# GREAT EXPECTATIONS:

## A Sociological Analysis of Women's Experiences of Maternity Care in the 'New' NHS

Thesis submitted in accordance with the requirements of the University of Liverpool for the Degree of Doctor in Philosophy by

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# Chapter One

## Great Expectations: Becoming a Mother in the 'new' NHS

### Introduction:

This thesis is a study of women's experiences of and attitudes towards maternity care services in the 'new' (post 1991 reform) National Health Service (NHS). At the most general level, the thesis is concerned to examine the impact of the organisation and delivery of maternity care in the 'new' NHS on women's experiences of becoming a mother. More specifically, the thesis is also concerned to assess whether the fundamental reforms of the National Health Service such as Working for Patients (1989) and subsequent policy initiatives within the field of maternity care (Winterton 1992; Changing Childbirth 1993) have led to modern maternity services being provided in a more 'woman-centred' manner. The research uses the methodology of a panel study which explores the experiences and views of a group of women users of NHS maternity care services as they move through each of the three 'stages' of the maternity care 'cycle' (i.e.; antenatal, labour/delivery and postnatal).

### Childbirth - A 'Contested Terrain'

The organisation and development of modern post-war maternity care services within England and Wales and also, to some extent, in other western societies, can be regarded as the product of a 'discourse of risk' promulgated principally by the medical profession. In Britain in particular, the central argument used to bring about fundamental change in the organisation of maternity care focused on the claim that a significant reduction in the risk of infant and maternal mortality can be achieved by shifting the primary location of birth from the home to the hospital., since this permits a higher degree of clinical intervention during the process of labour and delivery (Cranbrook Report 1959, Peel Report 1970, Short Report 1980). Critics have argued that the subsequent implementation of this policy has led to the progressive "medicalisation" of reproduction and childbirth, which has had negative consequences for women users of maternity care services. During the 1970's and 1980's, for example, research into women's experiences of modern maternity care routinely described such experiences as, variously, 'controlling', 'alienating', 'de-humanising' and 'stressful' (Arms 1975; Kitzinger 1978; Cartwright 1979; Graham and McKee 1979, Oakley 1979, 1980; Fearn et al 1982).

According to Becker and Nachtingnall (1992) medicalisation refers to the process by which human experiences are redefined as medical problems. Gabe and Calnan (1989) argue that within modern systems of health care medicalisation refers, inter alia, to the way in which the jurisdiction of medicine has expanded and now encompasses many conditions that were not formerly defined as medical entities - most notably childbirth. With the increasing professionalisation of medical institutions (Arney 1982, Hugman 1991, Williams and Calnan 1995), critics have also claimed that the corresponding growth in the use of technology in health care has created a cultural dependence on doctors which has removed peoples' ability to engage in self care (Illich 1976, Young 1995). Zola, for example, portrays medicalisation as a form of social control due to the fact that modern forms of health care create a reliance on medical expertise (Zola 1972). Within the context of this general process, Oakley suggests, consequently, that " .... the colonisation of birth by medicine [may be] viewed as a thread in the [wider] fabric of [society's] cultural dependence on professional health care." (Oakley 1979, p15).

In the opinion of several commentators, the process of medicalisation is closely associated with the notion of 'modernity'. Van Gennep, for example, notes that in 'traditional' or pre-modern societies, the progress of the individual through the life cycle is conventionally regarded as a 'natural' process, with various key stages, notably the transition to motherhood, marked by "rites de passage" (van Gennep 1966). According to Jordan, the relative decline in such external symbolic displays of celebration of the social transformation of the individual is commonly associated with the emergence of a more "modern" less "traditional" form of social order (Jordan 1983). However, the contrast between traditional and non-traditional, pre-modern and modern societies can be overdrawn, as the recent revival of interest in such issues as the sociology of the life cycle testifies (Dex 1987) As Arber and Ginn point out, although the distinction is useful analytically, at an empirical level, elements of the one ideal type of social order, for example 'traditional' society, can often be found in societies characterised by the contrasting ideal type viz. 'non-traditional'/'modern' societies (Arber and Ginn 1991).

Hence, modern societies often exhibit social tensions between what might be called the "traditional" and "non-traditional" elements of social order which co-exist within their more complex social structures. Certainly, in the late twentieth century, the process of becoming a mother illustrates how such supposedly 'modern' societies can display deep rooted social tensions and conflicts, which is reflected in the many contrasting and often contradictory ways different groups

think, feel and act in respect of the process of motherhood and childbirth. As Jordan (1983) observes in her cross cultural investigation of childbirth, there is in fact no society which views birth purely as a *physical* process, since all societies socially mark and shape women's transition to motherhood in some way or other. Not only is the advent of motherhood socially marked, but in modern society in particular this process has also become, to use Edward's phrase, a "contested terrain" (Edwards, 1979). As a large corpus of research suggests, the contemporary process of becoming a mother is one which is fraught with tensions associated with social conflicts over the management of pregnancy, birth and its aftermath.

A major focus of attention for research has been with the contrasting and conflicting 'frames of reference' or 'discourses' about the process of becoming a mother which characterise the different worldviews of, on the one hand, the carers of pregnant women (which in modern society, involves almost exclusively medical and nursing practitioners) and on the other, women themselves (Comaroff 1977; Oakley and Graham, 1981). A conflict or tension is typically seen to exist between the largely successful attempt of contemporary medicine to "medicalise" motherhood (in the sense of establishing medicine's 'right' to manage pregnancy and birth) and the apparent dissatisfaction of women with the form of 'maternity care' which emerged as a consequence of this process of 'medicalisation'. (Doyal 1979; Kitzinger and Davis 1979; Oakley 1979,1980; Macintyre 1981; Evans 1985; Hall et al 1985).

At one level, women's dissatisfaction with modern maternity care is sometimes presented as a general consequence of the "iron cage" of modernity, in a Weberian sense. That is to say, the emergence of a modern, hospital-based system of maternity care can be regarded as part of the general 'bureaucratisation' of modern life, whereby hitherto 'personal', or in Parsonian language 'affective' aspects of social life are increasingly treated in an 'affectively neutral' manner. (Parsons 1966, Davies 1995, 1996). At another level, the 'medicalisation of motherhood' is also seen as a site of tension or conflict which is essentially *gendered* in character. Many feminist researchers in particular see the 'medicalisation' of pregnancy and birth as the product of a *patriarchal* system of inequality[1] (Chesler 1972, Ehrenreich and English 1972,1973; Boston Women's Health Book Collective 1973; Arms 1975, Oakley 1984, Witz 1992, Davies 1995,1996). Such critics argue that this reflects the pursuit of the interests and concerns of a largely male

[1] Patriarchy involves, in Stacey's words "...the systematic organisation of women's oppression" (Stacey J, (1993) in Richardson and Robinson (eds), p53. The fluctuating fortunes of the concept of patriarchy in feminist thought are discussed in more detail in Chapter 5.

dominated obstetric profession on the one hand at the direct expense of its exclusively female clientele on the other (Nicolson 1993) - a view which the thesis characterises as a 'discourse of control'.

Feminist thought takes many different forms of course, reflecting in part the diverse experiences of women themselves. Liberal feminism, for example, which has its roots in the Enlightenment emphasis on justice, rationality and equality, emphasises the prospect of an essentially incremental or relatively piecemeal pattern of change, arising from discourse and debate about gendered or socially produced inequalities between the sexes. Radical feminism, by contrast, sees such gendered inequalities as much more deeply rooted in the self-interests of men/ 'patriarchy' (Millet 1970) and / or class divisions (Phillips, 1987). Consequently, radical feminism regards gender inequalities as less susceptible to change by rational discourse and / or education. The emergence of Black Feminism in the 1980's and 1990's (Hooks, 1984, Hill-Collins,1990) has contributed what might be described as a post-modern dimension to Feminist thought, underlining the difficulty of generalising about the nature of women's experiences in gendered social contexts. It is important therefore to acknowledge the diversity of feminist thought which is revealed by such general contrasts and equally importantly the diversity of opinion which occurs within these broadly different approaches, especially when one is examining the contribution which feminism has made to the critique of modern maternity care. Feminist critics of such a system of care not only differ in their views as to the nature of the problems which it creates for women but may also differ in their views about the nature of any possible 'solutions' - a point which is discussed at greater length in later Chapters. It is also important to underline the point that not all critics of modern maternity care are feminists - even though, arguably, the majority are.

In addition to the tensions between the 'discourse of risk' and the 'discourse of control', which have been outlined briefly above, in England and Wales at least, the development of modern maternity care has also been subject to the influence of a new 'discourse' or ideology during the late 80's and 90's, a discourse which the thesis describes as the 'discourse of choice'.

In the late 1980's, health care in the UK was subject to a right-wing libertarian-inspired programme of 'reform'. This was presented as an attempt to increase the power and influence of the patient or 'consumer' within the NHS by means of the introduction of 'market forces'/market mechanisms (Working for Patients 1989;

Local Voices 1992) - although Paton et. al. argue that cost containment was one of the principal motives underlying such reforms (Paton 1992, Ham 1992). In addition to this general programme of reform of the NHS as a whole, in the early 1990's policy initiatives within the specific area of maternity care also emerged as part of the same general package of reforms (Winterton 1992, Changing Childbirth 1993). These challenged the general thrust of the discourse of risk which had underpinned the broad development of maternity care policy throughout the post-war era in England and Wales. This new approach to maternity care policy and practice was in direct contrast to all previous policy directives in this field and represented a sea-change in 'official' thinking about such matters.

The last quarter of the twentieth century has been marked by the emergence of popularist right-wing libertarian ideologies, which have commanded widespread public support in a number of western democracies. Governments of this political hue have emphasised the primacy of market forces in the production and distribution of both goods and services and both the political and moral value of possessive individualism. Libertarian thinkers in particular have criticised state owned institutions on the basis, inter alia, that they are inefficient, costly and limit 'consumer' choice and therefore personal freedom.(C.f. for example, Nozick 1974 (USA) and Green 1990 (UK). Accordingly, governments have been exhorted to 'roll back' the involvement of the state in the organisation of civil society on the grounds of both cost and effectiveness.

In the UK, this change in political outlook found its expression in the attempts of successive conservative administrations in the 1980's and 1990's to roll back the frontiers of what, in a British context, is conventionally referred to as 'The Welfare State'. In Britain, the principal focus of concern has been with the state-run and state-owned system of public health care (the National Health Service), the public system of state education and the public system of state welfare benefits, since these areas are regarded as the three of the most expensive areas of public expenditure.

Whilst the level of political support for some populist right-wing governments in late modern societies appears to have waned in the final decade of the century, interestingly, the governments who have replaced them (from supposedly contrasting political positions), have sought to sustain many of the key elements of their predecessors political philosophy and practices. Galbraith argues that modern societies such as our own are now typically characterised by what he terms a

'culture of contentment' which is generally resistant to State Intervention in the affairs of Civil Society and tolerant/indifferent towards social inequalities, a change which all contemporary political parties tacitly or overtly acknowledge. In Galbraith's own words, "...communities that are favoured in their economic, social and political condition attribute social virtue and political durability to that which they themselves enjoy" (Galbraith 1992, p2). Whilst the phrase 'culture of contentment' itself is rather misleading, given that libertarianism has excited much critical comment and response, it nonetheless draws attention to the emergence of a broad political consensus which contrasts with the much sharper and overt political and class divisions which were characteristic of the early stages of development of 'modern' society.

These two major aspects of social change in late modern societies - the rise of a right-wing libertarian agenda for the 'reform' of modern societies and the rise of modern feminism - are likely, however, to be a source of tension within contemporary societies, for several reasons.

At a general sociological level, whilst libertarianism emphasises the primacy of individualism, formality and competition, feminism, even in its various guises, generally emphasises a quite different set of values. Most feminists stress the importance of personal relationships, for example, which they regards as worthy of consideration as a 'political' or public issue and many feminists also underscore the importance of what, in Parsonian language, could be termed the 'affective' or 'emotional' dimension of social life (Bowles and Klein 1992). Feminists also tend to emphasise the possibility and importance of creating more supportive and co-operative social relationships in contemporary societies, at least among women (Jackson 1993, Witz 1993). At the more specific level of political action, whilst libertarianism suggests that health care should be regarded as a *private,* 'commercial' matter, feminists typically regards this as a major *public* issue. For feminists, the transformation of gender inequalities in late modernity requires women to take control of their own reproductive capabilities, since it is these which constitute the basis for the persistence of the very gender inequalities which feminists wish to eliminate or at least ameliorate. (Corea et al 1985a, Hanmer and Allen 1980; Spallone 1989; Kitzinger 1985; Harding 1986)

## Becoming a Mother in the 'New' NHS

Health care policy and practice, but especially maternity care policy and practice, thus constitutes the site of several sources of tension or conflict within contemporary societies. This is particularly true in the case of the UK in the 1990's, where the NHS has been the subject of fundamental changes in both its policy and practice, designed to introduce 'market forces' into the organisation and delivery of public healthcare.

An examination of the degree of influence exerted over the development of modern maternity care by professional service providers cannot therefore be divorced from a consideration of the relative influence exercised by both libertarianism and feminism thought over maternity care policy and practice (Williams and Flynn 1997) - notwithstanding the fact that until comparatively recently (at least within Britain) maternity care has been largely shaped by the 'internal' influence of key groups of service providers.

A study of women's experiences of the process of becoming a mother within the 'new', 'reformed' or market-orientated NHS provides a vehicle for the examination of several key tensions affecting the development of modern society as a whole.. Such a study presents one with the opportunity to explore, for example, the potentially problematic relationship between both libertarianism and feminism in the context of their independent attempts to re-structure the organisation of health care in a modern society like Britain - an issue of some considerable importance to each, for very different reasons. At the same time, such a study also provides one with the opportunity to examine the degree to which the various 'professional' interests within modern medicine act to facilitate or 'resist' such 'external' attempts to change their existing practices. Concomitantly, a study of an attempt to reform professional health care practices within the UK is also likely to provide one with some indication of the relative success of libertarianism and feminism in their respective and very different attempts to challenge the 'medicalisation' of modern life in general and maternity care in particular..

