactions between midwives and their clients. I interpreted where decisions were being made or facilitated in order to identify passages which could be used as 'triggers'.
- When interviewing midwives and their clients I interpreted their spoken words, and unspoken 'body language', to guide my questioning.
- In analysing transcripts derived from interview tapes I used my interpretive skills (arising from my professional and personal viewpoints) to interpret data and to help in initial coding.

As mentioned above, I had assured midwives that my purpose was not to evaluate their practice. Despite my assurances, however, I was not totally successful in this; there existed a very narrow line between evaluating and interpreting practice. At times it was tempting to interpret the data in terms of evaluations of what I considered 'good' and 'bad' practice. Instead, I attempted to interpret the data in terms of how the intentions of the participants and the context of the situation were influencing their actions. This approach, I felt, would keep trust with the midwives. It also accords with postmodern approach which acknowledges problems in categorising in terms of 'binary sets' (Derrida, cited by Krell 1989) such as good and bad, wherein the

*'privileged term is constituted by what it suppresses and the latter returns to haunt it ...' (Krell 1989:72)*



Sawicki wrote that the use of such binary sets is limiting and constricts the thinking that can lead to new insights and approaches:

*'... it restricts our political imaginations and keeps us from looking for the ambiguities, contradictions and liberatory possibilities in the technological transformations of conception, pregnancy and childbirth.'* (Sawicki 1991: 86)

This study was based upon a philosophy of symbolic interactionism, and contained a strong hermeneutic element whereby I interpreted data, trying to get at the underlying meaning of the words and actions of the midwives and women in their care. As Sandelowski (1993:3) wrote, in the interpretive (or constructivist) paradigm reality is *'...multiple and constructed, rather than singular and tangible ... no two researchers will produce the same result.'*

The resulting frameworks are explanations of these processes as I saw them. As many writers have emphasised (for example, Rew, Bechtel and Sapp 1993) in qualitative research the researcher uses herself as an instrument for data collection and analysis; her knowledge, values and beliefs are acknowledged to influence the study. I used my experience as a midwife practising in the 'real world' to make sense of, and interpret, data, in order to help structure and densify the emerging categories and theoretical frameworks. The concept of theoretical sensitivity combines experience and knowledge to enable questions to be asked of the data. Glaser pointed out that there is a tension between avoiding approaching analysis with preconceived hypotheses, and yet becoming

*'...steeped in the literature that deals with both the kinds of variables and their associated general ideas that will be used.'* (Glaser 1978:3).

This implies caution with initial reading of the literature in order that exposure to any pre-existing theoretical frameworks that may influence analysis are avoided, or at least mentally put to one side (that is, bracketed) with full awareness of their possibility to influence analysis. Glaser (1978) emphasised the importance that categories and theories should 'fit' the data, in other words, the theory should emerge from what is in the data and the data should not be forced to fit a pre-existing theory. In fact, a search of the literature revealed no relevant theories specifically related to facilitating and making choices during pregnancy. Existing frameworks related to nursing situations, such as stroke prevention (Saynor 1982), acute surgical nursing (Biley 1992), or to more general care in pregnancy (Patterson et al 1990).



I made extensive memos (totalling several thousand words) that reflected upon pieces of data. Examples of memos are provided in Table 4.2. At the beginning of the study these memos were mostly influenced by my experience as a midwife; later, as my reading widened in topic (involving, for example, crisis theory, theories about power, and studies regarding trust) memos incorporated ideas from this reading, and integrated ideas derived from different theories. As my theoretical sensitivity developed, so the data became more alive and more possibilities for category identification became apparent. I do not claim that I have exhausted all possibilities; rather the reverse. I am left with the frustration of knowing that, should I return to the data in future years with the added knowledge, experience and insights I hope those years will give me, I am likely to find more ideas and categories within the data. As Glaser and Strauss point out, however, a grounded theory is not static; it evolves over time, and over situations.

Initial memos tended to be written in words that suggested ideas regarding, for instance, possible causes, conditions and outcomes of actions and strategies apparent within the data. As the study progressed and ideas and categories became more integrated, memos also took the form of diagrams which linked categories into frameworks. I believe that, as my theoretical sensitivity developed, so my interviewing technique became more sensitive to the issues that should be explored. For example, the concept of crisis emerged as worthy of exploration, and I became sensitised to cues regarding examples of crisis during interviews with midwives and women (as well as, of course, to several other issues). As noted above, however, I was aware that my interviewing technique should avoid 'leading' the participant towards areas into which they would not otherwise go; again there was a tension between my wishing to explore these areas and yet not forcing participants into them. Particularly in the earlier interviews I could see from the transcript a few occasions where I had possibly 'led' the respondent. On one occasion I had actually 'put words into her mouth' by suggesting how she felt about a situation. Fortunately, the woman disagreed with my perception of her feelings, and proceeded to give her own account of exactly how she felt, and the situation was thereby retrieved, but I tried to avoid repeating the same mistake, I think with success.



Interpretation of data and the construction of frameworks was a difficult, lengthy process. At the beginning the process was particularly slow. Much memo-writing was involved and the constant checking and rechecking of codes and categories within and between the data was often tedious. At times it was largely an act of faith that anything would emerge from the data. I tried out several coding schemes and discarded many, but gradually more robust codes and connections between them were established. Tables 4.2 to 4.5 show preliminary ideas on how various codes and categories could be combined into a framework. For example, the category Asserting Power in Table 4.2 was developed and, after much thought about what concepts the category really represented, was renamed Territory Mapping, as in Table 4.3. The other related categories of Sussing out and Reviewing were also being developed at the same time and needed renaming. The idea of Territory Mapping implied a process akin to map-reading and this suggested a range of vocabulary connected with mapping. Words such as surveying, exploring, and orienting came to the fore. These words seemed to describe the concepts underlying these categories and thus the categories were named.

The frameworks slowly took shape until the schemes appeared to 'fit'. From then on, only minor changes were needed. I am left with strong feelings about phrases often encountered to the effect that 'categories emerged from the data'. This gives to me the impression of a quiet, orderly, peaceful birth not requiring much effort on anyone's part. The reality as I experienced it was that of the categories being dragged into the world, screaming and protesting their desire to stay unidentified where they were. 'Birthing' the categories and frameworks was hard work, but rewarding when it was over: the categories and their linkages 'felt' right.

#### 8.4 Saturation

The ideal size of the sample in qualitative research is often hard to determine. As Sandelowski (1995) noted, too small a sample will produce thin theory, or even wrong theory (Morse 1995), whereas too large a sample will produce excessive data that cannot be analysed in sufficient depth and is wasted. Maximum variation was the ideal aimed for in this



study by sampling institutions, together with people and events occurring within them, whilst restricting the amount of data to what was manageable. Morse (1995) wrote that saturation of the categories, when nothing new seems to be appearing, is an indicator that the sample size is sufficient. Data collection should cease, Morse (1995) advises, when there is enough data to build a convincing theory. The richer the data, the earlier saturation will occur. Including the 6 interviews to establish the credibility of the frameworks, 54 transcripts were analysed, providing many thousands of words and representing approximately 50 hours of extremely rich data. Little of the data proved irrelevant to the analysis; the 'dross rate' (Field and Morse 1990) was low. I felt that saturation was evident in most of the categories, but am nonetheless left with a conviction that if sampling had continued that new dimensions could be added. As Glaser and Strauss (1967:22) emphasise, however, grounded theories exist to be added to and refined; what is interpreted as 'truth' and 'reality' by a group of individuals in one period of time, within a certain context, may not represent the entire 'truth' and 'reality' to other individuals in other times, in other contexts. Nevertheless, this grounded theory is offered as a robust explanation to account for the processes of facilitating and making informed choices during pregnancy, and it is hoped that it will form the basis for further development.

### **8.5 Conclusion**

This study has examined in depth an aspect of midwifery practice that has long required investigation. Offering informed choice is seen as an integral part of midwifery practice, and women want to make informed choices during pregnancy, but the issues influencing how choice is offered and made have not until now been studied. As well as suggesting some hypotheses for further exploration, this study has produced theoretical frameworks to account for the processes of facilitating and making informed choices during pregnancy, which it is hoped may be used to help structure, develop and inform midwifery practice. Campbell and Bunting (1991) write that the purpose of theory is to clarify the differences between the actual and the possible. In setting out these theoretical frameworks the actual situation when facilitating and making informed choices is described. It is intended that this account of the 'actual' may lead to identifying what is 'possible', thereby suggesting ways by which midwifery practice may be structured, informed and developed.



## **Part 4**

### **References and Appendices**



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## Appendix 1

### The role and responsibilities of the midwife

**Midwife:** The definition of a midwife adopted by the International Confederation of Midwives and International Federation of Gynaecologists and Obstetricians in 1972 and 1973 respectively, following amendment of the definition formulated by the World Health Organisation is:

'A midwife is a person who, having been regularly admitted to a midwifery educational programme, duly recognised in the country in which she is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery.

She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the postpartum period, to conduct deliveries on her own responsibility and to care for the newborn and the infant. This care includes preventative measures, procurement of medical assistance and the execution of emergency measures in the absence of medical help. She has an important task in health counselling and education, not only for the patients but also within the family and the community. The work should involve antenatal education and preparation for parenthood and extends to certain areas of gynaecology, family planning and child care. She may practise in hospitals, clinics, health units, domiciliary conditions or in any other service'.

The activities of a midwife are defined in the European Community Midwives Directive 80/155/EEC Article 4 (UKCC 1994) as follows:

'Member states shall ensure that midwives are at least entitled to take up and pursue the following activities:

- To provide sound family planning advice.
- To diagnose pregnancies and monitor normal pregnancies; to carry out examinations necessary for the monitoring of the development of normal pregnancies



- To prescribe or advise on the examinations necessary for the earliest possible diagnosis of pregnancies at risk.
- To provide a programme of parenthood preparation and a complete preparation for childbirth including advice on hygiene and nutrition.
- To care for and assist the mother during labour and to monitor the condition of the fetus in utero by the appropriate clinical and technical means.
- To conduct spontaneous deliveries including where required an episiotomy and in urgent cases a breech delivery.
- To recognise the warning signs of abnormality in the mother or infant which necessitates referral to a doctor and to assist the latter where appropriate; to take the necessary emergency measures in the doctor's absence.
- To examine and care for the newborn infant; to take all initiatives which are necessary in case of need and to carry out where necessary immediate resuscitation.
- To care for and monitor the progress of the mother in the postnatal period and to give all necessary advice to the mother on infant care to enable her to ensure the optimum progress of the newborn infant.
- To carry out the treatment prescribed by a doctor.
- To maintain all necessary records.'