## Studying the Process of Becoming a Mother in the 'New' NHS .

The creation of a research project designed to explore these issues commenced in 1992. The project was initially developed using a type of research design known as a 'panel study'. The essential 'logic' of such a study - which is discussed in more

detail later in the thesis - is to follow a particular group of people through a series of events or changes and to assess their reaction or attitudes to these changes periodically.

One of the principal strengths of this type of research design is that it allows one to assess the effect of *change* in a systematic, controlled manner, by focusing on the experiences of a single group *over time*. This is especially appropriate for the study of women's experience of maternity care, since maternity care provision occurs over an extended period of time (antenatally, during birth and postnatally). This reflects what the thesis terms women's maternity 'careers', through pregnancy, delivery and motherhood.

The panel study itself involved the selection of a sample of women users of maternity services, at an early stage in their pregnancy. Women's experiences of antenatal service provision, intrapartum care and postnatal services were assessed at three different points in time, in order to examine their attitudes to the care that they had received at each of these three stages. The first stage of the panel study began in 1992 and the third stage was completed in 1995. Since the general or structural changes in the overall organisation of the NHS were implemented in 1991, but the specific attempts to alter maternity care provision only began at a slightly later date (1993 onwards), the impact of the earlier more general reforms on the organisation and delivery of all NHS care may well have been rather greater during the period of the panel study than the impact of the later reforms which focused directly on the specific problems of maternity care. It was decided therefore to directly address this potential problem in the design of the research by examining, in a separate though related piece of research, a case study of a specific attempt to alter the organisation and delivery of maternity care in particular in line with the recommendations of the later programme of reforms, which focused solely on maternity care. This additional piece of research concentrated on an innovative concept, team midwifery, which seeks to alter the organisation and delivery of maternity care in a fundamental manner.

**Structure of the Thesis**

The thesis is divided into three broad sections. Section 1, examines the principal 'discourses' or perspectives around which the debate about the development of maternity care in late modern Britain has revolved. In view of the complex nature of the three main contrasting 'discourses' which have been outlined briefly above, a

review of the literature on the development of modern maternity care is conducted with specific reference to the 1991 reforms of the NHS and the subsequent development of maternity care services in the 1990's. This linkage of all *three* discourses (which the thesis refers to a discourses of 'risk', 'control' and 'choice') is an aspect of analysis which has not, to date, been produced elsewhere. Section 2 of the thesis, focuses on the research issues addressed and the methodology employed by the thesis. This section also presents the analysis of the evidence from the panel study of women's experiences of maternity care in the 'new' ('reformed') NHS. In addition, as indicated earlier, Section II presents an evaluation of an innovatory project designed to bring about a more "woman-centred" form of care through the development of a new form of service delivery - "team-midwifery". Section 3, summarises the principal conclusions of the thesis.

Within Section 1, following this introduction, chapter 2 reviews the principal professional or clinical rationale for the development of modern maternity care services which this thesis terms the 'discourse of risk'. One of the key assumptions of this discourse is expressed by the constant warning offered by modern obstetrics that no birth is 'normal' until it is completed. Childbirth is always 'safer', modern obstetrics argues, if it occurs under the management of obstetricians in a hospital which is equipped with the technological equipment necessary for undertaking interventions or monitoring the natural process of birth (Shearer 1986, Winterton Report 1992). Successive 'official' governmental (and other) committees supported this view, despite research which suggested that the supporting evidence for such a position is not as clear cut as might at first appear (e.g.; Butler and Bonham 1963; Huntingford 1985; Lewin and Olesen 1985; Oakley 1980; Mehl 1978; Tew 1990, Campbell and Macfarlane 1990). So dominant has this ideology become within modern medicine that virtually all economically developed countries (with the exception of Holland) have moved towards a target of maximum (100%) hospital delivery.

Consequently, the past forty years has witnessed a progressive re-location of the place of birth out of the home and into the hospital, with the alternative of a home birth becoming far less widely available - and this despite the fact that, as the discussion in Chapter 3 illustrates, what might be termed the 'internal validity' of the 'scientific' evidence used to support the 'discourse of risk' has been shown to be flawed (Tew 1990; Campbell and Macfarlane 1994). This long term shift in the direction of maternity care policy and service provision also generated a chorus of critical disapproval from women themselves, as both users and academic critics of

such a form of care, though with little immediate effect. The emergence of this alternative discourse - which the thesis terms the 'discourse of control' - is outlined and discussed in Chapter 4. A group of largely feminist-inspired researchers, whom one can describe as the harbingers of the 'discourse of control.' (e.g. Arms 1975: Oakley 1979, 1980; Cartwright 1979; Kitzinger 1980; Oakley and Graham 1981,1986; Evans 1985; Davis-Floyd 1992) emphasised that the professional, obstetrics-led management of pregnancy and birth, together with the increased use of routine monitoring and interventions during pregnancy and labour, has had a particularly negative impact on women's experiences of modern maternity care

A common theme underlying much of this feminist-inspired criticism focuses on the issue of social control. The move towards hospital based maternity services was seen to shift the locus of control away from lay people to professionals and also, equally importantly, from an earlier midwifery-led system of care (predominantly provided by women) to obstetrics, the majority of whose practitioners are men. The "discourse of control" underlines therefore, the link between the shift in the general type of maternity care provided (from the home to the hospital) and changes in the type of professional control exercised over women associated with the emergence of a modern, hospital-based system of maternity care. Although not all feminist critics offer specific prescriptions for changing the nature of maternity care provision, the thesis argues that an important sub-text of the discourse of control for some feminists at least concerns the need to recover the more "traditional" notion of 'natural' childbirth, which is seen to be closely bound up with female, rather than male, experiences of life (e.g. Kitzinger 1994).

Chapter 5 examines the principal points of difference (but also some of the possible continuities) between these two discourses or worldviews, the 'discourse of risk' and the 'discourse of control', the first reflecting the concerns and interests of obstetricians, the second the concerns and views of the service user, or more commonly the views of researchers purporting to represent the experiences and views of service users.

It is important, at this juncture, to point out that the term 'discourse', as employed in the thesis, does not simply denote a reference to the use of language per se as in the specialist field of 'discourse analysis', typified for instance by the work of Sacks (1963) and others. Rather, its use in the current context refers to the outlook, or in more anthropological terms, the weltanschaung or 'worldview', of a particular group or social collectivity. Moreover, the use of the term 'discourse' does not

imply that the existence of a particular discourse or worldview means that such a worldview is privileged or 'powerful', a la Foucault (1973). As the thesis attests, analysis of the various discourses surrounding the development of maternity care illustrates that discourses or worldviews can both acquire power and influence and also lose such power or influence (or at least be subject to serious challenge) without necessarily disappearing or losing adherents/supporters. Arguably, it is more appropriate to regard contrasting discourses or worldviews in late modern society as contenders for power rather than as forms of power in themselves, since this allows for the possibility of challenge and therefore change. What might be called the 'history' of the 'discourse of risk' illustrates this point very well. In the early stages of the development of modern maternity care in the UK, this discourse can be described as the dominant ideology structuring this development. However, even when the discourse of risk appeared to have reached the very apogee of its success in determining the nature of maternity care policy and practice (as in the 1980's in the UK), a substantial challenge to its apparent ideological hegemony was already underway.

In addition to the above concerns, major changes occurred in both health policy and practice in the UK during the 1980's and 1990's as a result of government reforms of the welfare state in general, and the NHS in particular. These changes, which are discussed at length in Chapter 6 of the thesis, have important implications for the development of modern maternity care, and represent the emergence of an entirely new discourse or worldview which stands in a problematic relationship to both the discourse of risk and the discourse of control. Within the British context at least, the thesis argues that this new discourse requires one to examine not only women's experiences of becoming a mother under a modern system of maternity care provision, but also women's experiences of becoming mothers within the 'new', recently 'reformed' NHS. The 1989 Department of Health White Paper (Working for Patients, implemented in 1991) signalled the emergence of a new 'market driven' philosophy behind the development of health care. This emphasised, amongst other things, the role of so called 'consumer choice' in the provision of health care services through, inter alia, the development of what has been referred to as 'internal market mechanisms'. This involved such organisational innovations as the creation of a division between the 'purchasers' and 'providers' of such services and the introduction of General Practitioner Fundholding (Working for Patients 1989).

In other words, the UK in the 1990's witnessed the development of what the thesis terms a 'discourse of choice' within health care provision. Some critics of the reforms also point to the importance of a possible 'sub-text' which could be described as a 'discourse of cost' or cost containment. Paton (1994), for example, claims that cost containment and even cost reduction constituted the principal motive, or the main 'text', behind the attempt to 'reform' the NHS. Whilst one would not wish to downplay the role which cost considerations have played in the drive to 'reform' the NHS, given that the very use of such terms as 'market mechanisms' implies the importance of the 'economic' dimension in the reform process, official references to the need to contain the increasing cost of the NHS are frequently accompanied by references to the 'needs' of NHS 'consumers' and the importance of providing such 'consumers' with more 'choice'. Whether these objectives are compatible, both in principle and practice, is one issue; whether they can be easily achieved within the context of a service in which the principal service providers constitute an especially powerful 'professional' monopoly, is quite another (Williams & Flynn, 1997).

The general reforms of the organisation of the NHS have been accompanied by a major government-inspired inquiry into the organisation of maternity care services in particular. The avowed aim of this specialist review was to develop maternity services in a way which ensures that they become more "woman centred", both by allowing women a greater degree of choice and involvement in the type of care they receive and by enhancing the role of midwives in the provision of routine maternity care. In 1991 a House of Commons Health Committee was established to examine the provision of maternity services on a national basis, the report from which was published in 1992 (the Winterton Report). This was followed by the establishment of an Expert Group designed to implement the findings of the Winterton Report, which itself reported in 1993 under the title of Changing Childbirth.

Prior to the publication of Changing Childbirth, the critique of modern maternity care services had been largely ignored by both politicians and obstetricians alike. From the early 1990's onwards however, Winterton (1992) and Changing Childbirth (1993) emphasise the importance of precisely those issues which constitute a central feature of the hitherto relatively neglected 'discourse of control'. Both reports explicitly criticise the principal medical rationale underlying the development of modern maternity care provision, the discourse of risk, and state that the issue of mortality should no longer be used to 'drive' policy and

practice in this field. The reports emphasise that "...maternity and obstetric services should be considered as a whole, and not exclusively in terms of their impact on mortality" (Winterton Report, 1992, page v). According to both Winterton and Changing Childbirth, women's needs should be at the centre of any deliberations on maternity care policy and maternity care services should be organised around these needs. The importance of maternal *choice* is underlined as central to several key aspects of service provision, notably women's choice as to the place of birth, birth plans and access to information (Winterton Report, 1992; Changing Childbirth 1993).

A potentially very important aspect of the current reforms of the NHS therefore, is whether they will indeed 'empower' the service user, by providing service users with more choice, thereby enhancing their control over service delivery. This question is particularly pertinent, since the *libertarian*-inspired attempt to reform the NHS highlights an issue - that of service user choice and control - which is also central to the *feminist* critique of modern maternity care or the 'discourse of control'. The degree of continuity and discontinuity between the three main 'discourses' on modern maternity care within the UK, the discourses of risk, control and choice, consequently form the principal foci of attention of Chapter 7.

Critics of maternity services in the 1970's and 1980's highlighted the rise of modern obstetrics as a key factor in the development of the character of modern maternity care, for instance. Such critics argued that the role played by this largely male-dominated profession ensured that this system of care became progressively more 'interventionist' in character over time, thereby 'medicalising' women's experiences of pregnancy and childbirth (c.f., for example, Schwartz 1990; Cartwright 1979; Graham and Oakley 1981; Doyal 1979). This naturally raises the question 'what effect, if any, have the reforms had on the behaviour of this specific group of service providers vis-à-vis their female clientele?'. In other words, are there any indications that service providers have become more responsive to women's needs and preferences within the 'new' NHS and if so, is this true equally of obstetrics as it is for midwifery?.

It is important also to consider whether or not the reforms have brought about change across *all* aspects or sectors of the service (i.e. across different roles and different locations) as well as at each stage of the 'maternity care cycle'. Whilst *some* changes may have occurred in the responsiveness of the service to its users, this may not necessarily prove true across the whole breadth of service provision

for a variety of reasons. An uneven pattern of change may be connected with the location, ideological outlook, and relative 'power' of different occupational groups within medicine (GPs, Obstetricians, Hospital and Community Midwives). As several writers have pointed out, within the medical profession different occupational groupings exercise quite different degrees of power and control, and the NHS reforms are likely to impact on the power and influence of these different occupational interest-groups in a variety of ways (Chamberlain and Patel 1994).

In addition to outlining and discussing the central research questions, chapter 7 also considers the type of research design and methodology needed to investigate such issues at an empirical level. The thesis argues that the type of approach needed to interrogate such matters requires the use of a structured and systematic type of research design and methodology, a strategy which represents a major departure from the type of methods conventionally used by feminist researchers in this field. Feminist research emphasises the importance of adopting distinctively 'feminist research methods', which until recently have normally been associated with a qualitative approach to empirical enquiry. The notion that feminist research must employ a distinctive methodology has, on the other hand, been increasingly challenged from within feminism itself, a issue which is discussed at greater length in chapter 7.

The thesis employs a panel study design as its primary method of enquiry. Although panel studies are rarely used in British sociology, this methodology is especially suited to research on maternity care since it allows one to examine the experiences and attitudes of a single group or cohort of respondents as they progress through the different phases of their maternity 'career', from pregnancy through to birth and beyond. The thesis also develops a unique form of measurement of women's needs, which takes into account not only the degree to which women were satisfied with the care which they received but also the relative importance or salience that they attached to key aspects of service provision.

Chapters 8, 9, 10, 11 and 12 present and discuss the results of the panel study's enquiry into the experiences of a group of women users of NHS maternity care services within the 'new' NHS. Chapter 8, for example, outlines the socio-demographic characteristics of the sample of women who participated in the study, whilst chapter 9 examines the group's experiences of antenatal care within the 'new' NHS. Chapter 10 examines panel members experiences of intra-partum care,

and chapter 11 focuses on the cohorts' experiences of post-natal care and motherhood.

In addition to examining women's experiences of the post-natal phase of NHS maternity care, chapter 12 also capitalises on the methodological opportunities provided by the use of a panel study design to carry out a series of comparisons between the sample's attitudes and experiences of maternity care prior to birth, with their subsequent attitudes and experiences during the post-natal phase. This is a distinctive and unique feature of the thesis, since the methodology allows one to assess the relative impact of the organisation of maternity care at the level of the individual over time, an issue which is vital for a number of reasons. Since a principal aim of the NHS reforms is ostensibly to improve the 'quality' of service provision, it is important to examine whether any improvement in the 'quality' of maternity care achieved by the reforms has also led to an improvement in the actual *health* of the service user. In addition to any concerns about 'cost efficiency', this must, presumably, constitute an important aim of any attempt to re-organise or 'reform' health care provision. In carrying out this longitudinal analysis of the panel data, the discussion pays attention to two particular issues;

(a) women's perception of the organisation of health care up to the point of birth, and
(b) their subjective perception of their own post-natal health

In the past, studies of maternity care, especially those carried out in the 1970's and 1980's, focused most of their attention on women's experiences of ante natal care, pregnancy and their experiences of birth or intrapartum care and comparatively little attention was paid to the post-natal period. Rather surprisingly, the potentially negative health consequences of the modern, unreformed system of maternity care has never been the subject of direct systematic enquiry, despite many allusions to this possibility by feminist critics in particular. Although previous research has highlighted the fact that women find modern maternity care provision 'dehumanising' and 'alienating' (Doyal 1979; Arney 1982; Oakley 1979,1980,1984; Macintyre 1981; Williams and Calnan 1996)[2] this does not in itself necessarily imply that these individuals experience poorer health as a consequence.

[2]The precise meaning or implications of such general terminology is difficult to find, and as the discussion in Chapter 5 indicates, the use of the term "alienation" is especially problematic.

However, and irrespective of the precise meaning of the term 'alienation', one might simply argue that women find the process of becoming a mother 'stressful', due to the fact that they feel they have little 'control' over this process of change. If so, then one might also reasonably infer that for some women at least, such an apparently marked level of stress may have harmful consequences for their long-term health. Certainly, recent research on social inequalities in health would lend credence to this assumption (Townsend et al (1988), Whitehead (1988), Marmot et al (1978). Marmot et al's research in particular, suggests that variations in the degree of social *control* experienced by individuals are linked to variations in both the individual's actual and subjective health status. It might well be the case that service users who feel able to realise their choices or preferences feel healthier and, indeed in that sense are healthier, than those who perceive that their preferences have been frustrated. Accordingly, in assessing the impact of the NHS reforms at the level of the individual service user, it is essential to examine not only the degree to which the reforms have enhanced user choice, but also the extent to which such reforms may also have improved the *health* of the individual as defined by the individual herself.

Whether the NHS reforms have succeeded in 'empowering' women by providing them with more choice and therefore more control over the type of care provided to them is therefore clearly an important question in this context. Whether such a process of empowerment may also lead to an improvement in the actual health of women service users is, arguably, an even more important and intriguing question. In considering the possible impact of the NHS reforms on women's experience of maternity care, this introduction to the central issues which the thesis addresses has focused on the intended or possible outcomes of this process of reform from the point of view of women as service users. It is important to note that in the case of the policy initiatives aimed directly at the reform of maternity care, the attempt to bring about a fundamental change in the organisation and delivery of such services has implications for women as service *providers* as well as for women as service users. As mentioned earlier, a central criticism levelled at modern maternity care by the 'discourse of control' is that the development of such care has been subject to strong patriarchal influences. This is reflected, for example, in the general approach adopted by the 'discourse of risk', which largely ignores the effect that the organisation of modern maternity care has on women users. Both Winterton (1992) and Changing Childbirth (1993), call for the development of a more women-centred form of service and regard what might be termed the 're-gendering' of the organisation of maternity services as a key element in this strategy for change. For

all so-called 'normal', or 'low risk', confinements, each report recommends enhancing the role played by midwifery in the management of maternity care, with the implication that obstetrics will operate in a more specialised but also less prominent role overall. An examination of the respective roles played by midwives and obstetricians, and indeed other occupational specialisms within the 'new' NHS, is a topic for discussion throughout Chapters 9-12. Additionally, Chapter 13 presents an evaluation of an innovative "Team Midwifery" project. This allows one to consider whether a *midwifery* led form of maternity care will bring about the improvements alluded to in Changing Childbirth (1993). The final Chapter of the thesis, Chapter 14, provides a summary of the thesis as a whole and concludes with a critical assessment of the impact of the NHS reforms on maternity care.

**Summary**

A key concern of the present research is to examine whether recent organisational changes in post 1991, 'market-orientated' NHS, have indeed had an effect on the character of maternity care provision, as reflected, for example, in women's experiences of and attitudes towards this service and if so, in what direction. Specifically, the thesis seeks to evaluate whether such market driven organisational changes have contributed towards a reduction or amelioration of the conflicts and tensions surrounding the process of becoming a mother in late modern society. The thesis is concerned not only with the process of becoming a mother, therefore, but also and crucially, with women's experiences of the process of becoming a mother within the "new" NHS. A central issue addressed by the thesis, therefore, is whether a *libertarian-inspired* programme of reform in the field of maternity care can provide a vehicle for empowering *women*.

# Chapter Two

## The Development of Maternity Care in the UK: A Discourse of Risk

### Introduction

Maternity services have attracted some of the highest levels of client criticism within the whole of the National Health Service (CSS 1980). This is not surprising when one considers that the development of modern maternity care has been the focus of major conflicts of interests, values and ideologies - especially in the latter half of the twentieth century (Graham and Oakley 1979, Arney 1982, Garcia 1990).

One of the dimensions which is central to any understanding of the current nature of these conflicts or tensions concerns the clinical "philosophy" which underpins the character and delivery of modern maternity care. Key elements of this philosophy are expressed in a succession of "official" statements about maternity care policy and provision which have emanated from a series of government inquiries following the establishment of the NHS in 1946.

The principal aim of the present chapter is to indicate how the development of formal policy statements about the nature of maternity care services progressively reflect what might be termed "a discourse of risk", - a discourse which is at the very heart of the problems about the nature of maternity services in late modern societies. In order to highlight the distinctive nature of this discourse, it is useful to examine the development of maternity care from the beginning of the twentieth century up to NHS Act in 1946 and the creation of the NHS in 1948, since this represents something of a watershed in clinical policy and practice

### The Development of Professional Maternity Care Services in the UK (1900 - 1948).

During the first half of the twentieth century there was no consistent pattern of maternity care throughout the UK. Following the Midwives Act in 1902, when midwifery gained legal recognition as a profession and better education was secured for midwives, the proportion of midwives who received formal training increased from 30% in 1905 to 74% by 1915 (Central Midwives Board 1916). Following formal training and registration as a qualified practitioner, the majority of midwives worked independently, with the women to whom they provided their

services paying a direct fee, although a minority were employed by agencies such as voluntary organisations or nursing organisations which served sparsely populated (and therefore low profit) areas (Robinson 1990; Walker 1954). The function of the midwife changed at the turn of the century from being that of a person without formal training who was "with the wife" during childbirth to a position where midwives were formally trained and educated to understand the requirements for a healthy pregnancy, labour and puerperium (Bent 1982).

During the first decade of this century, the attention of the public, professionals and policy makers increasingly focused on Public Health issues, such as sanitation and housing, and as part of this wider concern attention was directed to the high national rates of infant mortality (154/1,000 in 1900) and to a lesser extent the incidence of maternal mortality (4/1000 prior to the introduction of drugs to fight sepsis in 1936). Following the developing political concern about public health and specifically the high mortality rates, the Ministry of Health concluded that the provision of routine ante-natal care was one of the key factors which would achieve a reduction in maternal mortality and morbidity figures, and an expansion in the number of ante-natal clinics occurred (Allan and Jolley 1982)

Throughout this period the majority of births occurred in the home, and whilst ante-natal clinics were available in some maternity centres it was not until midwifery services began to be subsidised by Local Government Boards (LGBs) after 1915 and a series of Acts were passed (such as the Maternity and Child Welfare 1918, Local Government Act 1929, Midwives Act 1936) that a more homogeneous, publicly funded system of maternity care provision started to evolve. Despite what may be termed these relatively successful attempts to reduce the infant mortality rate, when the first government report on maternal mortality appeared in 1924 (Campbell 1924) the high maternal mortality rate attracted adverse publicity. The high figures were problematic to a government committed to raising the birth rate (politicians from all parties were concerned about the 1930's predicted fall in population) and politically embarrassing in themselves given the increasing awareness and understanding of public measures in the maintenance of the health of the nation.

**Greater Institutionalisation - the Birth of the NHS**

Until 1946 domiciliary (home-based) midwifery remained the predominant form of maternity care provision, although the rates of hospital confinement rose steadily.

This increase in hospital confinements is evident from an examination of the rates of hospitalisation in England and Wales pre-World War 1, when only 1% of births occurred in an institutional setting, and the rates for the period 1927-1946 when the numbers of births taking place in hospitals, nursing homes and Poor Law establishments rose from 15% to 54%. The trend towards increasing hospital confinements was given an added impetus by the second world war, when many pregnant women were evacuated from their own homes and had to be delivered in hospitals or maternity homes (Campbell and Macfarlane 1987).

During this period, the commonly held view amongst both professional and lay interest groups was that home births were unsuitable and inadvisable for the majority of women. The Women's Co-operative Guild (WCG) campaigned to improve the maternity and infant welfare services available to poor women in Britain, and highlighted the poor domestic sanitary conditions of many working-class mothers and their lack of rest post-birth as evidence of the need for greater institutionalisation. The WCG also advocated uptake of the local ante-natal facilities provided, although in 1915 a Local Government Board report on local clinics highlighted that, despite the claims made as to their advantages, many clinics suffered from "crowding and protracted waiting of mothers and their children". (Tew 1990 p80). The need to provide maternity beds was recognised by the LGB who noted in their Annual Report for 1917-1918 that;

> the cessation of building and the overcrowding of towns caused by the War have emphasised the needs for maternity homes for women who cannot safely or conveniently be confined in their own homes (p34)

In addition to the growing demand from 'representatives' of working class women for increased access to hospital-based maternity care, middle class women also campaigned for more maternity beds on the basis that this would provide them with access to specialist medical care and because anaesthesia was more readily available in hospitals. The increase in the state provision of maternity care can be seen in the Ministry of Health's "Memorandum in Regard to Maternity Hospitals and Homes" (1920), which notes that in preceding year, over 500 new hospital maternity beds were provided by local authorities and voluntary agencies. In talking about the function of hospital based maternity care services the Ministry of Health memorandum (1920, p 37) emphasised that;

> maternity hospitals...are mainly required in the large towns...they should be fully equipped to for the treatment of all complications and

> disorders of pregnancy and labour and for purposes of clinical treatment. They should provide, primarily, for abnormal or difficult cases, but also for a certain number of straightforward confinements

During the early part of the twentieth century there was therefore some common ground between different sections of both lay and professional opinion over such matters as the need to reduce the maternal and infant mortality rates and improve lying in facilities. However, there are indications even at this relatively early stage in the development of maternity service policy, that differences existed between the type of wide-ranging claims for better maternity service provision demanded by midwives and women's groups (such as the WCG), compared with the more narrowly defined *clinical* (and political) concerns of doctors and governments (Eden 1926). In this emerging debate between obstetrics and midwifery about the policy orientation and provision of maternity care services, both sides advanced competing claims to become the principal clinical 'managers' of childbirth. The respective duties of the midwife and doctor within the field of maternity care outlined in 1928 by a government committee reviewing the Midwives Act illustrates this concern about the professional division of labour in such matters;

> The midwife as the person responsible in the majority of cases for the care of the mother throughout pregnancy, confinement, and the puerperal period is the one to whom the main burden would rest. In all such cases there should be available the services of a doctor, with certain defined duties towards the mother, to whom the midwife should be able at all times to look for assistance when she is faced with difficulties beyond her ordinary competence and skill, and an obstetric specialist would be called in by the doctor to deal with exceptional circumstances. (Towler and Brammall 1986, p57)

Taken in conjunction with the increasing rate of hospital confinements during the first half of the twentieth century, several writers have argued that the displacement of birth away from the home and into an acute clinical environment increased the status of Obstetrics within medicine and that this in turn *re-enforced* the trend towards hospitalisation (Arney 1982, Schwartz 1990). Indeed, at the time when there was increased political concern regarding the national level of maternity mortality, professional reorganisation within the Obstetric profession led to the establishment of the specialist British College of Obstetricians and Gynaecologists (later the Royal College (RCOG) (Lewis, 1990). Against this political backdrop and changes in the professional organisation of clinical medicine, conflicting opinion emerged within the midwifery profession and the Women's Co-operative Guild both of whom favoured a midwifery-led service, particularly for "normal"

labours and uncomplicated pregnancies.

Concern within the midwifery profession as to the potentially rapid erosion of their responsibilities increased as a result of the heightened level of medical and political involvement in maternity care policy and practice following the proposals for the new National Health Service in the 1940's. Since 1911 (The National Insurance Act) General Practitioners had been guaranteed an income from areas *other* than maternity care, and had, as a result, typically left this particular service to the office of the midwives. Following the Midwives Act (1936) GPs were even less involved in the provision of maternity services as the act required all LGB's to provide an adequate, domiciliary service. However, during the negotiations for the NHS Act, GPs maintained that they should be entitled to provide maternity care within the new system of health care. Therefore, under the terms and conditions of the National Health Service Act (1946), a specified fee was paid to the GP dependent upon whether s/he was on the obstetric list, and as a direct consequence of this many GPs took an even greater interest in maternity (and specifically ante-natal) care, thereby reversing the previous tendency to leave this work to the midwifery profession.

In addition to the possible erosion of the responsibilities of midwives by GPs following the introduction of the NHS Act, there were competing claims by the obstetric profession as to the appropriateness of midwives' involvement in all aspects of caring for the pregnant or parturient (labouring) woman. A policy statement by the RCOG (1946) indicates the extent to which they felt that midwives should be involved in maternity care;

> midwives should not be regarded as competent to undertake *unaided* the antenatal care of the expectant mother, but should always work in collaboration with the general practitioner or the obstetrician.

It is therefore apparent that even prior to the development of the NHS, maternity care services were the site of tension between different professional groups and also between lay and professional interests.