## Appendix 2

### Characteristics of Participants

#### Midwives

**Midwife A:** F-grade full-time midwife, extensive experience of all midwifery departments in Unit, including community midwifery. Recently appointed to take charge of the antenatal clinic.

**Midwife B:** F- grade full-time midwife temporarily working in the antenatal clinic. Tape recording failed.

**Midwife C:** G-grade full-time midwife working in the GP Unit and the community. One young child of her own, delivered in the GP Unit.

**Midwife D:** G-grade part-time midwife working in the GP Unit and the community.

**Midwife E:** E-grade full-time midwife, qualified approximately one year ago, working in a Consultant Unit.

**Midwife F:** H-grade full-time midwife in charge of working in the GP Unit; mainly based there although slightly involved in Community work to provide cover. Extensive experience of hospital and community midwifery; about to retire.

**Midwife G:** E-grade midwife working part-time in a Consultant Unit antenatal clinic. Qualified for many years.

**Midwife H:** G-grade midwife working full time in Consultant Unit antenatal clinic.

**Midwife I:** E-grade part-time midwife working in Consultant Unit antenatal clinic. Has one child delivered there about a year ago.



**Midwife J:** E-grade part-time midwife working in Consultant Unit antenatal clinic.

**Midwife K:** H-grade midwife in charge of a Consultant Unit antenatal clinic. Intending shortly to retire. Extensive experience of hospital and community midwifery.

**Midwife L:** E-grade midwife working full-time in Consultant Unit antenatal clinic. Extensive experience of labour and postnatal care.

**Midwife M:** E-grade midwife working as a member of a midwifery team attached to a Consultant Unit serving an inner-city area.

**Midwife 1:** G-grade midwife working temporarily in Consultant Unit antenatal clinic. Extensive experience of community midwifery. Near to retirement.

**Midwife 2:** G-grade midwife working part-time as a community midwife, occasionally working at the GP Unit. Has a young child.

**Midwife 3:** G-grade midwife working part-time at the GP Unit and in the community. Has two young children.

**Midwife 4:** G-grade midwife working part-time at the GP Unit and in the community, and also for the midwifery 'bank' at one of the Consultant Units.

**Midwife 5:** Midwife manager running a midwifery service within a Consultant Unit (Provided information on computers in midwifery).

**Midwife 6:** E-grade midwife working full-time in a Consultant antenatal clinic (Provided information on computers in midwifery).



**Women:** all the following women were of British, Caucasian origin and in a supportive relationship with a partner unless otherwise stated. Their occupation is given as at the time of recruitment.

**Woman A:** Primigravida. Age 26. Worked as a clerk in a local Royal Air Force establishment.

**Woman B:** Para 1. Age 38. Worked full-time as a local government officer.

**Woman C:** Para 1. Age 28. Worked part-time as a clerk in a GPs surgery.

**Woman D:** Para 1. Age 25. Housewife.

**Woman E:** Para 1. Age 28. Housewife.

**Woman F:** Para 1. Age 30. Part-time secretary.

**Woman G:** Primigravida. Age 32. Representative for publishing firm, and farmer's wife.

**Woman H:** Para 1. Age 27. Housewife.

**Woman I:** Para 2. Age 31. Part-time care attendant (night duty).

**Woman J:** Primigravida. Age 25. Bank clerk.

**Woman K:** Para 1. Age 29. Housewife.

**Woman L:** Para 1. Age 35. Newly arrived from Malaysia; of Chinese origin.

**Woman M:** Para 1. Age 30. Housewife.



**Woman 1:** Para 4. Age 32.

**Woman 2:** Para 3. Age 28.

**Woman 3:** Primigravida. Age 20. Not married or in a permanent relationship.

**Woman 4:** Primigravida. Age 24. Housewife.



### Appendix 3

#### **Consent form (1): Midwives**

*Valerie Levy*

*(Address and telephone number supplied)*

Dear Midwife,

#### **Facilitating informed choice in childbirth: A study of midwives and their clients**

I am writing to invite you to take part in a research study.

One of the aims of our care is to enable women to make informed choices during pregnancy. As you will be aware, this has received a lot of support from the government as well as from midwifery and consumer organisations (for example, 'Changing Childbirth'). I suspect, however, that the process of facilitating and making informed choices is not quite so simple as is often portrayed. Therefore, I would like to see how decisions are facilitated and made in pregnancy, and what helps or hinders these processes; hence this research study.

If you agree to take part, I would like to interview you regarding what you think about the choices available to women during pregnancy, and how you go about facilitating them. I hope that I will then be able to identify some of the issues concerning making choices in pregnancy, from the midwife's point of view. I will visit you at a mutually convenient place, and the interview will take between twenty minutes to one hour. Although this will be tape recorded, I am the only person who will hear the tape. Anything that you tell me will remain confidential between you and myself. I will prepare a written report at the end of the study but there will be nothing whatsoever that could possibly identify you, or anyone else.

The study has been approved by the Local Ethics Committee. Although I am a practising midwife I am not employed by this Health Authority and have no connection or status within



it. I work as a lecturer in midwifery at the Royal College of Nursing in London, and am carrying out the research in association with the University of Sheffield.

I feel it is important to stress that I am not seeking to evaluate practice. This study is not about determining 'good' and 'bad' practice; rather it aims to describe processes as they are in the real world. I hope the results of the research will be useful to midwives in helping women to make choices in pregnancy.

By inviting you to take part in this study, I realise that I am asking you to spend an hour or so of your time and I quite understand if you would prefer not to take part. I believe, however, that the findings of the study will be of use to us in our practice, and therefore very much hope that you will agree to participate. If you would like to, please sign the slip below. If you would like any more information, I would be very pleased to discuss this further with you.

Yours sincerely,

Valerie Levy

Midwife researcher

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**Facilitating informed choice in childbirth: A study of midwives and their clients.**

I agree to take part in this research study. I understand that anything I say will remain confidential, and that I will be able to leave the study at any time without explaining my reasons.

Name.....

Contact Address and telephone no.

.....



**Consent form (2): Midwives***Valerie Levy**(address and telephone number supplied)*

Dear Midwife,

**Facilitating informed choice in childbirth: A study of midwives and their clients**

I am writing to invite you to take part in a research study.

One of the aims of our care is to enable women to make informed choices during pregnancy. As you will be aware, this has received a lot of support from the government as well as from midwifery and consumer organisations (for example, 'Changing Childbirth'). I suspect, however, that the process of facilitating and making informed choices is not quite so simple as is often portrayed. Therefore, I would like to see how decisions are facilitated and made in pregnancy, and what helps or hinders these processes; hence this research study.

If you agree to take part, I would like to interview you regarding what you think about the choices available to women during pregnancy, and how you go about facilitating them. I hope that I will then be able to identify some of the issues concerning making choices in pregnancy, from the midwife's point of view. I will visit you at a mutually convenient place, and the interview will take between twenty minutes to one hour. Although this will be tape recorded, I am the only person who will hear the tape. Anything that you tell me will remain confidential between you and myself. I will prepare a written report at the end of the study but there will be nothing whatsoever that could possibly identify you, or anyone else.

The study has been approved by the Local Ethics Committee. Although I am a practising midwife I am not employed by this Health Authority and have no connection or status within it. I work as a lecturer in midwifery at the Royal College of Nursing in London, and am carrying out the research in association with the University of Sheffield.



I feel it is important to stress that I am not seeking to evaluate practice. This study is not about determining 'good' and 'bad' practice; rather it aims to describe processes as they are in the real world. I hope the results of the research will be useful to midwives in helping women to make choices in pregnancy.

By inviting you to take part in this study, I realise that I am asking you to spend an hour or so of your time and I quite understand if you would prefer not to take part. I believe, however, that the findings of the study will be of use to us in our practice, and therefore very much hope that you will agree to participate. If you would like to, please sign the slip below. If you would like any more information, I would be very pleased to discuss this further with you.

Yours sincerely,

Valerie Levy

Midwife researcher

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**Facilitating informed choice in childbirth: A study of midwives and their clients.**

I agree to take part in this research study. I understand that anything I say will remain confidential, and that I will be able to leave the study at any time without explaining my reasons.

Name.....

Contact Address and telephone no.

.....



## Appendix 4

### Consent form (1): Women

*Valerie Levy*

*(address and telephone number supplied)*

Dear .....

#### **Facilitating informed choice in childbirth: A study of midwives and their clients**

I am writing to invite you to take part in a research study.

One of the aims of midwifery care is to enable women to make informed choices during pregnancy. This has received a lot of support from the government as well as from midwifery and consumer organisations. In the real world, however, making informed choices is not quite so simple as is often portrayed. The purpose of my research is to see how decisions are made in pregnancy, and what helps or hinders decision making.

If you agree to take part, I would like to interview you regarding what you think about the choices available to you during pregnancy, and how you go about making them. I will visit you at a mutually convenient place (your home if you wish), and the interview will take between 20 minutes and one hour. Although this will be tape recorded, I am the only person who will hear the tape. Anything that you tell me will remain confidential between you and myself, and although I will prepare a written report of the study there will be nothing in it that could possibly identify you, or anyone else. Participation in the study will in no way affect your care. Although I am a practising midwife I am not employed by this Health Authority. I work as a lecturer in midwifery at the Royal College of Nursing in London, and am carrying out the research in association with the University of Sheffield. This study has been approved by the local Health Authority Ethics Committee.



From this research I hope to be able to identify some of the issues concerning informed choices and making decisions during in pregnancy. I hope to gain a realistic picture of what happens 'in the real world' regarding making informed choices. I hope the results of the research will be useful to midwives in helping women to make choices in pregnancy.

By inviting you to take part in this study, I realise that I am asking you to spend up to an hour or so of your time, and I quite understand if you would prefer not to take part. I hope, however, that you will, because the findings of the study are intended to be useful to midwives in helping us to provide a high quality service. If you would like to join in, please sign the slip below. If you would like any more information, I would be very pleased to discuss this further with you.

Yours sincerely,

Valerie Levy  
Midwife researcher

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**Facilitating informed choice in childbirth: A study of midwives and their clients.**

I agree to take part in this research study. I understand that anything I say will remain confidential.

Name.....

Address

.....

.....

Tel .....



**Consent form (2): Women**

*Valerie Levy*

*(address and telephone number supplied)*

Dear .....

**Facilitating informed choice in childbirth: A study of midwives and their clients**

I am writing to invite you to take part in a research study.