**The Development of Maternity Care Policy under the NHS (1946-1991): The Discourse of Risk**

Administrative implementation of the NHS Act (1946) occurred in 1948 which, in conjunction with the 1946 Report of the Royal College of Obstetricians and

Gynaecologists (RCOG) and the Population Investigation Committee, resulted in an immediate increase in the provision of hospital maternity beds. Since maternity and child health services would fall under the remit of the new NHS, and given that there was political concern at the low birth rate during the 1930's, the RCOG/PIC investigation provided information which would be useful in the restructuring of services whilst concurrently addressing the "problem" of declining birth rate. The recommendation of the investigation was that institutional deliveries should be encouraged on the grounds of reduced 'risk' to mother and child in the event of 'unforeseen emergencies'. This promulgated the idea that "the institutional habit would be established for the large majority of confinements" (Tew 1990, p151).

This view was espoused despite the fact that there was evidence available which called into question the reasoning that a higher incidence of hospital births would lead to a fall in both infant and maternal mortality. Tew (1990) points out that justification for such a policy may have been misguided on, amongst other things, methodological grounds (a point which will be discussed in more detail in Chapter 3). She also emphasises that the Report dismissed the survey finding of much lower stillbirth and neonatal mortality rates for birth at home, although these included a disproportionately large number of poor mothers in poor housing and with large families, the demographic subgroup at highest *risk* of a fatal outcome. Instead, it picked on the fact that 5% of the births booked for home delivery developed complications for which they were transferred to hospital and suffered very high mortality. It was therefore considered that

> until the incidence of such emergencies can be reduced, there [was] good case for the encouragement of institutional delivery
>
> (Tew 1990, p151)

Despite such conflicting evidence, the late 1940's and early 1950's witnessed an escalation in the rates of hospital deliveries, reflected in the increasing rates of institutional confinement. Although it was the initial intention of the Ministry of Health to make provision for just 50% of births, by 1952 the number of births taking place in hospitals in England and Wales had risen to 64%. (Winterton 1992). The rationale behind this rapid escalation of hospital confinements is outlined in the 1955/6 Guillebaud Committee report on "The Obstetric Service Under the NHS", which advocated the provision of obstetric beds "for all women who need or will accept institutional confinement" on the basis that "institutional confinement provides the *maximum safety* for mother and child" (para 635).

Following the establishment of the NHS, maternity care was offered by hospital services, domiciliary midwifery services and GPs. Under the NHS, mothers could book care (both ante and intra-partum) from GPs as well as a midwife. This, in theory, gave women increased choice, but with the emphasis of care shifting away from local authority, midwifery run, ante-natal clinics, many closed. With a reduction in the number of centres in which midwives independently practised their supervisory skills, and an increase in the percentage of women electing to give birth either in obstetric units or GP units allied to large acute hospitals, there evolved a gradual erosion of alternative options to hospital delivery (Campbell and Macfarlane 1987) .

The development of maternity services within the NHS during the 1940's and 1950's was ultimately judged to be successful using, in particular, the yardstick of reduced rates of infant mortality. This decrease in mortality was widely assumed to be the product of the greater degree of centralisation of birth within the hospital system. Not surprisingly perhaps, in light of this reduction in the rate of infant mortality, the 1960's and 70's saw further organisational changes all of which re-emphasised the general tendency towards increasing clinical control of the process of becoming a mother.

**Totally Confined**

Central to the reorganisation of maternity care during the 1960's and 1970's were the Cranbrook Report (1959) and the Peel Report (1970). The Cranbrook Report advocated the expansion of hospital maternity services alongside domiciliary midwifery and recommended a more rigorous selection of patients for domiciliary hospital confinements At the same time it also endorsed the shift towards greater institutionalisation via recommendations that maternity beds should be provided for *70%* of confinements. On the role of the midwife, the report opined that she should be given every opportunity to participate in the maternity care of her patients to the fullest extent which her skills and experience entitled her.

The development of GP staffed maternity beds had occurred with the establishment of integrated GP units where GPs and community midwives were able to provide the full range of maternity care services under the umbrella of large hospital based facilities. In recognising the development of such units, Cranbrook recommended that "General Practitioner beds [should be] situated within or very close to consultant maternity hospitals or general hospitals with maternity departments

[and] Obstetricians should have overall responsibility for supervision of GP maternity beds" (para 217).

Whilst stating that "...nothing should be done to lessen the importance of the midwife..."(para 107), through its recommendations that "...a general practitioner obstetrician should, whenever possible attend all domiciliary confinements, to safeguard the mother and baby against unforeseen emergencies..." and that "...the conduct of a normal confinement is the joint responsibility of the doctor and midwife..." (para 212) the Cranbrook Report clearly enhanced the status and power of the obstetric profession within routine maternity care - an emphasis which was an important additional influence in steering maternity care provision in the direction of current practice.

The Cranbrook Report was the first thorough review of maternity services provided by the NHS, and although the committee supported the move towards increased hospitalisation of birth, they nonetheless at least partially acknowledged a residual case for home births - evidenced by their comment that "...the advantages of home confinement for the apparently normal case, probably outweigh the very slight risk of unforeseen complications..."(para 57). The benefits of a home birth were seen in terms of continuity of care. Home deliveries were deemed preferable in certain cases where a woman's complete obstetric history was known by the immediate team working with her, and could be integrated into the package of care provided.

The Cranbrook Report can therefore be seen as endorsing the general trend towards a hospital-based, obstetric-driven system of maternity care, whilst attempting (somewhat ambiguously) to leave the door open to some restricted choice of alternative, principally in the form of a GP-controlled domiciliary or home-based service. Barely a decade later however, this particular door of alternative opportunity was, in practice, slammed shut by the Peel Report, which was published in 1970.

The Peel Committee (1970) adopted an even more radical policy than that suggested by any of its predecessors. The Peel Report (1970) advocated that small isolated units should be replaced by larger units in general hospitals (para 283) and that;

> The resources of modern medicine should be available to *all* mothers and babies, and we think that sufficient facilities should be provided to

> allow for *100% hospital delivery*. The *greater safety* of hospital confinement for mother and child justifies this objective...[and consequently] the district hospital will be the obvious focus for all maternity services, hospital and domiciliary, in the area served by it". (para 277 my emphasis.)

The rationale for a policy of 100% confinement was that such a system of maternity care provided the 'safest' environment for women to give birth, regardless of any other factor. From 1970 onwards the general trend was to concentrate maternity services in District General Hospitals, and the idea that obstetric interventions improved the efficiency of the natural birth process, and hence its safety, came to dominate the organisation of maternity care. As a CSS report indicates, the terms of reference of both the Cranbrook and Peel Reports (the committees of each which were made up of senior members of the health care professions - and most of them clinicians) "...gave no encouragement to consider ways of making childbirth safer through measures other than an increase in hospital facilities. They did not ask such questions as: Is an increase or re-deployment of hospital facilities the best or the cheapest or the only way of reducing the hazards of childbirth." (CSS, 1980, p40/41).

This policy orientation towards maximum confinement within obstetric units was reinforced during the 1970's by a number of additional reports, despite a national fall in both the fertility rate and in the numbers of births. In 1971, for example, the Sheldon Report concluded that "evidence is quoted that modern intensive care not only would reduce perinatal mortality further but also would reduce handicaps among surviving babies" (1971 Section 7). The 1976 Report of the Committee on Child Health Services endorsed the recommendations of both the Sheldon and Peel Reports and in 1977 The Way Forward further emphasised that "concentration of [maternity care] provision in properly equipped and staffed units is likely to lead to improved standards of care for the new-born"(para 26). The Way Forward also noted that with the fall in the national birth rate and an increase in the rates of hospitalised births, many smaller independent "isolated" GP maternity units closed.

By the late 1970's therefore, over a period of scarcely more than three decades, the idea had taken root that modern maternity care should consist almost entirely of an obstetric-driven and wholly hospital-based system of confinement. The publication of the Short Report in 1980, together with its follow up in 1984 can now be seen as the virtual apotheosis of this idea. Whilst the UK perinatal mortality rate (the number of stillbirths plus the number of deaths occuring less than one week after

live birth per 1,000 live and still births) had actually decreased, the comparison with infant mortality data from other European countries was nonetheless judged to be unfavourable.

Table 2:1 Perinatal Mortality Rates per 1,000 Live Births, 1975, DHSS 1978

| | | | |
|---|---|---|---|
| Sweden | 11.3 | France | 19.3 |
| Denmark | 13.3 | England/Wales | 19.3 |
| Netherlands | 13.9 | Scotland | 21.1 |
| Norway | 14.1 | Italy | 23.6 |
| Germany | 17.4 | Portugal | 31.3 |

The Short Report drew attention to the potential for improvements in the period around birth, and suggested an investment of resources in health services, particularly in hospital-based medical services. The Committee established in 1984 to review the recommendations and effectiveness of the Short Report paid tribute to advances in obstetric technology and expertise which had, they felt, played a significant role in obtaining a higher survival rates for low birthweight babies than was generally thought possible a decade previously.

Hence, major developments in UK maternity care policy through the greater part of the twentieth century can be seen to centre around the idea of reducing the risk of infant (and to a lesser extent) maternal mortality through the increasing use of interventionist techniques. To achieve this, the location of birth has shifted away from home or domiciliary based care and a more "medicalised" form of maternity care has developed. In 1946, for instance, hospital confinements represented 54% of the total number of births, compared with 1% pre World War I, and in the 1990's, virtually all births - 98%+ - occur within a hospital-based, obstetrically orientated environment (Winterton 1992).

**Conclusion**

As reflected in the various official reports mentioned above, the desire to establish a clinically dominated system of maternity care was clearly executed in a relatively relentless and single-minded fashion, which one assumes reflected a common clinical belief in the scientific validity of pursuing such a policy. In practice however, as will be shown in the following chapter, strong evidence existed which questioned the scientific validity of the assumptions which underpinned this major shift in maternity care policy.

## Chapter Three

## A Policy of Risk or a Risky Policy ?

### Introduction

As has been shown in Chapter 2, the major thrust of the developments in maternity care policy since the inception of the NHS concentrated on the idea of reducing the level of infant (and to a lesser extent maternal) mortality through the progressive re-location of birth away from the home and into the hospital. Successive policy reviews argued that hospitals possessed the facilities and expertise to counter the potential of pathological risk. As both The Peel Report (1970) and The Way Forward illustrate, this "discourse of risk" formed the central intellectual plank of modern maternity care policy in the UK. The Peel Report (1970), for example, observed that;

> there seems a gradually increasing appreciation in the profession and amongst the general public that confinement in hospital is the *safest* arrangement irrespective of considerations of finance or convenience ...we consider that the *greater safety* of mother and child justifies the objective of providing hospital facilities for every woman who desires or needs to have a hospital confinement. Even without specific policy direction the institutional confinement rate has risen...so that discussion of the advantages and disadvantages of home or hospital...is in one sense academic (para 248)

whilst The Way Forward (1977) commented that:

> it is important to seek to achieve a further reduction of the mortality rates. Concentration of the provision [of maternity services] in properly equipped and staffed units is likely to lead to improved standards of care for the new-born. Intensive care should be concentrated in a small number of designated units...Under used and inefficient maternity units...may be closed where alternative services exist (p xxiv)

Whilst a decrease in maternal and infant mortality rates and the corresponding rise in rates of hospitalised births were officially used to justify the development of this policy of maximum institutionalisation (Cranbrook 1959, Peel 1970, Sheldon 1971, The Way Forward 1977, Short 1980) evidence has existed throughout the major part of this century which calls into question the scientific validity of these basic assumptions. As Oakley observes, the development of a situation whereby today over 98% of births occur in hospitals is:

> "a story of piecemeal evolution guided by unevidenced assumptions and unwavering faiths of different kinds, not to mention the strong hand of powerful interest groups" (Oakley 1984, p214)

The research which presented a challenge to the scientific validity of the 'discourse of risk' was largely developed from within the medical profession, or, as in the case of Tew (1977, 1978, 1979,1981,1985,1990) in a closely allied specialist occupation such as medical statistics. Utilising secondary data which relates to both the development of maternity care in the UK, and also to the development of modern medicine, the current chapter examines what might be called this 'internal' critique of the rationale for the development of modern maternity care policy outlined in Chapter 2.

The first section of this Chapter begins with a critique of the assumption which lies at the very heart of the 'discourse of risk' - namely the belief that there is a "cause and effect" relationship between the rise in hospital births and the decline in mortality. In the second section, this challenge to the discourse of risk is linked to wider debates in sociology concerning the impact of modern medicine on contemporary society. This latter part of the chapter highlights the relative neglect of the question of infant and maternal *morbidity* by the 'discourse of risk' compared with medicine's almost obsessive concern with the issue of mortality, especially neonatal and infant mortality and still births. Evidence suggests that infant and maternal morbidity may well have *increased* as a consequence of the increased level of clinical intervention, associated with the rising number of hospital births.

**The Case of the Missing Negative Correlation**

Arguably one of the most iconoclastic critiques of the development of the modern British system of maternity care was mounted by Marjorie Tew (1977, 1978, 1979,1981,1985,1990) a professional medical statistician, whose work was nevertheless initially dismissed or ignored by the medical profession. On the basis of a detailed examination of the official statistical data available, Tew's research challenged medicine's belief that the negative correlation between falling rates of infant and maternal mortality and increasing levels of medical intervention following the switch from home to hospital as the predominant place of birth, represents a cause and effect relationship.

Firstly, Tew points out that such an assumption clearly ignores the possibility that

such a negative statistical correlation is simply an artefact of another confounding variable - namely a general improvement in women's health (due to social change in, for example, diet and family planning). Secondly, and even more dramatically, she directly challenges the validity of the statistical argument that such a negative correlation does indeed clearly exist at an empirical level - the claim which provides the cornerstone of successive policy arguments for increasing the proportion of institutional confinements.

By concentrating on mortality data collected since the establishment of the NHS Tew argues that in order to support the hypothesis that an increase in the rate of hospital births will bring about a reduction in perinatal or maternal mortality, as implied by the Cranbrook Committee (1959) and the Peel Committee (1970), such data would need to show a significant negative correlation between the annual change in the proportion of births occurring within hospitals on the one hand, and the annual change in the mortality rates on the other. In practice, her own statistical analysis (based on data from all 15 NHS Regions) failed to find a single example of such a negative correlation and in more than half the cases studied the correlation was positive. In other words, in a key empirical test, firm evidence in support of medicine's basic assumption about the effectiveness of hospital based maternity care is hard to find.

Indeed, on the basis of Tew's analysis, there is even evidence that the relationship between mortality and hospital confinements is the *reverse* of that which modern medicine assumes - although Tew's work does not necessarily furnish an adequate explanation of such contrary findings. As recent debate emphasises, whilst

> "few follow Tew so far as to assert that the negative correlation between year to year decreases in the perinatal mortality rate (PNMR) and increases in the level of hospitalisation implies that hospital birth is *more* dangerous that home birth there is (as yet unchallenged) evidence to suggest that the statistical association between the increase in the proportion of hospital deliveries and the fall in the crude PNMR seems unlikely to be explained by a cause and effect relation...*there is no evidence to support the claim that the safest policy is for all women to give birth in hospital or for the policy of closing small obstetric units on the grounds of safety.*(Winterton Report 1992, pvii, my emphasis).

The problems associated with the interpretation of mortality statistics have also been highlighted by Macfarlane and Mugford (1984) and Campbell and Macfarlane (1987, 1996) in a review of the debate and the evidence about the

comparative safety of home versus hospital birth. Before 1975, information relating to perinatal mortality was only available from occasional cross-sectional surveys such as The First Report on the 1958 British Perinatal Survey by Butler and Bonham (1963) or Chamberlain et al's 1970 study of British Births. However, as Campbell and Macfarlane (1987) note, even these surveys indicated that hospital obstetric units (consultant units) typically experienced significantly higher rates of perinatal mortality when compared with the rates for home births or births occurring in GP Units.

Whilst the relative mortality rates appear to differ significantly dependent on the place of birth (viz specialist obstetric unit, GP unit or home), to assume such a clear association between mortality and place of birth pays no heed to factors such as "the complex, social and medical selection process which influenced choice of birth" (Campbell and Macfarlane 1987, p26). That is to say, those women who deliver in hospital units could well have been advised/chosen to do so if they were graded as falling into "high risk" categories (which themselves experience higher rates of perinatal mortality). Conversely, those who deliver either in GP Units or at home may be "low risk" and therefore experience lower rates of perinatal mortality. This may be one factor which contributes to the disparity in mortality data (1970) between consultant obstetric units (27.8/1000), home (4.3/1000) and isolated GP unit (5.4/1000).

Although this is a possibility which Tew herself acknowledges in an article in the Lancet (1979,p523) to the effect that "...consultant units did indeed have a greater share of births at moderate and high risk than other places of delivery" she goes on to say (in a letter to the Editor) that "...this excess was sufficient to explain only a very small part of this excess mortality in hospital".

Indeed, if one considers the perinatal mortality according to the place of birth in England & Wales 1975-84, the statistics indicate differing rates of perinatal mortality both between particular hospitals themselves and between specific hospitals and other places of birth. As the following table shows, far from there being a clear cut case for hospital births, the situation is, at the very least, highly complex.

Table 3:1 Place of Birth / Perinatal Mortality Rate per 1000 births

| Year | All | NHS Hospital A | NHS Hospital B | Other Hospital | Home |
|---|---|---|---|---|---|
| 1975 | 19.2 | 5.0 | 20.4 | 14.1 | 18.6 |
| 1976 | 17.7 | 4.2 | 18.8 | 14.1 | 18.5 |
| 1977 | 16.9 | 5.2 | 17.7 | 10.5 | 22.9 |
| 1978 | 15.5 | 4.9 | 16.1 | 9.7 | 20.8 |
| 1979 | 14.6 | 3.7 | 15.0 | 9.9 | 24.3 |
| 1980 | 13.3 | 3.7 | 13.6 | 9.0 | 25.0 |
| 1981 | 11.8 | 2.8 | 12.0 | 6.3 | 21.2 |
| 1982 | 11.2 | 2.0 | 11.4 | 7.5 | 20.1 |
| 1983 | 10.4 | 2.1 | 10.5 | 6.7 | 23.3 |
| 1984 | 10.1 | 2.0 | 10.2 | 7.1 | 21.5 |
| 1985 | 9.8 | 1.6 | 9.9 | 7.7 | 21.7 |

(Source: OPCS Birth Statistics(FM1) and Mortality Statistics(DH3) in Campbell and Macfarlane (1987, p33) - NHS Hospital 'A' = hospital without consultant obstetric unit)

The complex nature of the data on perinatal mortality is further illustrated by the fact that whilst the table above would appear to indicate that those women who give birth at home have higher rates of perinatal mortality, an examination of the statistics relating to home births reveals an even more complicated picture. In 1979, in a study of planned and unplanned home births in England and Wales, figures for those women who delivered at home were broken down into *planned* home births (i.e.; those mothers who were deemed to be low "risk") and *unplanned* home births. This analysis suggests that the perinatal mortality rate for planned home births was 4.1/1000 whilst the corresponding figure for unplanned home deliveries was 67.5/1000 (Campbell et. al. 1984),. Further evidence to support the low perinatal mortality rate for planned home births exists from studies in the USA and the Netherlands. One of the most comprehensive studies as to the benefits / risks of home and hospital births was conducted in 1977 by Mehl who, in a matched sample comparison between home and hospital deliveries (that is to say for women thought to be at a similar level of "risk"), concluded that home births were safer than hospital births. The study matched 1,046 planned home birth women with 1,046 women who had booked a hospital delivery for maternal age, parity, socio-economic status and risk factors and found that "although as many mothers and babies survived the hospital births as the home births, the home birth group had appreciably better outcome" (Mehl, 1978, p113). Indeed, when one examines the perinatal mortality rates from the Netherlands, where one third of *all* births occur at home are attended by midwives, the case for advocating a policy of 100% hospital births seems even more unsound. In 1986, perinatal mortality in Dutch hospitals was 13.9/1000 whilst for home births it was 2.2/1000 (Campbell

and Macfarlane 1996)

As the work of both Campbell et al (1984), Macfarlane and Mugford (1984) and Murphy (1984) indicates, the decline in the number of women who elected to give birth in their home led to an increasing proportion of births in the home being unplanned (and as shown above, such unplanned home births experience significantly higher levels of perinatal mortality).

**Mortality and Risk: The Problem of Cause**

If one examines the statistical evidence about the historical direction of infant and maternal mortality during the course of the present century, it is possible, therefore, to argue that - contrary to dominant medical opinion - the explanation for the decline in mortality rates may, at the very least, be multi-causal. The dominance of the prevailing interventionist approach to health is generally justified in terms of its effectiveness in controlling disease and improving the overall levels of health within the population. If one looks at the historical pattern of change in the level of infant mortality, however measured, during the course of the twentieth century, it is apparent that this has been falling rapidly from the beginning of the century (i.e.; prior to the directive encouraging the institutionalisation of birth). In other words, the level of infant mortality began to decline during a period in which the number of hospital-based births was generally *low* and the proportion of births occurring in hospitals (of whatever kind) represented only a small proportion of the total number of pregnancies.

As early as 1927, in examining the underlying reasons for variations in international perinatal mortality rates, Dame Janet Campbell argued that in European countries which had a significantly lower perinatal mortality rate than England and Wales such as Holland, Denmark and Sweden "...there is wide difference between the social conditions and habits of life in these countries and in many parts of England and Wales". Although recognising that the differing systems of maternity care provision may themselves have had an influence on the mortality rates, a Ministry of Health Report (Campbell 1927) concluded that the most important factor accounting for the differential perinatal mortality rates was the superior social conditions and general health of the population in Holland, Denmark and Sweden.

Similarly, when the Departmental Committee on Maternal Mortality and Morbidity

(Ministry of Health 1932) investigated the problems of childbirth in Britain, its

> unequivocal finding was that the safety of childbirth was directly related to the quality of the mother's general health during pregnancy. This was in turn related to...[such aspects of her general health as] her nutrition, and the hygiene of conditions in which she lived. (CSS Report 1980, p15).

The general conclusions of both the Protection of Motherhood Report and the 1932 Ministry of Health Report, that social conditions have a major impact on both local and national infant and maternal mortality rates, are not of course surprising when seen in the much wider historical context of the work of such researchers as McKeown (1965) who demonstrated a connection between the rising prosperity of industrialising societies and falling mortality rates. McKeown identified the three main determinants for the decline in mortality from infectious diseases from the mid nineteenth century as being: improvements in nutrition brought about by improved agricultural farming methods, increased imports of wheat and the expansion of transportation networks; environmental measures such as better sanitation and a cleaner water supply combined to reduce the risks of water borne diseases and typhus and finally an increased awareness of the benefits of limiting family size (which had a secondary effect of decreasing rates of infanticide)

Similarly, McKeown and Lowe's work (1966), suggests that increasing longevity within industrialising societies in the nineteenth century had little to do with improvements in medical practice (such as immunisations and advances in medical technology). Rather they attribute the prominent fall in mortality rates to identifiable improvements in the standard of living, especially sanitary reforms and improved nutrition. This is well illustrated by McKeown's analysis of the falling rate of fatalities from Tuberculosis in the nineteenth and twentieth centuries - a fall which is often attributed to medical intervention. His work demonstrates that a significant decline in the number of TB related deaths had already occurred prior to the development of any effective medical diagnosis, let alone medical treatment (McKeown 1972, p92).

Although the work of researchers such as McKeown's have been open to criticism on the grounds that this type of research does not identify all the possible influences on the declining death rate, and that mortality rates in themselves only provide a limited measure of health and take no account of issues such as the quality of life and the reduction in pain and suffering, such work nonetheless highlights the fact that socio-economic conditions clearly play an important role in

maintaining or changing public health.

As early as 1936, the British Medical Association publicly recognised that variations in the levels of health of the general population were associated with variations in the levels of maternal and infant mortality;

> maternity and its conduct are not concerned merely with attendance during the actual process of delivery...it is obvious that this whole period and event cannot be isolated from the rest of the health history of the mother, whether before, during, or after the period of actual pregnancy and parturition (page 656).

and in the First Report of the British Perinatal Mortality Survey - 1958, Butler and Bonham (1959, p 132) acknowledge that:

> for many years it has been known that social factors - poor hygiene, overcrowded houses, faulty nutrition - have been a major cause of infant and child death...an amelioration of social conditions has taken place with a parallel dwindling in infant and child mortality. It has been possible...to understand how a position in a social hierarchy comes to be associated with a corresponding position on the scale of mortality...the course and outcome of pregnancy depends upon the mother's social experience over a long period.

The impact of socio-economic variables on infant mortality rates is further highlighted by a Institute of Medicine study (Kessner 1973) which considered risks to mothers from a number of sources and the corresponding mortality rates. Statistics were broken down to highlight the influence of ante-natal care on mothers with *social risks* (poor education, large families, lack of financial support, unwed status); *medical risks* (high blood pressure, toxaemia of pregnancy, diabetes); and *low risks*. The data again highlights the fact that there are other determinants of risk which affect mortality rates other than that which is nominally described as "medical"

Table 3:2 Results of Pre-natal study of 142,017 Births in New York (Kessner 1973).

| Pre-natal Care | Social Risks | Medical Risks | Infant Deaths |
|---|---|---|---|
| Adequate | No | No | 8.7 / 1000 |
| Adequate | Yes | No | 12.3 / 1000 |
| Adequate | Yes | Yes | 29.9 / 1000 |
| Poor | No | No | 21.0 / 1000 |
| Poor | Yes | No | 34.9 / 1000 |
| Poor | Yes | Yes | 55.1 / 1000 |

One might of course wish to go even further and argue that aside from obvious and overt examples of physiological or clinical "abnormality" - for example the genetically determined shape of a woman's womb - many medical conditions are themselves closely correlated with such socio-demographic factors as class position (The Black Report 1980).

One must therefore question the fundamental rationale put forward by both politicians and obstetricians alike when justifying the particular form of maternity care policy and practice developed in the UK, especially since the fall in infant and maternal mortality occurred during a period which saw dramatic improvements in the overall standard of living,. Such a claim carries little weight unless it can be shown that the risk of death (to mother and/or baby) from a home birth is higher than for a hospital birth and this can be shown to be true over an extended period of time and that the subsequent fall in infant and maternal mortality witnessed in the twentieth century in particular was greater amongst hospital confinements than amongst home confinements. In practice however, as a wealth of literature has highlighted, there is little conclusive evidence to support the development of a maternity care policy based on such assumptions, and the evidence which is available casts doubt on the validity of the monocausal argument that increasing the rates of hospital births will decrease the rate of mortality.

Between 1940 and 1960 when the principal direction of UK maternity care policy was initially established, Britain witnessed social and economic changes of a kind which were potentially of great significance for the incidence of infant and maternal mortality. Not only had the overall standard of health within the population continued to rise since the turn of the century, but in the years immediately following the Second World War women were continuing to limit the size of their families through the widespread use of contraception - and both these factors are commonly regarded as important influences on perinatal mortality rates (Dunnell 1979; National Center for Health Statistics 1978; Graham 1993). A reduction in both the number of children women were having and the age at which they were having them (i.e.; a reduction in mothers of higher parity and "older" mothers) is likely, cateris paribus, to reduce the number of women who fall into "high risk" groups which in turn reduces the probability of perinatal mortality (CSS Report, 1980) .

In looking at changing mortality during the 1950's and 1960's it is clear that a number of social changes affecting perinatal mortality rates, such as age, number

of children previously born, birth weight and gestation of infant, together with a general average increase in prosperity need to be taken into account (aspects of social change which led Galbraith (1958) to describe this period as the "Age of Affluence") .

A more striking criticism of the validity of the reasoning which lay behind the development of UK maternity care policy is derived from an examination of the data concerning social inequalities in the pattern of perinatal mortality. It is apparent that social disparities in perinatal mortality remain between social classes, even when the rates of hospitalised birth represent almost 100% of all confinements (and the final target of modern maternity care policy has therefore been achieved). This can be seen in the 1989 OPCS Mortality Statistics which demonstrate a clear and continuing link between perinatal mortality and social class up to the end of the late 1980's (Tew op cit., Campbell and Macfarlane 1994).