One of the aims of midwifery care is to enable women to make informed choices during pregnancy. This has received a lot of support from the government as well as from midwifery and consumer organisations. In the real world, however, making informed choices is not quite so simple as is often portrayed. The purpose of my research is to see how decisions are made in pregnancy, and what helps or hinders decision making.

If you agree to take part, I would like to interview you regarding what you think about the choices available to you during pregnancy, and how you go about making them. I will visit you at a mutually convenient place (your home if you wish), and the interview will take between 20 minutes and one hour. Although this will be tape recorded, I am the only person who will hear the tape. Anything that you tell me will remain confidential between you and myself, and although I will prepare a written report of the study there will be nothing in it that could possibly identify you, or anyone else. Participation in the study will in no way affect your care. Although I am a practising midwife I am not employed by this Health Authority. I work as a lecturer in midwifery at the Royal College of Nursing in London, and am carrying out the research in association with the University of Sheffield. This study has been approved by the local Health Authority Ethics Committee.

From this research I hope to be able to identify some of the issues concerning informed choices and making decisions during in pregnancy. I hope to gain a realistic picture of what



happens 'in the real world' regarding making informed choices. I hope the results of the research will be useful to midwives in helping women to make choices in pregnancy.

By inviting you to take part in this study, I realise that I am asking you to spend up to an hour or so of your time, and I quite understand if you would prefer not to take part. I hope, however, that you will, because the findings of the study are intended to be useful to midwives in helping us to provide a high quality service. If you would like to join in, please sign the slip below. If you would like any more information, I would be very pleased to discuss this further with you.

Yours sincerely,

Valerie Levy  
Midwife researcher

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**Facilitating informed choice in childbirth: A study of midwives and their clients.**

I agree to take part in this research study. I understand that anything I say will remain confidential.

Name.....

Address

Tel .....



## Appendix 5 Transcript and preliminary analysis of data from Midwife C

Transcript	Preliminary Codes	Memos
<p>MC Parentcraft classes - do you want them - have you thought about them?</p> <p>WC I haven't really, to be honest with you. I didn't last time ...</p> <p>MC You didn't come at all?</p> <p>WC No, I was in the middle of still commuting backwards and forwards to London and then when I left I was working at XX so I just never really bothered</p> <p>MC The choice is yours, they're there if you want to come. There's two lots of classes; there's one on the Monday afternoon at XX clinic and one on the Friday afternoon here. If you felt that you just wanted to come along for the exercises and relaxation you can do that, or if you want to come to the whole class you're quite welcome, or if you don't want them, that's up to you.</p> <p>WC Yes, that's quite open then. I've honestly not thought about it but I suppose I ought ...</p> <p>MC Think about it, they don't start until you're about 28 weeks and if you decide that you want classes then either call in or ring us, or ask somebody at clinic, and we can sort it out then</p>	<p>Asking about woman's choice</p> <p>'She knows how she feels'</p> <p>Leaving choice up to woman</p> <p>Setting parameters</p> <p>Giving opportunity to think about choice</p>	<p>The woman is being given the option of attending classes, which are held at specified times and place. The midwife has the power to set the parameters, then it is up to the woman. But how far does the midwife's power extend, what rules, policies etc is she bound by?</p>
<p>VL Do you teach the parentcraft classes?</p> <p>MC Right, well, at first, about 'do you want the classes', every patient, or every person who comes along to book are offered classes and it's their choice as to whether they come or not - we find that a lot of multiples don't necessarily want to come to the talks, but they just want a refresher on their breathing techniques, and relaxation It was interesting that she said she hadn't attended classes before - and I know that her little girl is 6 if not 7 now, and it's some time since she had dealings with babies. So it was really to find out</p> <p>VL And does that influence at all the classes you give them?</p>	<p>Offering choice</p> <p>Acknowledging previous experience</p>	<p>The midwife is giving the woman a free choice, are there occasions when she would attempt to guide the woman towards a course of action?</p>



## Appendix 5 (cont)

Transcript	Preliminary Codes	Memos
<p>if there was interest there, if she wanted to come, the fact that there are choices or 2 days is sometimes beneficial to them, because quite a few girls work quite late on their pregnancy, and so they find the Monday or the Friday fits in better</p> <p>VL So, if she decided she didn't want to come, would you be happy with that?</p> <p>MC Yes, it's entirely her choice, she knows how she feels, so there's no pressure on her at all. If she decided she didn't want to come that would be fine by me.</p> <p>VL Would there be any woman you would try to persuade to come to parentcraft classes?</p> <p>MC I think the primigravidas we recommend to come because they've never been through pregnancy, they've never been through labour before, so it gives them an insight into what they could expect, obviously you can't say this is going to happen, or that is going to happen, but at least you can give them an idea of what they could expect to happen, and you could also inform them of the choices they have, for example if they wanted pain relief or not. So I think with the primigravidas, we recommend them to come, but it is their choice.</p> <p>VL Do you teach the parentcraft classes?</p> <p>MC Yes. We don't do the exercises, there are 2 sisters who run the classes who generally take the exercises, but all the rest of the midwives take it in turns to do the talks.</p> <p>VL When you're teaching the parentcraft, or whatever, are you mindful of the fact that the women might end up at the (Unit A)?</p> <p>MC Yes</p> <p>VL And does that influence at all the choices you give them?</p>	<p>Asking directly if she was interested</p> <p>Asking indirectly</p> <p>'She knows how she feels'</p> <p>Steering towards a choice</p> <p>Providing a knowledge base for later choice</p> <p>Working with other professionals</p>	<p>The midwife asked directly if she was interested in classes, but she will also be gaining impressions without asking directly.</p> <p>A consequence of the woman 'knowing how she feels' (an in vivo code) seems to be that the woman is deemed to be free to choose.</p> <p>The midwife is agreeing to her choice but what if the woman did not know how she felt, or the midwife did not think she knew? In this case (primigravida) the midwife would steer her into coming.</p> <p>How does working with others affect midwives facilitating choices? Does it restrict them in any way?</p>



## Appendix 5 (cont)

Transcript	Preliminary Codes	Memos
<p>MC I don't think it influences the choice of whether they actually come or not, but certainly if I'm doing the talk there's a sort of indirect question 'where are you booked to have the baby?' that you can find out, and find out as well whether they're primips or multips, because sometimes the multips like to share their previous experiences with everyone, and we always try to inform them what happens at (Unit A) or (Unit B), if they do end up going there.</p> <p>VL Do you find it easier to inform women about likely outcomes - pain relief or whatever - if you're confident they're going to deliver here in (Unit C), rather than (Unit B) or (Unit A)?</p> <p>MC I don't think there's any difference with the general information about pain relief, but it may be that we can't give them in depth information about epidurals because at (Unit C) we don't offer that service, but we can inform them this service is available at (Unit A) or (Unit B) and the basic principles behind it but we can't go into detail.</p> <p>VL Would you expect the (Unit B) or (Unit A) midwives to do that?</p> <p>MC Yes, I think I would be able to tell them ... well, maybe not, because the (Unit B) midwives or (Unit A) midwives are not going to have (Unit C) booking ladies, but the girls who are actually booked at (Unit A) are actually invited to a Consultants talk, where epidurals and forceps deliveries are discussed, so probably the (Unit A) midwives taking the classes wouldn't give any more detail than we do.</p> <p>VL So you'd leave it, hoping they'd find out at the Consultants evening - you'd just give them an overview.</p> <p>MC An overview, yes. Obviously if they wanted more information, we could get more information, yes, we could get more information for them.</p>	<p>Asking indirectly Sussing out</p> <p>Implicitly approving</p> <p>Unable to provide information</p> <p>Obtaining info</p>	<p>This midwife feels unable to provide info about a service they not give in her maternity unit. Why? Surely she knows quite a lot about epidurals, or enough to give a fair amount of info. She is only prepared to give limited info if she is not carrying out the deed herself. She indicates she is willing to act as an intermediary by passing on info from the professionals who provide the service. Is this to do with ownership? Or work demarcation? Or both?</p>



## Appendix 5 (cont)

Transcript	Preliminary Codes	Memos
<p>MC Any thoughts about feeding this time?</p> <p>WC Yes, I'd like to breast feed again</p> <p>MC She'd previously told us she'd breast fed her first baby, and she'd been quite successful at feeding, so I was just trying to find out if she was happy with it, and I think I would have expected her to say yes, she would breast feed this time, which fortunately she did. I'm not a believer they must breast feed - I basically feel they must be happy doing it to be successful and I will give them all the help and encouragement I can to help them be successful, but if their heart's not in it they're not going to be successful anyway. If they're not sure and if they're wavering then yes, I would say give them all the encouragement to breast feed, they have to try, and obviously give them all the help in those initial first few days, but if somebody said 'no, I'm definitely going to bottle feed, I don't want to breast feed,' I feel they wouldn't be happy breast feeding, and wouldn't be successful anyway. Obviously, she suggested she breast fed previously, and she'd like to breast feed again, so I didn't feel there was any need to discuss that any further.</p> <p>VL Right. There were perhaps other things that were more important to discuss then, so that could be put away for the time being.</p> <p>MC Yes</p> <p>MC And have you thought about how long you'd like to stay in?</p> <p>WC Yes, a few days, for a rest! Yes, 3 or 4 days</p> <p>MC It's up to you, you can stay as long as you like!</p> <p>WC I suppose a lot of people just like to get home ....</p> <p>MC I think perhaps with their second, because they've got a little one at home a lot of the time, and they think 'they'll get to miss me' ...</p>	<p>Sussing out</p> <p>Implicitly approving</p> <p>Prioritising</p> <p>Asking directly</p> <p>Offering choice</p>	<p>Midwife acknowledges that woman must be happy with choice otherwise she will not be successful (or perhaps will not comply?) She did not actually ask if the woman was happy with breast feeding, she assumed this - part of sussing out? She appears to want the woman to breast feed (as would most midwives) and would influence her towards it if she was not sure. On what other occasions would she use this (?) gentle persuasion? - or even strong persuasion to influence choice?</p>