**Modern Maternity Care and Morbidity: A Lacunae in "The Discourse of Risk".**

As the preceding discussion has shown, UK maternity care policy has consistently developed in a particular direction, emphasising the desirability of virtually 100% hospital confinements in order to reduce infant mortality. In practice, empirical evidence in support of such a policy is either lacking or contradictory. The argument in favour of such a policy - that hospital births are 'safer' than home births would appear to be unproven in a strictly statistical sense. What is more, an additional criticism has also been made that, depending on how one approaches or defines the notions of 'safety' and 'health' then a so-called 'modern' system of maternity care may actively be harmful than more traditional domiciliary based approaches.

This second vein of criticism stems from what one might describe as a "lacunae" in the discourse of risk, namely the relationship between modern maternity care and infant and maternal morbidity. It is evident from the recommendations of the Short Committee (1980) that, inter alia, the major focus of maternity care policy has been almost exclusively that of infant mortality. Questions about the general and post natal morbidity of women have been largely ignored by the mainstream professional and political debate on maternity care, despite the obvious connections between pre-conceptual and ante-natal maternal health, birth weight, infant mortality and an individuals' race and class position. Inequalities in both mortality and morbidity rates relative to class, gender and race were, of course,

highlighted by the publication of the Black Report (1980) and The Health Divide (1988).

One aspect of hospitalisation and its corresponding increase in the use of interventions which is liable to impact on the mortality/morbidity figures has remained largely unevaluated. This is the potential increase in risk to both woman and child if they are exposed to a blanket policy of routine medical interventions which may not be appropriate in all cases. Arms writes of hospital procedures and practice that;

> although the woman is not the target of hospital routine and intervention, she is, most assuredly, the victim. When the delivery room is in active use for example she may be artificially stimulated for the simple purpose of moving her body to the delivery room as fast as possible so that other births will not be kept waiting. She is shifted from room to room and rolled from bed to bed; she is examined internally by several attendants she does not know, and poked, stabbed and strapped down, and checked out by several more.(Arms 1975, p37)

That women are potentially exposed to increased "risk" within a hospital environment is referenced by, amongst others, the work of Tew (1990). In exploring the relationship between falling rates of infant and maternal mortality and increasing levels of medical intervention in this area, she highlights that not only should account be taken of the impact of social change on mortality rates, but she also claims that the belief that increasing medical intervention has positively contributed to the continuing fall in mortality may, in itself, be false.

Within the Obstetric profession, many see their role as "...identifying the maternal characteristics and conditions likely to lead to perinatal problems" (Tew 1990), with the consequence that procedures have been developed to prevent "adverse" outcomes. Frequently these involve shortening the pregnancy/labour as this is thought to be of benefit to both infant and mother and the rates of inductions (during a period which saw a corresponding rise in hospital confinements) demonstrate the frequency with which the obstetric profession used interventionist techniques.

In 1958, for example, the national induction rate stood at 13%, rising to 13.4% in 1964, 26% in 1970 and had trebled to 39.4% by 1974. Moreover, given that these figures are national averages the local rates of induction fluctuated widely from this mean, with induction rates for individual consultant obstetricians as high as

75% in some areas (Cartwright 1979). Such practices remain common within the 'new' NHS - in a recent Audit Commission Report (1997), 26% of pregnancies were induced and 47% were speeded up (augmented).

Although obstetricians have argued that increases in the levels of technology and expertise available in hospitals may reduce the levels of perinatal mortality, a number of studies have suggested that one result of the increasing survival of low-birthweight babies is that rates of cerebral palsy increased (Hagberg et al 1984; Powell et al 1986; Stanley and Atkinson 1981; Stanley and Watson 1992). As far as maternal health is concerned, several studies have demonstrated that increasing levels of hospital confinement have also been associated with the increased use of such radically invasive techniques as Caesarean section - up to a point where the clinical justification for such major surgical procedures has been questioned (Francome et al 1993, Tew, 1990; Cartwright 1979; Arms 1975, Inch 1982). As Francome comments;

> A caesarean birth carries more risk for the mother than vaginal birth, and yet in Britain today a woman is almost three times more likely to give birth by caesarean section than she was twenty years ago. This dramatic rise to one in every eight births may mean an increased risk of maternal death and poses many serious questions. Are some of these operations being performed unnecessarily ? If not, why are there such striking differences in caesarean rates between countries, between hospitals, and between individual obstetricians ? (Francome et al 1993, cover)

As such authors argue, the clinical justification for the use of such techniques is often unclear. In addition, the increasingly high levels of interventions (such as inductions and caesarean sections) performed on healthy populations of predominantly 'normal' women suggest that increasing levels of hospital confinement may be associated with the tendency to adopt 'high-tech' approaches to birth which are not always clinically justified or necessary. There is strong evidence to suggest that increasing the level of hospital confinements may often lead to the unnecessary "medicalisation" of birth itself. Under such circumstances, the 'modern' process of becoming a mother would appear to be more akin to being treated for an illness as opposed to experiencing a largely 'natural' physiological event (Comaroff 1977, Parsons 1975).

Most importantly, as Tew, amongst others has argued, increased levels of physical/surgical intervention during the process of birth can be injurious to the

health of the mother and carry their own degree of (iatrogenic) risk. That is to say, such an "invasive" system of maternity care may increase the risk to the health (both physical and psychological morbidity) of the mother and baby if not to their actual survival (mortality) (c.f. Mehl 1978)

Evaluations of modern maternity care in terms of its consequences for maternal and infant *morbidity*, as distinctive from its impact on maternal and infant mortality, are noticeable by their relative absence from the debate. Furthermore, consideration of the morbidity effects (as distinct from mortality) of differing systems of care would require an assessment which gives equal weight to the post natal period as well as to the ante natal and intrapartum periods of care, and this would, in turn, require evaluation of the role of both Acute (Hospital based) and Primary (GP/Community) services.

**Conclusion**

> To advertise any remedy or operation, you only have to pick out all the most reassuring advances made by civilisation, and boldly present the two in relation of cause and effect: The public will swallow the fallacy without a wry face. It has no idea of the need for what is called a control experiment.
>
> George Bernard Shaw (1906)
> (Preface to the Doctor's Dilemma)

The present chapter has sought to emphasise that, although the development of maternity care policy in the UK has followed a consistent goal of creating an almost wholly hospital-based system of maternity care, this policy has itself been subject to major criticism on its own terms. That is to say, critics (often from within the medical establishment itself) have attacked what might be called the "internal" logic of the "discourse of risk" which is the central intellectual justification for such a policy.

It has been pointed out, for example, that the frequently repeated claim by a succession of public reports on NHS maternity care services that hospital confinements are "safer" than home confinements is open to dispute at an empirical level. In addition, critics have also pointed out that the assumed relationship between falling levels of perinatal mortality and increasing rates of hospital confinements has not been convincingly demonstrated scientifically. As Campbell and Macfarlane (1987, p59) remark "...*perhaps the most persistent and striking*

*feature of the debate about where to be born, however, is the way policy has been formed with very little reference to the evidence*".

Hence, it has not been proven that hospital confinements are "safer" than home births in the sense that the former have singularly reduced the level of perinatal mortality. Rather, the falling level of perinatal mortality during the twentieth century in particular may have been caused, in part, by wider social and economic changes largely independent of the changing character of maternity care.

At a different level altogether, the criticism has also been made that the rise in the rate of hospital confinements has been accompanied by the increasing use of medical technology and surgical intervention - and that this represents an additional risk to the health of mothers and babies, even though it may not have increased the risk of infant or maternal death (Mehl 1978; Tew 1990). In certain respects therefore, modern maternity care may be less "safe" than the more traditional domiciliary orientated system which it undermined and ultimately replaced.

The development in the UK of a maternity care policy which views hospital confinement as the 'norm' reflects a widespread Western medical ideology which sees the main object of medicine as the 'curing' of 'illness' caused by a 'breakdown' in the human body. This is now increasingly referred to as the 'bio-medical' view of clinical practice (Freund and McGuire 1991). This form of practice is primarily concerned with "curing" illness rather than enhancing health, and regards physical intervention at the level of the individual, using the tools of science and technology, as its essential *modus vivendi*. One of the major consequences of the development of modern medical practice along such lines is that the 'sick' are now 'cured' in hospitals which increasingly use expensive 'high tech' forms of treatment (Schwartz 1990). Whether such an approach is either necessary or desirable in the management of pregnancy and birth has become an issue of some controversy (Winterton 1992).

Writing in 1975 about the development of the maternity care services over the previous two decades, a leading obstetrician commented that;

> When a football team find itself at an embarrassingly low position in the league, there tends to be a flurry of activity - managers are sacked and large sums of money are likely to be spent to buy expensive talent, and often with little effect. I think that I detect a similar tendency in maternity care...there is often the unspoken assumption that more expensive facilities and expertise will inevitable improve our league standings...we

> may have assumed too lightly that more sophisticated management necessarily brings benefits to women, the dangerous argument that more means better - for example the elimination of domiciliary deliveries, greater access to ante natal beds the development of better predictive scores to identify high risk patients, the use of more direct measure of foetal growth and well being, various policies of elective induction of labour, the acceleration of labour by accurately controlled oxytocics, and continuous monitoring of the foetal heart in labour. This is the face of modern obstetrics...Those of us whose experience and training has embroiled us in the high drama of complicated obstetrics find it difficult to avoid an emphasis on safety, and we tend to retreat into the position that pregnancy can only be considered safe in retrospect. However, we have to ask ourselves how effective and costly [and here cost can be perceived as not only monetary but also the cost of physical trauma and emotional distress] are our screening and safety devices. *What price has to be paid for their safety by the 98% of pregnant patients who have surviving infants? - and in any case what do we mean by the use of the word patient as applied to a perfectly healthy pregnant woman.* (Kerr 1975, p3-5, my emphasis)

Aside from the criticism that the key assumptions which underpin the practice of modern maternity care cannot be justified in its own terms (viz as a means of reducing mortality), modern maternity services have also been subjected to criticism from another quite different source - namely the principal recipients of the service itself. During the 1970's and 1980's, the emergence of feminist inspired research in particular highlighted an entirely different set of concerns, creating an alternative form of "discourse". It is to a consideration of what might be described as this "counter cultural" perspective that we now turn.

# Chapter Four

## Women's Experiences of Modern Maternity Care - A Discourse of Control

### Introduction

The previous chapter presented a critique of the development of modern maternity care policy in the UK, which suggests that many of the key assumptions upon which this policy was based are tenuous. In particular, there would appear to be no definitive 'scientific' proof to support the central claim of 'the discourse of risk' that the relocation of the place of birth from the home to the hospital reduces the risk of infant mortality.

The current chapter examines an additional criticism of the development of such a policy - namely that its central aims were pursued and implemented in the teeth of substantial dissatisfaction from those intended to be its primary recipients, women. Moreover, this dissatisfaction has been revealed, not by research conducted by the medical profession, but by research conducted principally by academics, many of them women. This has led to the construction of quite a different discourse or worldview on maternity care, a discourse which the thesis describes as a 'discourse of control'. This particular discourse or worldview is not one that complements the 'discourse of risk'. Rather, the 'discourse of control' represents a very substantial challenge - one might even say 'threat' - to the 'discourse of risk'.

### The medicalisation of motherhood - an "external" critique

As Chapter 2 demonstrated, successive policy reports during the 1960's, 1970's and 1980's advocated the re-location of birth out of the home and into the hospital on the grounds that such a move would reduce the national rates of perinatal mortality. Alongside the shift in the place of delivery, this "hospitalisation" of maternity care was accompanied by the increased use of interventionist methods, derived from new technology, in order to both monitor women during pregnancy and to control the process of delivery itself. (Arms 1975; Cartwright 1979; Doyal 1979; Macintyre 1981; Rakusen and Davidson 1982, Evans 1985).

At the same time, the 1970's and 1980's also witnessed the emergence of a new body of research (much of it feminist in origin) which demonstrated that the social conditions of women's lives may affect their health. Several writers have

highlighted the fact that material conditions such as poverty have an important influence on health. They argued that this was especially relevant when considering the health of women, many of whom had lower incomes and fewer material resources than men of equivalent age, educational and occupational status (c.f., for example Graham 1985,1987; Oakley 1992). Furthermore, 'ideological conditions' such as the social conceptions of masculinity and femininity prevailing in particular societies were also regarded as having an important impact on the health of women (Nathanson 1975, Gove and Tudor 1973). This last claim is particularly important since, as Hockey argues, "the dominant conceptions of health which underlie the theory and practice of medicine, can themselves be seen as one of the constraining conditions of women's lives..[since]...both the medical view of what constitutes women's "health", and medical responses to ill-health, help shape women's bodily and emotional experience" (Hockey in Richardson 1993, p250).

Within the area of maternity care service provision, the development of a predominantly "hospital-based, consultant-run and technology-orientated system of maternity care" (Schwartz 1990, p47) was seen to have led to what Hanmer describes as a "de-naturalising of motherhood" (Hanmer 1993, p240). With a rise in the number of births occurring within specialist units and the increasing use of technology in order to justify medical intervention in the process of pregnancy and birth, critics from outside the medical profession argued that pregnancy and birth were no longer regarded by medicine as a 'natural' function of women's biology.

From a strictly physical point of view, giving birth could be thought of as a "biological" process. However, in any culture giving birth and becoming a mother are viewed as "social" events of great significance. The transition to motherhood is typically seen to bring about a change in an individual's social status through a change in their role relationships. Consequently, role changes of such significance have been described as a "life event" by Oakley (1980, p179) and a "rites de passage" by van Gennep (1966). As several writers have pointed out, such a view of childbirth and the advent of motherhood is of central importance for understanding the problems surrounding the provision of maternity care services (LeMasters 1957, Hobbs 1965, Graham and McKee 1980, Oakley 1980). The work of Graham and McKee illustrates some of the problems experienced by modern mothers regarding the changes associated with becoming a mother. They found that many new mothers initially experienced anxiety and stress as a result of their own concerns about their ability to care for their baby. This was then typically

followed by a period in which "the locus of women's depression [following childbirth] shifted from problems associated with being a mother (and...problems of baby care) to problems associated with being a housewife, and specifically problems of boredom and isolation" (Graham and McKee 1980, p37)

Hence, "life events" can cause a shift in an individual's social relationships and are likely to affect not only the individual's own sense of self, but also his/her previously held assumptions about their capabilities and roles within a social environment. As Oakley comments;

> "there is a crucial dialectic between the way childbirth happens in modern industrial cultures and the way mothers are supposed to be - married, at home, economically disadvantaged, and blessed with a maternal instinct that enables them to rear children without first learning how to" (Oakley 1980, p98).