## Appendix 5 (cont)

Transcript	Preliminary Codes	Memos
<p>WC Yes, - I think she'll be quite well catered for</p> <p>MC And she's not 'young' young, is she</p> <p>WC No, so I think she'll quite enjoy popping in to see us - I think 3 or 4 days,</p> <p>MC It just gives us an idea today, once you've delivered if you feel you're quite happy, and you've the feeding going, and you want to go, no problem. Or if you want to stay longer, it doesn't matter ....</p> <p>MC With the length of stay in hospital, again it's choice, they can stay as long as they like. Obviously, primips we encourage to stay at least 5 days if possible especially if they want to breast feed. If they haven't had dealings with babies before they're both having to learn, and they can be difficult times, but if someone said 'no, I definitely want to go home,' and there was no medical reason why they shouldn't, there's no pressure on them to stay. Obviously the care will continue into the community.</p> <p>VL Would you be involved in looking after the woman in the (Unit C), and also when she goes home?</p> <p>MC We all work in the (Unit C) and out in the community. I couldn't say 'yes, I will see this woman in the (Unit C) and then at home', because it depends on off duty rotas, but we all work in community and in the hospital,</p> <p>VL So it's quite probable, or possible, that you'd see her throughout?</p> <p>MC Yes.</p> <p>VL Are there any other issues regarding length of stay that you've come across when discussing this with mothers?</p> <p>MC I think mums who are having their second baby, if their first baby is quite young they tend to want a fairly early discharge home, because they think their little one is going to miss them, and they're going to fret without their mummies. So I think those women go home quite early, but I</p>	<p>Setting parameters</p> <p>Steering</p> <p>Setting conditions</p> <p>Working with others</p> <p>Past experience</p> <p>Taking circumstances into account</p>	<p>MC will continue to provide care to the woman when she goes home and so perhaps who feels more able to give full information - compare with memo re epidurals</p>



## Appendix 5 (cont)

Transcript	Preliminary Codes	Memos
<p><i>think when they get to third babies they learn their mistake! So they stay in a longer period of time but we can point out these issues to them, but it's their choice, and as I said, as long as there's not medical reason for them to stay they go home. We do make sure there is somebody at home before we discharge them to community. They don't want to be going home just a day or two after delivery to just them and the baby.</i></p> <p><i>VL Does it matter at all about housing conditions?</i></p> <p><i>MC It could do, but again, my thought is that the baby is going home to those conditions no matter how long they stay in hospital, and it's got to go to those conditions whether it's at 3 days or 6 days, so I don't think there's anything we can do - we can't improve those conditions in that time</i></p> <p><i>MC Depending on the history she's giving you -</i></p> <p><i>WC When I had XX at (Unit A), I just phoned them out of courtesy to say I think she was on the way, I do that sort of thing ... ?</i></p> <p><i>MC Yes please, if you can, it just gives us</i></p> <p><i>WC ... That little bit of time</i></p> <p><i>MC Yes to get your notes out, and we can be expecting you at the door, if you had a one and a half hour labour last time, hopefully you're going to have a short labour this time as well ..</i></p> <p><i>WC But it was an all day thing. I knew at 6 in the morning it was on its way because I got spots in my pants and therefore I knew - and that's why I phoned (Unit A). When it's your first you don't really know, do you, and I was really expecting it to be pains and contractions, which I never really got, my waters broke, and so ..</i></p> <p><i>MC You were lucky ..</i></p> <p><i>WC Yes, very.</i></p> <p><i>MC As part of being a health professional you</i></p> <p><i>MC It's always nice to have a phone call to expect a lady, gives you time to get the notes out,</i></p>	<p><i>Practising</i></p> <p><i>Organising</i></p> <p><i>Taking circumstances into account</i></p>	<p>Choices offered by the midwife will obviously be influenced by their personal experiences. What if these don't accord with local policy?</p> <p>The midwife feels powerless to influence social conditions</p>



## Appendix 5 (cont)

Transcript	Preliminary Codes	Memos
<p>to make sure they are due, you can see how they laboured last time, this lady had a fairly short labour, and we could then prepare the labour ward for when she came in, If it's during the night we can make sure someone's at the door, because obviously the doors are locked during the night. It's nice to know someone's coming in, and if they're not sure, we can advise them if they ring up and they say their contractions are every half an hour, you wouldn't necessarily want them to come into hospital that early. Obviously if they wanted to, that's fine, but if they were saying 'do I need to come in,' then you could give them advice over the phone rather than bringing them to the hospital too early.</p> <p>VL So it would be completely up to the woman to decide when she wanted to come in</p> <p>MC Depending on the history she's giving you - obviously if someone said her waters had broken and there was all this dirty water coming, then whether she was contracting or not you would want to see her. But depending on the history, not necessarily so.</p> <p>MC We usually go through this, which is the advice we give you about diet -</p> <p>WC (laughs) Yes - well I'm pretty good really, I think, I eat plenty of fruit and vegetables, in my last pregnancy I smoked and I cut it out about two and a half years ago -</p> <p>MC But you know the things you should be eating and the things you should be avoiding</p> <p>WC Yes, yes I do, I think.</p> <p>MC Do you drink at all?</p> <p>WC Occasionally</p> <p>MC As part of being a health professional part of a midwife's job is about giving advice about diet but with XX being part of the health service I</p>	<p>Predicting</p> <p>Organising</p> <p>Taking circumstances into account</p> <p>Asking directly</p>	<p>MC is processing information from the woman to help her to answer questions and steer her in the right direction. There are processes here involving recognising cues, and integrating cues, direct information, personal and professional experience and professional knowledge. The midwife susses out the woman's circumstances etc before she can advise or guide (?steer) her. How does she do this 'sussing out'? (Not a good term, perhaps, colloquial, but it will do for now).</p>



## Appendix 5 (cont)

Transcript	Preliminary Codes	Memos
<p><i>expected her to know about diet and a healthy diet, what she should be eating, and what to avoid, which is what came across to me with the answer she gave to me, and the fact she had stopped smoking, I didn't need to advise her on smoking. If I do get people who smoke obviously I do advise them of the dangers, but then again, we can't say 'you must stop smoking' you can only advise them of the danger to the mum and to the baby and we say as well when they go home, about taking the baby into a smoky atmosphere</i></p> <p>VL <i>The mum's a clerk working in a surgery? Suppose she were a midwife, and she said she would smoke? Have you come across this before?</i></p> <p>MC <i>Not actually having to give advice to a midwife who smoked, no! I still think if it was a midwife who smoked I would still try and advise her, pointing out the dangers of smoking, asking her if she'd ever thought about wanting to give up. I don't think it would make any difference if she were a midwife or not. I mean, obviously she's going to be aware of the dangers of smoking, but I think for somebody just to point out 'look, these are the dangers and you know these dangers' - so no, I don't think it would make any difference.</i></p> <p>VL <i>What about drinking?</i></p> <p>MC <i>The denial risks - as XC's first visit to the</i></p> <p>MC <i>When I asked her if she did drink, the answer she gave was 'occasionally' and the recommendations or advice is that an occasional glass of wine is fine, so again, I didn't think there was any need to give any more details about that, really. I think it depends on the answer a person gives you, if they said 'yes, I drink a bottle of wine every night' and at weekends they have 3 bottles of wine then yes, we would give them advice, but not on this occasion, I didn't feel there was any need to give her any more.</i></p> <p>MC <i>Do you go to the dentist regularly?</i></p> <p>WC <i>Yes</i></p>	<p>Assuming knowledge base</p> <p>Assessing need</p> <p>Avoiding being prescriptive</p> <p>Unable to advise</p> <p>Not differentiating</p> <p>Steering</p> <p>Using up to date information</p> <p>Assessing need</p> <p>Asking directly</p>	<p>Some of the choices the midwife would like the woman to make are unrealistic. How does the midwife guide the woman then?</p>



## Appendix 5 (cont)

Transcript	Preliminary Codes	Memos
<p>MC Did you send off for your exemption certificate?</p> <p>WC Yes</p> <p>MC ... To get free dental treatment</p> <p>WC Yes in fact I went a couple of days after I sent it off and there wasn't anything needing doing, so ..</p> <p>MC Good - - - do you know about the benefits that you're entitled to?</p> <p>WC Not particularly, no, because it's all changed, hasn't it? And with only working part time I'm not sure - no, I don't know</p> <p>MC I don't think I can tell you either, because they've recently changed and I'm not sure, because you haven't been with the same employer, and it's now changed to I think 6 months before you can claim. The best thing to do is to go to the DHSS and pick up the new leaflet which we haven't got as yet</p> <p>WC Yes</p> <p>MC They're months behind in sending them out to the people that need to know!</p> <p>MC The dental visits - on XX's first visit to the surgery I actually booked her in at the surgery so I already knew what I asked her previously which was only 1 or 2 weeks prior to this so it was still fairly still fresh about what I asked her at the surgery, and when were filling out to send off for their exemption certificate we tell them they're entitled to free dental treatment during their pregnancy and afterwards, so when I asked her if she'd sent off her exemption certificate it was just</p>	<p>Unable to advise</p> <p>Checking</p>	<p>The midwife does not know the information, but perhaps she should do, or maybe the woman will perceive that she should. How do the midwife and the woman feel about the midwife not knowing? Are they both happy with the reason provided? Is there an expectation that the midwife should have all sorts of knowledge at her fingertips? Under what circumstances will the midwife not give information which may facilitate choice? That is, she may not know the information, or does not wish to impart it (as in section re epidural) or is not confident enough to, or perhaps believes that to give complete information may influence a woman to make a choice the midwife does not wish her to make. Or of course there may not be time to give all the necessary information</p>



## Appendix 5 (cont)

Transcript	Preliminary Codes	Memos
<p><i>a check to make sure she had retained what I'd told her at the surgery and in fact she'd already been. Benefits - I'm afraid I'm out of touch with those! I haven't done a booking clinic for some time so I think it was feasible for me to say to her the best place for her go was the DHSS because she was a sensible enough person to follow through that information. Somebody else who wasn't sure, who I probably got the feeling that I couldn't rely on them to go, I'd probably make arrangements to follow that up. And I actually have been to the DHSS to pick up the new benefits leaflet!</i></p> <p><i>VL So you didn't know the answer to that particular question but you knew the people who would do.</i></p> <p><i>MC Yes, that's right. I mean, we don't deal with it on a day to day basis and I've said here, it is changing, so I sent her to the right place for the information.</i></p> <p><i>VL Do you find that happens often - not necessarily with DHS benefits, but you're asked questions you don't really know the answers to?</i></p> <p><i>MC Sometimes we are, yes. If I don't know the answer and I'm not able to obtain the answer immediately, then I'll tell them where to go to find out the information, or if that's not possible find out myself and either make an appointment to come back to us, or we can telephone them at home - I don't think it's fair to leave someone in the balance if they specifically ask something.</i></p> <p><i>MC Feel free if there is anything; if you have strong wishes or dislikes or anything about your labour or care before and after. If you want to write them on there - obviously when you come in we read them, and if there's things that are not clear then you can discuss it with whoever's on at the time. We do try to meet your wishes most of the time unless we advise you otherwise .. but just because it's there you don't have to write. If you've got no preferences .... Some people feel they have to write something, but you don't have to.</i></p>	<p><i>Referring</i></p> <p><i>Setting conditions for referring</i></p> <p><i>Referring</i></p> <p><i>Following up</i></p> <p><i>Treating fairly</i></p>	



## Appendix 5 (cont)

Transcript	Preliminary Codes	Memos
<p>MC The birth plan page is obviously if they have thoughts about how they would like their labour and delivery conducted. Some people have strong views and we can get 2 if not 3 pages of what they would like. When they first come into hospital we sit down with them and discuss with them, and anything that as a midwife we're not happy with we can discuss that with the patient - why they wanted it, and any way that we could work round that. We have got to be safe in our practice, but obviously to fit in with their wishes as far as practicable. So I think it's important to discuss what they have written when they come into hospital and why they feel they want to do whatever they want to do. I've had quite a number of people who were worried because they haven't got any particular wishes but because this was a birth plan, and they were told this was their page and they could write on it, they felt they needed to write on it, and then they were worried when they couldn't think of anything to write on it, which is why I pointed out, don't feel you have to put something there if you don't have any particular wants.</p> <p>VL So you come across this quite frequently, that they don't really mind?</p> <p>MC Yes, a few of them, they want to be guided by the midwife, they say, they've got no particular strong points that they want to write down, but one or two have said to me 'Oh, I don't know what to put'. So I point out you don't have to.</p> <p>VL How do you feel about that?</p> <p>MC I think it's nice they can feel confident in what the midwife's doing, and will be guided by us, but I think there are more and more that are writing down plans, what they do and don't want.</p> <p>VL How do you feel about that situation when you have got perhaps several points that the mother has written down?</p> <p>MC That's fine, as long as they are not endangering the mother and baby in any way, as</p>	<p>Discussing</p> <p>Using professional judgment</p> <p>Being safe</p> <p>Accommodating</p> <p>Reinforcing right not to choose</p>	







**Appendix 5 (cont)**

Transcript	Preliminary Codes	Memos
<p>VL So do you feel she was supported by the midwifery service?</p> <p>MC Yes, she was. From the onset that's what she wanted. And as a midwife we're duty bound to attend her in labour but nobody could really find a reason to say no.</p>	<p>Professional responsibility</p>	
<p>MC The choice is yours, they're there if you want to come. There's two bits of classes, there's one on the Monday afternoon at (first baby) clinic and one on the Friday afternoon here, and if you feel that you just wanted to come along for the exercises and relaxation you can do that, or if you want to come to the whole class you're welcome to come, or if you don't want them that's up to you.</p> <p>MC Yes, that's quite open then. I've actually not thought about it but I suppose I might...</p> <p>MC Think about it and if you want to, they don't start until you're about 26 weeks and if you decide that you want the classes then either call by or ring us, or ask somebody at clinic, and we'll sort it out then.</p>	<p>Tentative agreement to think about it</p>	
<p>PVC Well, to be honest, I don't think I'm going to bother, but the answer to her question really - but then, I don't really think I've given it much thought, to be honest. I mean, I just don't think it's me to go to something like that. I know I shouldn't say that but it just doesn't interest me whatsoever.</p> <p>VL Is it the thought of perhaps sitting with a lot of other women during pregnancy, or having to go out to do it, or perhaps you don't feel you need the information?</p> <p>MC Oh, I think everybody could do with the information, what I've got there is obviously good advice, I don't know what it is, whether it's an embarrassment factor, I don't really know - at 36 weeks they start - I just don't know.</p>	<p>Refusing</p> <p>Hasn't thought</p> <p>Not her style</p> <p>Openness</p>	



### Appendix 6: Transcript and Preliminary analysis of data from Woman C

Transcript	Preliminary codes	Memos
<p>MC Parentcraft classes - do you want them? Have you thought about them?</p> <p>WC I haven't really, to be honest with you. I didn't last time</p> <p>MC You didn't come at all?</p> <p>WC No, I was in the middle of still commuting backwards and forwards to London and then when I left I was working at (first baby) so I just never really bothered</p> <p>MC The choice is yours, they're there if you want to come. There's two lots of classes, there's one on the Monday afternoon at (first baby) clinic and one on the Friday afternoon here, and if you felt that you just wanted to come along for the exercises and relaxation you can do that, or if you want to come to the whole class you're quite welcome, or if you don't want them that's up to you.</p> <p>WC Yes, that's quite open then. I've honestly not thought about it but I suppose I ought ...</p> <p>MC Think about it and if you want to, they don't start until you're about 28 weeks and if you decide that you want classes then either call in or ring us, or ask somebody at clinic, and we can sort it out then.</p>	<p>Assuming content</p> <p>Providing reason for not wanting to attend</p> <p>Past experience</p> <p>Tentative agreement to think about it</p>	<p>WC does not like the idea of exercising with other women she would be embarrassed by that although the other parts of the classes she would find useful.</p> <p>Although she is saying she is thinking about it, this does not mean that she will attend. She may be saying this to avoid embarrassment, but she does not want to go and I think she will not attend because she has already decided not to go.</p>
<p>WC Well, to be honest, I don't think I'm going to bother, but the answer to her question really - but then, I don't really think I've given it much thought, to be honest. I mean, I just don't think it's me to go to something like that. I know I shouldn't say that but it just doesn't interest me whatsoever.</p> <p>VL Is it the thought of perhaps sitting with a lot of other women during pregnancy, or having to go out to do it, or perhaps you don't feel you need the information?</p> <p>WC Oh, I think everybody could do with the information, what I've got there is obviously good advice, I don't know what it is, whether it's an embarrassment factor, I don't really know - at 28 weeks they start - I just don't know.</p>	<p>Refusing</p> <p>Hasn't thought</p> <p>Not her style: ?personalising</p>	<p>Has not really thought about it because she has already decided not to go</p>



## Appendix 6 (cont)

Transcript	Preliminary codes	Memos
<p>VL When you say embarrassing, what would you actually mean?</p> <p>WC Well, just moaning and groaning with other women, probably!</p> <p>VL Oh I see - so it's the exercises</p> <p>WC Yes - which I suppose it's totally - it's silly really - they are, there's six or seven of them now.</p> <p>VL No, it's not silly at all</p> <p>WC I mean, I'm not an embarrassed sort of person, that doesn't - but then I must be in some ways - but I think it's more to do with that, sort of being there, puffing and panting with other women, it just doesn't give me any enthusiasm whatsoever, it just turns me off, if you like, it's not something I'd really like to do.</p> <p>VL You wouldn't go to yoga or anything like that!</p> <p>WC No, I don't go to anything like that, I mean I go swimming or out on my bike, but I don't even go to keep fit or .. never have done.</p> <p>VL So, were you thinking this when the midwife kept reading that one, but I don't read them cover</p> <p>WC I probably was, yes. But parentcraft - they're informative as well as, you see I didn't really know - it's not just exercising then, they do other things as well, do they?</p> <p>VL As far as I know, yes, they would spend the first bit on talking about pregnancy and labour, and what actually happens, and then the last bit is spent on the exercises - that's how a lot of them are carried out, but it depends on which midwife is doing them.</p> <p>WC I suppose I ought to go because it is one way of meeting the midwives here in (Unit C), there is quite a handful of them really, and you don't get to see all of them, I don't think, not always, but it might be - maybe once you've been once you're all right, it's the initial going -</p> <p>VL Why would you think it's important to meet all the midwives?</p> <p>WC Well, you never really know which one's going to be on that night or day that you go in.</p>	<p>Assuming content</p> <p>Providing reason for not wanting to attend</p> <p>?Denigrating more probably avoiding conflict and also avoiding assertive behaviour</p> <p>Rationalising decision in terms of the advantages to her</p> <p>Selecting reading to meet individual needs</p> <p>Specific info</p> <p>Taking cover</p> <p>Rationalising choice to attend</p>	<p>WC does not like the idea of exercising with other women: she would be embarrassed by this although the other parts of the classes she would find useful.</p> <p>Although she is saying she is silly, she may not mean this. Instead she may be saying 'YOU may not understand, but that's the way I am and I shall stick to that!' It may be a tactic to avoid asserting her refusal.</p> <p>Having been reassured her feelings are acceptable to me, she proceeds to make slightly more assertive comments. WC is 'sussing me out' at this point.</p> <p>WC knows that parentcraft is not only exercising - she is probably still sussing me out!</p>



## Appendix 6 (cont)

Transcript	Preliminary codes	Memos
<p>VL And would you have liked to have met the midwife? <i>in my diary, as I say, goes quite a bit into what she's done, and two or three of her friends,</i></p> <p>WC Yes, I would. I mean, I do know two or three of them, and each time I've been for an antenatal it's been a different one, so it just is sort of nice to see who they are, there's six or seven of them now, I'm not sure really how many there are, but <i>not</i> there's quite a handful, isn't there? So I feel I'd like to meet them all eventually, you know, throughout, you're not just a piece of paper to them and they're not to you - it is nice to ... <i>imposed in me rather than going to them</i></p> <p>VL What about the actual information at the classes - would you go for that?</p> <p>WC Yes, well sometimes I've done that - not so</p> <p>WC Yes - I wouldn't mind, although it's second pregnancy there still are things - still read back, I mean I've got quite a lot of leaflets, booklets that the hospital have already given me. <i>and I would do for this one - but I suppose these classes are quite</i></p> <p>VL Have you read all of them? <i>only - if there's a crowd of women all together it's probably easier to</i></p> <p>WC Snippets - Ems diary, that's quite good, I keep reading that one, but I don't read them cover to cover, but there are bits in them. One time I was getting twinging pains and I wondered what's this, and it was handy to read through. And my blood pressure was up one time, and it was quite nice to read, you know, the things you are supposed to be doing, to reduce it, and it's useful to see it there in black and white to give you a bit of comfort and reassurance that you're all right, and not in trouble, and the baby's all right. <i>then I started work at six and I was only twinging,</i></p> <p>VL So would you tend to sit down and read them from cover to cover, or would you just go to them when you've got a specific problem to see what it says? <i>if feeling ill or anything, I would like to -</i></p> <p>WC No, well they're upstairs by the side of my bed, and most nights I'll pick one up and just flick through it, and think I've not read that bit, then I'll read it, so by the end of the time I'll probably have read it cover to cover, but not in correct order, you know, it's as and when something's happened to me, the movements started and at the moment it's quite vigorous, every day quite a few times during the day as well, not just two or three times, it's moving quite a lot, and it's quite nice</p>	<p>Gathering info</p> <p>Focusing info</p> <p>Relating to self</p> <p>Rationalising decision in terms of the advantages to her</p> <p>Selecting reading to meet individual needs</p> <p>Rationalising Specific info</p> <p>Relating to Taking advice experience</p> <p>Reassuring herself</p>	<p>Apparently, WC's primary reason for attending classes is to meet the midwives, not so much for the information, and certainly not for the exercises!</p> <p>When reading parentcraft material, WC tends to read bits as she needs to, to answer specific questions.. She finds this reassuring and helpful. She also reads bits at random if she has no particular need for specific information.</p>