Whilst the rationale for the re-location of birth out of the home and into the hospital was repeatedly justified by obstetricians and policy makers alike on the basis that the hospital was "safer" than the home, during the 1970's the maternity services came under increasing public scrutiny. An alternative "frame of reference" emerged, which began to question the rationale and ideology underpinning the organisation of modern maternity care. This challenge originated largely from the response of women and specifically women's groups.

Throughout the late 1960's, 1970's and early 1980's, women's attitudes towards and experiences of pregnancy and childbirth increasingly became the focus of public, professional and academic attention following national debates regarding the increase in the number of hospitalised births and the high rates of induction and other interventions within hospitals. A conference in 1976 highlighted, "a birth without medical intervention is virtually unknown in many industrialised countries" (International Federation of Gynaecology and Obstetrics 1976), and as a growing body of social science research in particular began to reveal, the process of becoming a mother was increasingly experienced by service users as "alienating", "de-humanising" and "disempowering" (Shaw 1974; Arms 1975, Cartwright 1979; Doyal 1979; Scully and Bart 1978; Graham and McKee 1980; Macintyre 1981; Oakley 1979,1980; Jacoby 1988; Ball 1989; Tew 1990).

**Becoming A Mother under the clinical gaze of modern maternity care practice**

Boyd and Sellers (1982) characterise the experience of modern childbirth and the advent of motherhood in the following manner;

> It is very strange how unprepared we all are for...birth...There are books about pregnancy...There are even more books about child care - each one reflecting a current fashion, or the prejudices of the author. Most of us manage to find a book which chimes in with our own fashions and prejudices. But when it comes to the process of giving birth, nobody likes to talk about it in detail. So we get the vague idea that it is messy, it hurts and it is surrounded by old wives' tales...Until of course it happens to us. Then we discover the truth that although it's messy nobody notices, that although it hurts the pain is bearable as long as we know exactly what is happening, that the old wives tales which everybody advised us to ignore are usually quite true and that *everything is happening so fast that people are taking decisions we don't understand, without listening to our questions and certainly without asking our opinion* (my emphasis)
>
> (Boyd and Sellers, 1982, page xiii)

Whilst one might assume that such an image of birth is either generalised or atypical, the description given above incorporates many of the common critical themes to emerge about the maternity services during the 1970's and 1980's. Whilst some women were happy with the care (or specific elements of care) that they received during the course of their pregnancy and delivery, a number of studies which focus specifically on the experiential, and therefore subjective, dimension of pregnancy and birth highlighted that over the course of their "maternity career" (viz. during pregnancy, birth, and postnatally) a large number of women expressed widespread, and often lasting, dissatisfaction about the care that they received (c.f. for example, Shaw 1974, Richards 1975, Rich 1977; Graham and McKee 1980; Macintyre 1981; Reid and McIlwaine 1980; Cartwright 1979; Kitzinger and Davis 1979, Oakley 1979, 1980; Kirkham 1983; Shapiro et al 1983; Jacoby 1988).

Maternal satisfaction with the process of becoming a mother is regarded by a number of authors (e.g., Kitzinger and Davis 1979, Oakley 1979,1980; Boyd and Sellers 1982; Prince and Adams 1978; Graham and McKee 1980; Ball 1989) as an important issue, since an expectant mother's

> "...feelings may be crucially important to her health and..her baby. How the mother...feels about her antenatal care [for instance] will decide whether or not she attends her clinic, takes her vitamin pills, goes to relaxation classes, whether potential problems are detected...How frightened she is may determine whether she trusts and talks to her doctors and midwives, whether she wants painkillers, whether she wants to hold her brand new baby or not, whether she

> wants to persevere with breastfeeding or would prefer not" (Boyd and Sellers 1982, pxiv).

As mentioned earlier, the experience of becoming a mother (in both the physical and social sense) is a major "life event" for women (Oakley 1980). Consequently experiences of pregnancy, birth and post natal adjustment may affect not only a woman's own sense of self during the process, but can also have a profound effect on her feelings towards her baby and her ability to care for her child. This may be particularly true if her expectations do not correspond with the reality of her experiences and her self-perceived needs remain unmet. Hence, whilst the process of becoming a mother is, at base level, a physical process, the emotional response of women to such a life change is of central importance to her sense of personal and social well-being (Cartwright 1979, Oakley 1979, 1980, Kitzinger and Davis 1979, Davis-Floyd 1992). As the Select Committee on Violence in the Family noted;

> evidence from a large number of sources all emphasises that the birth and new-born period is of major importance for the development of relationships which my have a profound and lasting influence on the future development of the child and the family...Much of our evidence stressed the importance of "early bonding" between mothers and their children immediately after birth and the need to ensure that the whole birth experience is handled in hospitals with...sympathy and sensitivity...(1977, page xxxviii)

Of course, it could also be argued that variations in individual or personal circumstances are likely to have a major impact on women's attitudes towards and experiences of pregnancy and childbirth, and one might therefore expect to find considerable differences in women's response to maternity care services (Macintyre 1981). In practice however, there appears to be a high level of agreement amongst women users of maternity care services about the nature of the problems surrounding the delivery of such services, and in the most part irrespective of their background - a homogeneity of opinion which is rarely found amongst users in other areas of health care provision. Furthermore, this similarity of opinion is apparent at each of the three stages of the "maternity care cycle", viz antenatally, intrapartum and postnatally.

**Women's Experiences of and Attitudes Towards "Modern" Antenatal Care**

Debates about the appropriate location of the place of birth and the very nature of pregnancy and the process of birth itself have led to a situation in which modern mothers are often exposed to two, contradictory images of pregnancy (Comaroff

1977; Oakley and Graham 1981;1986). On the one hand, pregnancy may be seen as a natural process whereby women are able to retain a sense of control over the birthing process and during which medical intervention is regarded as largely unnecessary. On the other hand, pregnancy is represented as a "process during which the woman is "taken over" by physiological factors and must submit to medical advice and active obstetric techniques" (Macintyre 1981, p3). Huntingford, for example, notes that a situation has arisen whereby "...technology has been allowed to take precedence over the needs of individuals" (Huntingford 1978, p243). Each perspective tends to reflect, not surprisingly perhaps, the experiences and interests of the quite different "constituencies" which are involved in the use, provision and critique of maternity care services - which the remainder of this chapter will seek to demonstrate.

Women's experience of "modern" antenatal care usually involves a number of common procedures or elements which affect virtually all women during the course of their pregnancy. These include regular antenatal check-ups, often carried out both at the GP surgery and at a hospital, dietary and lifestyle changes and ultrasound monitoring (Oakley 1979; Macintyre 1981; Boyd and Sellers 1982; Graham and McKee 1979;1980; Reid and McIlwaine 1980).

Antenatal care in the UK is usually provided in one of three ways - care provided exclusively through the GP service (involving both GPs and community midwives), care provided exclusively through the hospital service (involving obstetricians and hospital midwives) or, more usually, what is commonly known as "shared care" which is a combination of the two. In addition, many hospitals, GPs, midwives and other groups run antenatal classes, which women may choose to attend if they so wish.

According to Oakley (1979), the most common pattern of antenatal clinic visits is for the first antenatal check-up to occur before the twelfth week of pregnancy (78%), and for a total of 13 visits to the clinic to occur before delivery - a pattern of care which has changed little over a number of decades (Audit Commission 1997). Irrespective of wherever and whoever provides the majority of antenatal care, the likelihood is that at some stage during their pregnancy women will visit a hospital antenatal clinic (for antenatal tests, ultrasounds etc.). The checks, tests and screening that women routinely undergo include weight checks, urine tests, fetal abnormality tests (such as for down's syndrome, spina bifida), ultrasound monitoring and the measurement of blood pressure (Oakley 1979; Arms 1975; Hall

et al 1985, Marteau et al 1992).

The responses of women to such care indicated that there were a number of common areas of dissatisfaction with the provision of antenatal services both at the Acute (or hospital) level and also at the Primary (or General Practitioner) level of care. One of the most common criticisms identified in the research literature in general about hospital antenatal clinics is that such clinics induce a feeling of *depersonalisation,* with many women reporting that they felt as if they were on a factory conveyor belt (e.g., Graham and McKee 1980; Hall et al 1985; Reid and McIlwaine 1980). The manner in which most hospital antenatal clinics are organised according to Rakusen and Davidson "...makes a mockery of the concept of care" (1982, p35), in that such clinics suffered a range of common problems, including a lack of privacy, long waiting times followed by a brief processing procedure and a short period of consultation. This is re-enforced by the work of such writers as Boyd and Sellers (1982), Oakley (1979), Reid and McIlwaine (1980), Davis-Floyd (1992) and Hall et al (1985), all of whom report similar experiences from users of antenatal maternity care services. The following extracts provide an illustration, in the words of the women themselves, of their response to modern forms of antenatal care:

> Mother A: "It's like a cattle market, a production line. You queue up and in you go and out you go. They just say are you alright ? And most people say yes I'm alright unless they've had something drastically wrong. The doctor has a quick feel around and he says right we'll see you in 4 weeks time. And that's it, in and out in a couple of minutes. Well, I suppose they must know what they are doing: if there was anything wrong they would have said so. I haven't had any bad treatment; they're all very kind. But I suppose they get so many people, when they say their bit at the end it's all automatic, like a parrot, no tone in the voice. They just say it off pat: they don't have time to get involved with people. There's no personal touch at all. You're just a body to them. A body with a name"(Oakley 1979, p281).
>
> Mother B: "When the patient is lying down they're at a disadvantage. their personality I would say is deprived of them almost in that horizontal position" (Oakley 1979, p282).
>
> Mother C: "I didn't like...having to wait so long...(Macintyre 1981, p135
>
> Mother D "...it was quite horrible...it's like a cattle market the way you're sort of pushed and then "Goodbye.(Macintyre 1981, p135)

Similarly, as one mother in Rakusen and Davidson's study commented "...doctors and nurses at [antenatal] clinics talk about you to the nurses and to each other as if

you were a prize marrow lying there on the couch..."(1982, p35). Although many women typically reported that clinic staff, particularly midwives, were "kind" or "efficient", the organisation of the hospital antenatal clinics and the short consultation period did not lend itself to the development of conversation.

Accordingly, many women felt unable to ask questions or obtain the appropriate information about their antenatal experiences (Macintyre 1981, Shapiro et al 1983, Kirkham 1983). As Oakley (1979) indicates in her study of first time mothers, respondents felt anxious about a number of issues relating to both their baby and the changes that accompany their own role transition to motherhood. More than a third of Oakley's sample (39%) said that they were worried about having a deformed baby; 35% were concerned about how they would cope with giving up work (and the change in lifestyle); 32% reported fears about the actual birth itself whilst 14% expressed concern about how they would look after the baby. Due to the way in which the antenatal clinics were organised, a large proportion of women reported that they were unable to voice these concerns effectively, nor were they able to understand either the reasons for, or the results of, many of the procedures (or tests) that they were subject to. In other words, women reported that they had important information needs which were unmet. This situation may be arise as a result of both the physical organisation of antenatal clinics and, potentially, from the inability of staff to communicate effectively to their clientele. As Graham and McKee note in their study of motherhood, "the style of interaction [in antenatal clinics] worked against both the asking of questions by the mothers and the giving of full and comprehensible answers by the staff" (1979, p54) and as Hubert illustrates in her study of pregnancy and childbirth;

> "...even where there is excellent medical supervision, and even serious attempts to communicate knowledge, there is in fact a wide gap between the fund of knowledge held by doctors, midwives and so on, on which they base their concept of normality in pregnancy and the limited and very diverse beliefs and ideas held by many of the women they deal with" (Hubert 1974, p37)

The obstetric and organisational "rationale" for this approach to the provision of hospital antenatal care is justified on the basis that it would not be possible to see every woman for a lengthier period given the time constraints placed on such antenatal clinics, (Davis Floyd 1993). However, the actual experience of such a system of care appears to engender feelings of depersonalisation and anxiety in women users (Oakley 1979,1980; Kitzinger 1978 in Kitzinger and Davis 1978; Reid and McIlwaine 1980; Graham and McKee 1979). Whilst their own pregnancy

is the focus of personal concern for many women, for the clinic staff who see a large through-flow of women, the antenatal process may become routinised (Davis-Floyd, 1992)

Furthermore, many women in the British Way of Births study (Boyd and Sellers 1982) also reported that staff at their antenatal clinic did not give them advice either in the right *way* or at the right *time*. Respondents indicated that when information was provided, this was often through the provision of leaflets rather than through active discussion which they would have preferred. This demand for information relevant to women's personal needs, ideally on a face-to-face basis, makes even more sense when one discovers that many women in late modern societies have little prior knowledge about the clinical and personal dimensions of motherhood (Oakley 1979, Boyd and Sellers 1982, Davis Floyd 1992). Speaking of her feelings about becoming a mother, one mother in Davis-Floyd's study commented that;

> One day early in my pregnancy it dawned on me that I was actually going to have a baby. Shortly after that I realised with a thud that I *didn't know anything about babies,* much less about having them. And so I thought, well who is there to talk to who does know ? And then I realised that *I didn't know anyone who had a baby* (Davis-Floyd 1992, p34, my emphasis)

Such feelings do not appear to be uncommon. Whilst 79% of first time mothers in Oakley's 1979 study of first time mothers had held a new-born baby, only 23% had actually changed a nappy and/or bottle fed a baby prior to becoming a mother and only 18% felt that they knew a lot about babies. Such a situation may be even more common today, with the decline of the extended family and the increased geographical mobility of the population.

Many women regarded their antenatal classes as a valuable source of information and advice, although in the British Way of Birth study (1981) 41% of women said that they did not attend such classes, citing the inconvenient timing or the lack of classes in the local area as the principal cause of their non-attendance. In her study of first time mothers, Macintyre (1981) also found that women did not necessarily find the information they had been given at such classes appropriate or timely. The reasons which women gave as to why these classes *were* useful included the fact that only small numbers of women attended these sessions (and therefore discussions were focused and more personal) and they were conducted in a relaxed and informal atmosphere. Such classes also helped to prepare women for what would practically happen during labour and delivery.