## Appendix 6 (cont)

Transcript	Preliminary codes	Memos
<p>to read what other people have experienced as well, and Em's diary, as I say, goes quite a bit into what's she's done, and two or three of her friends, - medically it's quite nice, constipation, that's another thing I seem to get a lot of, whether it's the iron tablets - but it's quite nice to read that these things do happen and, you know, that you're not just one person on your own, and not sort of ringing up every five minutes</p> <p>VL So when you look up your leaflets and read something you think Oh yes, that's what happened to me rather than going to them specially when you've got problems</p> <p>WC Yes, well sometimes I've done that - not so much this time but I certainly did with ((first baby)) I used to go to the books specifically, if something had happened to me and I needed to read up on it then I would do, yes, and I would do for this one - but I suppose these classes are quite informative about that, they probably - if there's a crowd of women all together it's probably easier to discuss how they're feeling as well, I suppose I really ought to think about going ! (laughs).</p> <p>VL Yes, as the midwife says, it's your choice.</p> <p>WC Yes.</p> <p>VL You said you couldn't go last time.</p> <p>WC Well, I couldn't because I was still working and I was sort of backwards and forwards, and then I started work at xx and I was only temping, and I would have lost my money if I hadn't gone to work, so I carried on, you know. And I mean I'd like to carry on as far as possible with this one, I'm not feeling ill or anything, I would like to -</p> <p>VL You'll think about it! (laughs).</p> <p>MC Any thoughts about feeding this time?</p> <p>WC Yes, I'd like to breast feed again</p> <p>WC Well, I'd certainly like to breast feed, there's no doubts in my mind about that, and with (last baby) I was feeding for about three months, and I'd like to do the same again if possible.</p>	<p>Gathering info</p> <p>Relating to previous (bad) experience</p> <p>Focusing info</p> <p>Relating to self</p> <p>Planning</p> <p>Making life easier</p> <p>Rationalising</p> <p>Relating to previous experience</p> <p>Relating to previous (good) experience</p>	



## Appendix 6 (cont)

## Appendix 6 (cont)

Transcript	Preliminary codes	Memos
<p>VL So this was a very short section - was that because there was nothing to say about it?</p> <p>WC I suppose a lot of people and his 1st baby</p> <p>WC No - I'm quite confident about it I think. ((first baby)) was born in summer and she did have water by bottle now and again, but she didn't really like it - it made her (?) to be honest, it was quite a large teat and she was used to a nipple instead. No I'd certainly like to, if I can, but you don't really know, do you?</p> <p>VL That's right, but all being well -</p> <p>WC Yes.</p> <p>VL And what influenced you to decide you'd like to breast feed this time?</p> <p>WC Because I enjoyed it last time. there was a definite bond. And it's easier for me, (first baby) works nights, the baby will be with me in the room anyway, and instead of traipsing downstairs to the kitchen, it would be easier - it's on tap isn't it, as such</p> <p>VL What influenced you to breast feed (first baby)?</p> <p>WC I don't really know, it just seemed the most natural thing to do. (Partner) was quite keen as well that I did, and again this time, it just seems the right thing to do, I would never say I won't bottle feed, because you just don't know whether you're going to be able to breast feed or not, but you've certainly got to try. I can't think why - money, I suppose money has to come in somewhere, it's not really costing you the extra, is it, whereas if you're bottle feeding it's quite expensive.</p> <p>VL OK - what about the next section, how long you're staying in for?</p> <p>MC And have you thought about how long you'd like to stay in?</p> <p>WC Yes, a few days, for a rest! Yes, 3 or 4 days</p>	<p>Relating to previous (bad) experience</p> <p>Rationalising</p> <p>Considering needs of younger child</p> <p>Planning</p> <p>Making life easier</p> <p>Keeping options open</p> <p>Has already decided</p>	<p>Women will often need to consider the needs of others - eg other children, partners, own friends and work colleagues - how will this affect choice, how do they balance needs?</p> <p>Women have to consider the needs of others - eg other children, partners, own friends and work colleagues - how will this affect choice, how do they balance needs?</p>



## Appendix 6 (cont)

Transcript	Preliminary codes	Memos
<p>MC It's up to you, you can stay as long as you like!</p> <p>WC I suppose a lot of people just like to get home</p> <p>MC I think perhaps with their second, because they've got a little one at home a lot of the time, and they think 'they'll get to miss me'</p> <p>WC Yes, I think she'll be quite well catered for</p> <p>MC And she's not 'young' young, is she</p> <p>WC No, so I think she'll quite enjoy popping in to see us - I think 3 or 4 days,</p> <p>MC It just gives us an idea today, once you've delivered if you feel you're quite happy, and you've the feeding going, and you want to go, no problem, or if you want to stay longer, it doesn't matter .... anyway, it will just give me a couple of days rest. And to adjust to the new baby</p> <p>WC Well I still think 3 or 4 days would be nice ... obviously she said that was possible to do that, and (first baby) will be all right, I mean it's not as though she will be here on her own, is she, I mean she's still at school during the day. No, I'd like to say that I'd still like to go for the 3 or 4 days.</p> <p>VL Right, so you seem as though you've already made your mind up about this - and the breast feeding (laughs)</p> <p>WC Well I have really, why I say 3 or 4 days - you need time to adjust I think 24 hours fair enough, people might think that's great, get home, but I shall never forget the day I brought (first baby) home, we wasn't living here, we was living in a flat down the road, but it was daunting. I just brought her through the door, and I just sat down and sobbed because you've got a small child or baby in your arms - it was there for you to look after - you've got nobody to help - I mean you have got people to help, but it seemed as if that was it, you know, you've come away from hospital where you've had on-service really, haven't you, and although obviously it will be different this time because you're a little bit more aware of it, but I still think you need a few days to adjust, and the feeding, it doesn't just happen just like that, you've got to get that right. But there again, that</p>	<p>Acknowledging others may feel differently</p> <p>Rationalising</p> <p>Considering needs of younger child</p> <p>Balancing needs</p> <p>Rationalising using past (bad) experience</p>	<p>Women will often need to consider the needs of others - eg other children, partners, even friends and work colleagues - how will this affect choice, how do they balance needs?</p> <p>Narrative here regarding previous unfortunate experience which she will obviously never forget. This has a strong influence on her present decision.</p> <p>Although she says things may be easier, she sounded doubtful and I really think she has made her mind up.</p>



## Appendix 6 (cont)

Transcript	Preliminary codes	Memos
<p>might come easier the second time, I just don't know -</p> <p>VL It's obviously an experience that's quite vivid</p> <p>WC Oh yes, yes, I mean she was a very good baby, I never had too many problems with her - I still don't, she's a good girl, but I - I can't remember how long I was in with her - 5 or 6 days I think,</p> <p>VL It sounds about right for that time ago</p> <p>WC Yes, 5 or 6 days - a couple of days at (Unit A) and the rest - that's right, I mean if I'm going to have her - or it - here at (Unit C), it is so close anyway, I mean schools' just round the corner, we're not far away at all. And it just gives you that little bit - I mean it's like a major operation - it's not something simple, so I think with having one at home anyway, it will just give me a couple of days rest. And to adjust to the new baby. And of course it might help her a little bit, with not - I don't know, I don't know how she's going to react. She's quite keen about it at the moment, but you don't know, do you?</p> <p>VL But I suppose if after 2 days you want to go, you can.</p> <p>WC Yes. Yes. But I don't think I probably will (laughs). Stay there as long as I can!</p> <p>VL This next one here is where you were asking for information about telling the hospital when you are in labour.</p> <p>WC Ah, right.</p> <p>WC When I had (first baby) at (Unit A), I just phoned them out of courtesy to say I think she was on the way, I do that sort of thing ...</p> <p>MC Yes please, if you can, it just gives us</p> <p>WC ... That little bit of time</p> <p>MC Yes to get your notes out, and we can be expecting you at the door, if you had a one and a half hour labour last time, hopefully you're going to have a short labour this time as well ..</p>	<p>Assuring that she will 'won't fuss' and will try to be ready - ?demonstrating conformity</p> <p>Asking directly for information</p>	<p>Considering needs of first child in relation to rationalising decision - trying to think of positive angles</p>



## Appendix 6 (cont)

Transcript	Preliminary codes	Memos
<p>WC But it was an all day thing, I knew a 6 in the morning it was on its way because I got spots in the pants and therefore I knew that - and that's why I phoned (Unit A) - when it's your first you don't really know, do you, and I really expecting it to be pains and contractions, which I never really got, my waters broke, and so ..</p>		
<p><i>something I must have thought of at the time.</i></p>		
<p>MC You were lucky ..</p>		
<p>WC Yes, very</p>		
<p><i>something I must have thought of at the time.</i></p>		
<p>WC Right - I shall phone again, just to let them know I'm on my way. I mean, obviously if my waters have broken I won't fuss or anything, but I shall certainly try to be ready - for them, really.</p>	<p>Assuring that she will 'won't fuss' and will try to be ready -</p>	
<p>VL Were you getting there the information that you wanted?</p>	<p>?demonstrating conformity</p>	
<p>WC Well all I needed to know really, when I went to (Unit A) I just phoned them, out of courtesy to say I thought I'd be on my way sometime that day, and I just needed to know whether I needed to do the same there (ie (Unit C)). Although I don't know whether you really do need to, though, I mean you can just turn up, can't you?</p>	<p>Asking directly for information</p>	
<p>VL Oh, sure, they won't send you away again (laughs)</p>		
<p>WC I hope not (laughs)</p>	<p>Claiming knowledge</p>	
<p>VL I think it's just so they can get your notes out, and prepare a room for you so that you don't have to hang around</p>		
<p>WC Yes, well I'll see how this one goes, but with (first baby) I needed to be in there quick and sorted out really. And I hope the same goes this way. Yes, I think that's - Yes I think so, she just said it would be a help to them, but I think that's all they say it for, that's all they really need to know so they can get the room ready and the bed sorted out and whatever. I don't know if they ever get fully booked here at (Unit C)?</p>		
<p>VL I don't think so, they'd always make room for another one! Even if you had to labour in the bath (laughs).</p>		



## Appendix 6 (cont)

Transcript	Preliminary codes	Memos
<p>WC (laughs) that's right, yes.</p> <p>VL But you were obviously still concerned about this, even though you were still early on your pregnancy.</p> <p>WC Yes - I don't really know why - it's just something I must have thought of at the time.</p> <p>VL It's not something that you've been worrying about?</p> <p>WC Oh no, not at all, I don't think I've really got any worries, to be honest. I don't think so anyway! The holiday was a bit of a worry, but you just don't quite know what - I've never flown before, not being pregnant - MC We usually go through this, which is the advice we give you about diet -</p> <p>WC (laughs) Yes - well I'm pretty good really, I think, I eat plenty of fruit and vegetables, in my last pregnancy I smoked and I cut it out about two and a half years ago -</p> <p>MC But you know the things you should be eating and the things you should be avoiding</p> <p>WC Yes, yes I do, I think.</p> <p>MC Do you drink at all?</p> <p>WC Occasionally</p> <p>WC Well, I think I know what I should be eating, really.</p> <p>VL Have you made any changes to your diet because you're pregnant?</p> <p>WC I'm eating more fruit, definitely.</p> <p>VL Is that because you feel an urge to eat more fruit (laughs) or because you think it would be good -</p> <p>WC Well, I think it's good for me really, we probably are eating healthier, anyway. (Partner) has put on a bit of weight, so I think all of us are probably consciously - even (first baby) is eating</p>	<p>Admitting and realising lack of knowledge</p> <p>Claiming knowledge</p>	<p>Decisions will be made intended to affect general lifestyle rather than just for the pregnancy. What happens if there is conflict?</p>



## Appendix 6 (cont)

Transcript	Preliminary codes	Memos
<p>more fruit as well. Also, this time of year, you don't tend to eat the stodgy foods you would in the winter. So I think our diet has got better. We're not eating so much red meat either, mainly chicken and fish, so -</p> <p>VL Would you say that's more a general health consciousness, rather than -</p> <p>WC Yes, more general, the three of us really -</p> <p>VL You just happen to be pregnant -</p> <p>WC Yes, yes, I don't think - I mean we could all eat better I daresay, I've just sat down and had two chocolate biscuits, but (laughs) - there's nothing you can do about it, is there, I just fancied it (laughs)</p> <p>VL (laughs) The next one is about the dentist and your benefits.</p> <p>MC Do you go to the dentist regularly?</p> <p>WC Yes</p> <p>MC Did you send off for your exemption certificate?</p> <p>WC Yes</p> <p>MC To get free dental treatment</p> <p>WC Yes in fact I went a couple of days after I sent it off and there wasn't anything needing doing, so ..</p> <p>MC Good - do you know about the benefits that you're entitled to?</p> <p>WC Not particularly, no, because it's all changed, hasn't it? And with only working part time I'm not sure - no, I don't know</p> <p>MC I don't think I can tell you either, because they've recently changed and I'm not sure, because you haven't been with the same employer and it's now changed to I think 6 months before you can claim. the best thing to do is to go to the DHSS and pick up the new leaflet which we haven't got as yet</p>	<p>Acknowledging and rationalising lack of knowledge</p> <p>Pursuing info</p> <p>Acknowledging lack of knowledge</p> <p>Usual health practices</p>	<p>Decisions will be made intended to affect general lifestyle rather than just for the pregnancy. What happens if there is conflict?</p>



## Appendix 6 (cont)

Transcript	Preliminary codes	Memos
<p>WC Yes</p> <p>MC They're months behind in sending them out to the people that need to know!</p> <p>WC Well I always go the dentist regularly, and I've got my exemption certificate, like I say, I really haven't got sorted out in my mind what I'm entitled to, maternity benefits, not the exemption certificate or prescriptions or anything like that, it is the - well, what money you're entitled to, to be honest.</p> <p>VL But you'll go along to the -</p> <p>WC I'll go along to the DSS - they're just open at the wrong time, half past nine to half past 12 I think, and they don't open again till half past 2, so a bit of the wrong time really. But I will go along. And they'll probably even be able to tell me at work, you know, I think it's a Mat B 1 form I need, and they'll give me one at work, I've been working and paying a stamp. But, I did read the leaflet, and reading the leaflet I'm only entitled to statutory sick pay, which is 8 weeks, isn't it? 8 weeks I think, but they'll confirm at the DHS, that's where I need to go,. But I am surprised, although I suppose they can't - that the midwife didn't actually know. I thought she might have more of an idea - that's why I mentioned I didn't know. But then not everyone is the same case are they, everybody's different, there's a lot of information to store up there -</p> <p>VL I think what had happened there was it had just changed and she hadn't had the leaflets through.</p> <p>WC Yes. Well in the Bounty pack was the leaflet, but it was April 93, so if that's the one that changed - I don't know, so that's the one I've been reading, so it might be totally the wrong one, like she said, it had changed. So I do need to go to the DHS.</p> <p>VL Yes, I think you might find there's another one since then, just to confuse everybody.</p>	<p>Taking action to access info</p> <p>Pursuing info</p> <p>Acknowledging lack of midwife's knowledge</p> <p>Rationalising m's lack of knowledge</p> <p>(so am I!)</p> <p>Planning action</p>	<p>MC did not seem to mind too much that the midwife did not know. Under what circumstances would mind/not mind?</p>



## Appendix 6 (cont)

Transcript	Preliminary codes	Memos
<p>WC Everybody else, yes. They are not easy reading, are they. (laughs) Definitely not.</p> <p>VL (laughs) This is the last one here - it's about birth plans.</p> <p>MC There is a page here which says 'Birth plan'</p> <p>WC Right</p> <p>MC Feel free if there is anything, if you have strong wishes or dislikes or anything about your labour or care before and after, if you want to write them on there - obviously when you come in we read them, and if there's things that are not clear then obviously you can discuss it with whoever's on at the time, and we do try to meet your wishes most of the time unless we advise you otherwise .. because it's there you don't have to write - if you've got no preferences - some people feel they have to write something, but you don't have to.</p> <p>WC I was looking - I've got these things at the side of my bed, I sat there with a pen the other night - there are certain things that - I don't like the gas and air, I don't like that shoved in my face, VL Is that from your experience last time?</p> <p>WC Yes. It reminded me of the dentist when I was a young girl, and it made me feel quite nauseous, that rubber mask, and the midwife said she could change it to the mouthpiece, but it still made me feel - I didn't want it, so I wouldn't want - so I need to write that down really, it's information for the midwife. Obviously I'd like (partner) there, so they need to know that, and if I have to go to (Unit A) or wherever I'd like him to come with me, so there are quite a few things I feel I ought to put on there for them.</p> <p>VL Are there any other things?</p> <p>WC I don't really want an epidural.</p> <p>VL Why's that?</p> <p>WC (laughs) The thought, I think, rather than - but then if I had to have a Caesarean I think I would want to have an epidural if they could do it.</p>	<p>Already decided</p> <p>Relating to previous bad experience</p>	<p>A lot of the choices have already been made, in the light of her previous experiences. Will primigravida require more help from the midwife to make choice</p>



## Appendix 6 (cont)

Transcript	Preliminary codes	Memos
<p>I'd like to be awake, I'd like to be aware, of what's going on. But then at the time I might - I don't know, I might want them to knock me out (laughs). But the way I feel at the moment, I wouldn't want one unless it was really necessary, unless I had to go down for a Caesarean, I'd have one then but I wouldn't want one otherwise. I didn't really have any pain relief with (first baby) to be honest ... and I'm not sure if the midwives here - if you need stitches do the midwives - would they do the stitches - do they do the stitches or do they call the doctor out?</p> <p>VL Probably it would be the midwife.</p> <p>WC Oh well, that's all right then.</p> <p>VL Would that influence you .....</p> <p>WC No not at all really</p> <p>VL Whether you had stitches or not?</p> <p>WC No I'd rather it was my own doctor if it had to be a doctor that did it. Do they normally call your own doctor out, do you know?</p> <p>VL Yes, I believe so, but it would depend on who was on call.</p> <p>WC Right, so it would be whoever.</p> <p>VL Right, but I do believe that most of the midwives there would stitch you, most midwives can do that, I would think all of the (Unit C)midwives could as they're all G grade -</p> <p>WC That's right, yes.</p> <p>VL Why would that make a difference to you?</p> <p>WC I don't know really. Confidence. I've got a lot of confidence in Dr X - whether that's because he once trained to be a gynaecologist I don't know -</p> <p>VL Confidence that he's stitch you up - nicely?</p> <p>WC Nicely, yes (laughs) Yes. And it's not very nice is it, I had a few with (first baby), it was</p>	<p>No prior experience</p> <p>Setting conditions</p> <p>Identifying future needs</p> <p>Prior knowledge of individual - trust in that person</p>	<p>What is the relevance of trust in making choices?</p>



## Appendix 6 (cont)

Transcript	Preliminary codes	Memos
<p>mostly inside, and it was a little bit painful, but it was the doctor that did that, and she tried to do 2 stitches that were quite close together, and she did that without freezing the second part and I sort of shot up a bit, and that's something - I don't really remember the birth very much, but the stitches after.</p> <p>VL It's funny the things you - well, it's not funny at all, but it's remarkable ..</p> <p>WC Yes (laughs) what things - yes, but probably because I did have a pethidine shot but I think they gave that to me a good 40 minutes after I'd been there, so I don't think it was really working - I don't know, how long does it take to work?</p> <p>VL About 30 minutes to an hour</p> <p>WC So it wasn't really - it was more afterwards -</p> <p>VL Which might not have been a bad thing</p> <p>WC No, oh no. The other thing I really did suffer with quite badly was afterpains, and I didn't know what they were and never said anything to anybody really, when I was at (Unit C) last time - do they give you painkillers for that, even when you're breast feeding?</p> <p>VL I've never worked at (Unit C) so I don't know what they do, but I imagine they would - if you ask for a couple of panadol half an hour before you feed, they will be working</p> <p>WC Yes, because that was quite - I remember lying awake thinking Oh, that's painful, worse than the birth. But I don't think there's really anything else at the minute. I've been thinking about this birth plan. I've always liked the idea of a water birth as well, it's always looked so relaxing, but I don't think they've got the facilities at (Unit C) to do it, they might have at (Unit A), I'm not sure really.</p> <p>VL If they did, would you choose it?</p> <p>WC Yes I think I probably would.</p> <p>VL Why would that be?</p>	<p>Comforting</p> <p>Good for baby</p> <p>Seen on TV</p> <p>Previous experience</p> <p>Rationalising worry about tests</p> <p>Relating to previous (bad) experience</p> <p>Facilities not available</p>	<p>Previous experience may not be useful, it may give little indication of what may happen this time</p>



## Appendix 6 (cont)

Transcript	Preliminary codes	Memos
<p>WC I don't know, it just looks so soothing - I mean, if I had another birth like with (first baby) I wouldn't have a chance, there just wouldn't be the time for it, but I think if the labour was going on, a couple of hours or more, it would be quite nice. You relax in the bath anyway, there's nothing nicer at the end of the day to get into a bath, which I do most nights, and you seem to be - well, you're weightless, aren't you.</p> <p>VL Yes, it varies an awful lot. But from what</p> <p>VL You think that might be nice in labour.</p> <p>choices -</p> <p>WC Yes I do. I don't know if it's good for the baby, I haven't read much about it, because I suppose because we haven't - knowing we haven't got the facility at (Unit C)- I've only seen it on the television, you know, it always looks quite -</p> <p>VL A lot of what you're saying seems to reflect very much your previous experiences.</p> <p>WC Yes, I think you probably do, don't you. With your first you just don't know what to expect really. I suppose you shouldn't really expect anything with your second because they're all totally different, but at least you've got some sort of any idea - I don't know if that's a good thing or a bad thing really! (laughs). Knowing what's going to happen to you. It's got to come out somehow or other (laughs). You can't worry too much about it, can you? I worried once or twice, just lately I think - you know, I've had all the tests and everything, and everything's all right, but you've still got that niggling feeling, is everything all right, but that again must only be natural, I'm not unique in thinking that, surely?</p> <p>VL No indeed. If you think about the first question most women ask after the baby's born, it's Is it all right, and then Is it a boy or a girl.</p> <p>WC Well I was totally different, I asked how many toes has it got - (partner) was born with an extra toe, so that was ...</p> <p>VL What do you feel overall about the choices that are available to you?</p> <p>WC I think we're quite lucky here at (Unit C), actually, I haven't met all the midwives, but the</p>	<p>Setting parameters for being well provided for by obstetric services</p> <p>Comforting</p> <p>Good for baby</p> <p>Seen on TV</p> <p>Listening to advice</p> <p>Retaining right to make choice</p> <p>Previous experience</p> <p>Rationalising worry about tests</p>	







## Appendix 6 (cont)

Transcript	Preliminary codes	Memos
<p>VL Attitude?</p> <p>VL And do you feel that that sort of attitude during</p> <p>WC From the mother, you know. relationship with the midwives?</p> <p>VL Your attitude?</p> <p>WC Yes, I do. Yes. The way Dr X introduced me</p> <p>WC Yes. X - he said to her This is the other nice lady I was meaning to tell you about. And I thought</p> <p>VL And what would you say that was? lady (laughs). You know yourself - I do work at the</p> <p>WC Well I'm pretty easy going I think. Again, I remember at (Unit A) there was actually 6 of us delivering at the same time, which is quite a lot to be coping with, but they still left us pretty much on our own until the last few minutes, which was nice, I mean we didn't actually request that although it was nice, and then when I was being stitched up the doctor said Well at least I'm doing you and not the one up the road because she'd screamed and screamed, and I know pain can be quite bad, but I'm sure it doesn't need to be expressed quite so badly - I don't know, the poor lady might have been in an awful lot of pain, I don't know. It varies a bit, I think.</p> <p>VL So you feel your easy going attitude helped?</p> <p>WC Yes, yes, I think it did, and (partner) as well, he's not pushy - he's laid back.</p> <p>VL So you feel this helped with when ...</p> <p>WC Yes...</p> <p>WC Yes, I think so, yes, there was no rushing (partner) away, he was there and they made us a cup of tea, and well - they gave me the baby straight away and I delivered the afterbirth then I think, and they started stitching me, and that's when (partner) took the baby, and she wasn't really put in her cot till we went up to the ward.</p> <p>VL And you feel that might not have happened if you'd been more pushy?</p> <p>VL Yes, it's nice, isn't it - it is a nice cosy room.</p> <p>WC Probably, yes, I think they'd have thought Well lets get this one out, you know, a like I say there was 6 of us there and it could have been like a conveyor belt, but I didn't feel that at all - I didn't go up to my bed till 6 o'clock, so we was there a good 3 and a half hours, which was nice - not sort of rushed about, had a cup of tea.</p>	<p>Working upon building rapport with professionals</p>	



## Appendix 6 (cont)

Transcript	Preliminary codes	Memos
<p>VL <i>And do you feel that that sort of attitude during pregnancy can also help develop a relationship with the midwives?</i></p> <p>WC <i>Yes, I do. Yes. The way Dr X introduced me to midwife X - he said to her This is the other nice lady I was meaning to tell you about. And I thought That's nice, they introduce you as a nice lady (laughs). You know yourself - I do work at the surgery anyway, you do see some - I mean we've had some in today, some obstreperous people, and it does get your back up, you can't let them see that, but I think if you tend to be a bit boisterous, or a bit pushy, they think Well I'm not going to bother with her. And I wouldn't want that, and I'm not like that, you know, so I definitely wouldn't get that, but I think - it's human nature isn't it, you get someone and you think Here they come again (laughs).</i></p> <p>VL <i>That's right, so you'd prefer to be a bit laid back, not pushy.</i></p> <p>WC <i>Yes, I do, yes. But I think that's my nature anyway, the way I am. So if that made the birth any easier, I don't know! (laughs)</i></p> <p>VL <i>Well, they say a lot is mind over matter, so if you've got an easy going attitude and you're laid back about it -</i></p> <p>WC <i>Yes...</i></p> <p>VL <i>Are there any other issues that occur to you about choice in childbirth - how you make them, what helps you ...</i></p> <p>WC <i>No - I would like to see the labour room, and I daresay they give you a tour, they did at (Unit A) - my mum came to that, and she felt good about it, that it's not a white stark room, you know.</i></p> <p>VL <i>Yes, it's nice, isn't it - it is a nice cosy room.</i></p> <p>WC <i>Well actually I've not been in it since it's been redecorated - it was purple I think, which wasn't very becoming. But at (Unit A) it was like a poppy wallpaper, and a spotlight so they can switch all the lights off and just leave the spotlight which again was very relaxing.</i></p>		<p>WC places importance of getting on well with professionals caring for her. Attributes she cites for getting on with professionals are being easy going', not expressing pain excessively, and not being too demanding or 'boisterous and obstreperous' which 'puts backs up'. The consequences of this she cites as her partner being able to stay with her longer, and the staff not being anxious to 'get rid of her'. She perceives a 'payoff' in building a good relationship with staff, and she is obviously anxious to be on good terms with them. She said it was nice to be introduced as a 'nice lady'. Is WC really as 'easy going' as all that regarding choices? What strategies did she use when choosing with the midwife whether to go to parentcraft? If a woman does not wish to be confrontational or even assertive in making decisions but nevertheless know what they want, how do they go about establishing their choice? What about the woman who is confrontational about the choices she wants to make - what effect does this have on the woman, her attendants and others? What strategies may she use? Or perhaps there are circumstances when the most easy going' woman will become confrontational - what are these, what happens?</p>



## Appendix 7

### Outline Definitions of Midwifery/Obstetric terms

**Amniocentesis:** An invasive procedure during which a sample of amniotic fluid is aspirated by needle from around the fetus. From this, fetal cells are cultivated and examined for genetic abnormalities such as Down's syndrome. This test may be offered following a triple test revealing a high risk of Down's syndrome (or other specific disorders).

**Booking clinic:** The clinic attended towards the beginning of a woman's pregnancy where details of her social, medical and obstetric history are recorded and decisions are made regarding for instance where she is to receive antenatal care and where she will be delivered. Information is provided by midwifery and medical practitioners regarding aspects of childbirth and relevant health education advice is given. The health of the woman and her present pregnancy are assessed. (NB please see Appendix 1 for the role of the midwife).

**Childbirth:** Pregnancy, labour and the puerperium.

**Chorionic villus sampling (CVS):** An invasive procedure whereby a sample of placental tissue is aspirated by needle, during early pregnancy. Examination of the cells obtained may indicate fetal abnormality.

**Down's syndrome:** A chromosomal disorder producing varying degrees of learning disabilities together with an increased risk of heart abnormalities.

**Konakion:** Synthetic Vitamin K, often given by injection to the newborn baby to assist blood clotting factors and prevent haemorrhagic disease.

**Klinefelter's syndrome:** A chromosomal disorder found in males which affects growth, fertility and possibly intelligence and learning abilities.

**Parity:** The number of children borne. For example, a Para 1 will have borne one child, a primipara will be expecting her first child. A multipara will have borne more than one child.

**Postnatal period:** The 4 weeks following delivery.

**Puerperium:** The 6 - 8 weeks following delivery.

**Screening tests:** Tests carried out on the whole of the population at risk in order to identify those with the disorder. An example would be the triple test.



**Spina bifida:** A disorder whereby the spinal cord fails to develop properly. The abnormality may be incompatible with life, or may cause gross disability, or may only cause minimal disability. Often, some degree of permanent paralysis results.

**Syntometrine:** A drug given by intramuscular injection which causes the uterus to contract. It is often given at the birth of the baby to hasten the expulsion of the placenta.

**Third stage of labour:** The part of labour between the birth of the baby and the expulsion of the placenta and membranes. This usually lasts approximately 5 to 15 minutes and constitutes the period around which the woman is at most risk of uterine haemorrhage.

**Toxoplasmosis:** A disease transmitted especially by cat faeces which causes minor symptoms in a pregnant woman but may have devastating effects upon the development of the fetus.

**Triple test:** A series of tests performed upon a sample of blood taken from the woman in early pregnancy to determine whether her fetus is at high or low risk of certain abnormalities such as Down's syndrome and neural tube defects (spina bifida and/or anencephaly).

**Ultrasound scan:** A non-invasive procedure by which the fetus and placenta (and other structures) may be visualised by means of high frequency sound waves. The fetus may be examined for abnormalities such as neural tube defects, limb anomalies, heart and other defects. The position of the placenta may be visualised and the general size and development of the fetus monitored as well as its gestational age assessed.



## Postscript