An important source of dissatisfaction to emerge with antenatal care however concerns the expressed need for information by *second time* (+) mothers, many of whom felt that it was often presumed by medical personnel that their information needs were less than those of first time mothers (Boyd and Sellers 1982; Davis Floyd 1992; Graham and McKee 1980).

Whilst many women reported that they were able to find information via books and by 'asking persistent questions', even when women did ask questions their questions were not always answered satisfactorily. One women reported the following conversation between herself and the hospital doctor (Oakley 1979, p282-283):

| | |
|---|---|
| Nancy: | I said I was worried about being pregnant so soon after the appendicitis. And he said it just showed what a healthy person I was |
| Researcher: | What did you feel about that ? |
| Nancy: | Well, it wasn't really answering my question. |
| Researcher: | It didn't reassure you ? |
| Nancy: | Not really, no. |

Whilst this is a personal and subjective experience of professional / client interaction, the sentiments aroused are commonly found in the research literature about the provision of information within the acute maternity services;

i: This [an ultrasound test] was done by the hospital; I found it very disappointing. I was very excited about seeing my growing baby. the person who did the scan did not explain what she was doing or what she could see. She was more interested in her machine costing so much than she was in me or my baby(Boyd and Sellers 1982, p44).

ii: ...They [doctors] don't realise you go down to these places [hospital antenatal clinics] and you're a little bit nervous and it's all a bit above your head type of thing, and you can't really talk as freely as you would like, and all the questions seem to come an hour after you've left, you know, the questions you wanted to ask, and I don't really think they appreciate this (Oakley 1979, p283).

iii: ...I suppose I just want to be told more about what's happening, about what they're doing (Oakley 1979, p283)

iv: ...They don't tell you anything unless you ask them and when you ask them they answer you as if you're silly. I ask which way the baby's lying and how much it weighs now. Just natural questions. Well it's about *this* big and it weighs about a pound and it lies *this* way. They make you feel silly, so I don't ask them now. They just answer you as though they don't really want you to ask them (Oakley 1979, p285)

Such findings re-enforce the notion that "...women found that there was a tendency

not to take their questions seriously [and] questions about symptoms which although subjectively important were not seen as clinically important tended to be dismissed" (Graham and McKee 1977,p16; Shapiro et al 1983).

In Cartwright's study of childbearing and induction (1979), nearly 1 in 5 women felt that, with hindsight (i.e.; following the birth of their baby), they would have liked to know more about labour and delivery. Furthermore, any discussions which were held tended to be within lay circles, since only 25% said that they had talked to a midwife about the later stages of pregnancy and birth, only 20% had spoken to their GP about this and only 10% had discussed the matter with a hospital doctor.

A third major area of dissatisfaction to emerge from the literature regarding women's experiences of hospital antenatal care concerns the fact that, during the course of their antenatal visits, many women reported seeing different medical staff at each visit - a lack of continuity of care which was seen as both problematic and disorientating as the following comments illustrate;

> Mother I: You seem to see a different doctor every time you go. They don't really examine you, they just look at your stomach and say you're all right and that's it. That's all I've ever had. They could, you know, talk to you. Because if you start to talk to them about something they say well ask the girl at the desk. They treat you as another pregnant body really. The nurses are always nice...The first time I went I had a nice doctor: he was very nice. But since then they've all been - just in, look at your stomach, you're alright, see you in 2 weeks time which you don't because you don't see the same doctor (Oakley 1979, p285).
>
> Mother II: I never saw the same doctor twice, they were examining you as if you were part of a car (Boyd and Sellers, 1982, p28)

The advantages of continuity of carer and the importance of getting to know the midwife or doctor who will deliver the baby are highlighted by many women as of great importance when recounting their experiences of pregnancy and birth (Oakley 1979, 1980, Boyd and Sellers 1982, Davis-Floyd 1992, Rakusen and Davidson 1982, Winterton Report 1992, Changing Childbirth 1993; Page 1997). As long ago as 1966 a report of the Royal College of Midwives highlighted the importance of a good working relationship between women and those taking (professional) care of her. However, in Oakley's study of first time mothers (Oakley 1979), three quarters of respondents had never seen the person who delivered their baby prior to the actual birth itself - a situation which is not unusual even in the early 1990's (Winterton 1992). Whilst the many and varied descriptions of women's experiences of care in high technology consultant units show that care

in either large, "illness-orientated" institutions or at GP practices does not necessarily result in an impersonal and unrewarding experience, there are, nonetheless, a number of common problem areas. As Hall et al point out;

> "...the most commonly reported complaints from women are of lack of information or feedback, lack of advice (or the provision of confusing or conflicting advice), the ignoring of their so-called minor ailments of pregnancy and the anxiety (rather than reassurance) engendered by antenatal visits...The increasing centralisation, specialisation and task orientation which has characterised antenatal care in its attempts to increase the efficiency of its prediction, diagnosis and management of...pregnancy may have militated against the achievement of antenatal care's other set of goals." (Hall et al 1985, p111)

It is worthy of note that the antenatal care provided in GP clinics would appear, prima facie, to be more in line with women's expressed needs. A greater proportion of women reported being more satisfied with their experiences in local GP antenatal clinics, citing reasons for increased satisfaction as smaller clinics, reduced waiting times and the fact that women felt that they were receiving a more personalised service. In a study of antenatal care in Aberdeen, for example, women reported higher levels of overall satisfaction with GP care compared to hospital care:

Table 4:1 Overall Satisfaction (%) with Antenatal Care by Usual Place of Care
(Hall et al 1985, p93)

| **Satisfaction** | **GP** | **Hospital** |
|---|---|---|
| Dissatisfied | 0 | 0 |
| Fairly Dissatisfied | 1 | 5 |
| Mixed Feelings | 15 | 12 |
| Fairly Satisfied | 32 | 43 |
| Satisfied | 52 | 40 |

This study also demonstrated that women felt that they received a more personal and sympathetic form of antenatal care from GP's compared with obstetricians;

Table 4:2 Rating of Manner of Type of Staff (%)
(Hall et al, 1985 p 93)

| **Manner** | **Obstetrician** | **GP** |
|---|---|---|
| Unsympathetic | 5 | 0 |
| Fairly Unsympathetic | 12 | 1 |
| Average | 47 | 17 |
| Fairly Sympathetic | 19 | 29 |
| Sympathetic | 16 | 53 |

**Giving Birth - the delivery of hospital intra-partum care.**

The development of a modern, hospital-based approach to maternity care has not only affected the organisation of antenatal care - and therefore women's experiences of pregnancy. Equally, if not more importantly, the development of modern maternity care has transformed the nature of intrapartum care and, accordingly, women's experience of the very process of birth itself. Gordon underlines the often traumatic experience of birth itself within a modern clinical environment, commenting that "whether or not a mother's experience of childbirth is a happy one depends not only on the physical attention she is given but also on the care she receives for her emotional needs...Childbirth is emotionally and physically very demanding, and nearly every mother-to-be is anxious" (Gordon 1979, p201).

Whilst research into women's experiences of childbirth and motherhood has indicated that some women regarded giving birth within a modern obstetric unit as a positive experience, a large number of studies record maternal dissatisfaction with key aspects of their care (Oakley 1979, 1980; Cartwright 1979; Graham and McKee 1980; Graham 1985; Porter and Macintyre 1984; Kitzinger 1980). Many women said that on arrival to hospital and during the first stage of labour they were not made to feel welcome. Indeed, some mothers reported that they were left alone at some point during their labour. This in turn may have had an impact on other aspects of women's experiences, notably the relatively poor quality of the information provided to them by key personnel involved in their care.

One particular element of "birth management" which a large number of respondents in various studies felt had caused them stress whilst they were in labour concerned the use of a number of medical procedures. These included the use of enemas or suppositories, the mechanical monitoring of contractions, episiotomies (the cutting of the birth canal to assist delivery) the shaving of pubic hair (now largely abandoned), induction of labour, vaginal examinations during labour, epidurals, the use of forceps/vacuum extractor to deliver their baby and the cutting of the umbilical cord immediately following the birth (Oakley 1979, 1980; Cartwright 1979; Kitzinger 1981, 1992; Jacoby 1988). When such medical procedures were undertaken, respondents commonly reported that there was little discussion about what was happening or the reasons for this, as the following examples illustrate;

Mother P: I'd liked to have been warned what could possibly occur

> if the baby was overdue - and the causes. That was awful. No-one explained. They all just came and did what they had to - no explanations whatsoever, and left me...I wish I had been prepared in some way because it was so frightening. I was scared stiff having things done and not knowing what it was, as though you were just a thing - not a person with a mind (Cartwright 1979, p95).
>
> Mother Q: They should explain what they are going to do when they start mucking about (Cartwright 1979, p95)
>
> Mother R: I was in a lot of pain; I was told I would have Pethidine and gas & air - never asked whether I wanted these, although I had during my pregnancy said that I did not want them. the effects of these left me feeling detached from my body, still feeling all the pain and petrified that I would fall off the bed. Nobody ever told me that I did not have to lie down all the time (Winterton Report 1992, page xxii)

In the 1981 British Way of Birth study the most common areas of complaint from mothers regarding their experiences of labour were reported as being concerned with induction, monitoring and to a lesser extent drugs (Boyd and Sellers 1982), a finding which mirrors the results of earlier work undertaken by Oakley (1979) and Cartwright (1979) whose research indicated that women found these specific types of interventions a particular source of dissatisfaction.

Importantly, the level of use of such interventions by medical staff during labour and delivery has risen substantially with the increase in the rate of hospital confinements. Tew (1990, p156) for example, notes that between 1958 and 1966 the rate of forceps deliveries increased by 50% and caesarean sections by 61%. In the opinion of a Health Committee Report (Winterton 1992), the growing use of such procedures as induction and episiotomies during this period reflects a general trend within medicine as a whole. The report comments that "...like other branches of medicine, obstetrics has been swept away by fashions in which treatments have been introduced because they are available and not because they are of proven value" (Winterton, 1992, page xlix).

As Table 4:3 (overleaf) illustrates, whilst there have been fluctuations over time in the use of specific types of intervention, a high proportion of mothers in the "new" (post 1991 reform) NHS experience some form of intervention during labour and delivery. However, as the House of Commons review of maternity care (Winterton Report 1992) explicitly states, "...procedures introduced to deal with specific circumstances became routine without proper evaluation. Perhaps the most outstanding example of this in recent times is the induction of labour...at the height of this fashion it is alleged that induction rates in some hospitals reached 70%..." (page xlix). This echoes Friedson (1970, p78) who argued that "...it is characteristic

of our culture that the medical profession has first claim to jurisdiction over the label of illness and anything to which it may be attached, irrespective of its capacity to deal with it effectively", a process which has since come to be known as the process of 'medicalisation'.

Table 4:3 Use of Interventions - National Averages (%)

| | 1958 | 1974 | 1979 | 1985 | 1989 | 1996 |
|---|---|---|---|---|---|---|
| Induction of Labour | 13 | 39.4 | 37.0 | 17.3 | 12.0 | 27.0 |
| Accelerating Labour | --- | 1.4* | 10.5 | 12.1 | | |
| Episiotomy | 16 | 48.0 | 52.0# | 37.0 | | 27.0 |
| Caesarean Section | 2.7 | 5.2$ | 8.0& | 10.5 | 11.0^ | 17.0 |
| Use of forceps | 4.7 | -- | 13.0** | 9.1 | | 6.0 |
| Ventouse Delivery | | | | | | 5.0 |

Key: *= 1970 ** = 1977 # = 1980 $=1972 &=1980 ^=1990

(Sources: OPCS Monitors 1981, 1984 Maternity Statistics Series MB4; DHSS/OPCS Hospital Inpatient Enquiry, 1982-1985; Graham and McKee 1980; Tew 1990; Winterton Report 1992; Cox and James 1995; Audit Commission 1997).

Importantly, a major factor underlying women's dissatisfaction with such practices was not only the physical trauma of undergoing such procedures (and their associated iatrogenic risk), but also the feeling that insufficient information was provided regarding why such procedures needed to be undertaken. Women who reported dissatisfaction with key aspects of 'birth management', frequently commented that they were not expecting such procedures to occur and often did not understand why such procedures were necessary (Oakley 1979, 1980; Cartwright 1979; Boyd and Sellers 1982; Kitzinger 1979;1992 Macintyre 1981; Graham and McKee 1980)

The major sources of dissatisfaction with monitoring were that mothers reported that they would have liked to move around more during labour but were prevented from doing so by attachment to the monitors, and that medical staff often paid more attention to the monitor than to the woman herself, viz;

> Mother U: As soon as I got hooked up to the monitor, all everyone did was stare at it. The nurses didn't even look at me any more when they came into the room - they went straight to the monitor. I got the weirdest feeling that it was having the baby, not me (Davis-Floyd 1992, p107).

> Mother V: There was a light flashing as well, it kept fluttering and. I didn't know, I kept saying "why has it gone flashing, is that alright ?" They said "oh yes, it's just the light" but I had the feeling it was her (Macintyre 1981, p174)

The adoption of a "high-tech" approach to the organisation of labour and delivery, with its emphasis on the use of technology to increase "safety", appears to place the mother-to-be at the fringe of events rather than at the centre. The fact that women generally wish to be an active participant in the birth of their baby is highlighted by women's attitudes towards the use of drugs during their labour (Macintyre 1981). Whilst some women reported that the use of pain killers had provided them with a welcome break from pain, many said that they were not aware of the side/after effects of pain killing drugs and this might have influenced their decision whether to have them or not;

> Mother X: I was induced and given an injection of pethidine which sent me into a state of semi-consciousness. This made me unaware of where I was, what I was doing etc. The treasured moment when the baby arrived was lost as I was unconscious and only remember little bits of the labour. I would never have pethidine again. That mixed with gas and air made me very sick both before my baby was actually born and afterwards. I was unconscious for about three hours afterwards (Boyd and Sellers 1982, p104).

Similarly, the use of epidurals and caesareans elicited negative, as well as positive, responses from women - interestingly those women who replied that their experiences of such procedures *had* been "good" frequently mentioned that they were given detailed explanations about what would happen at all stages of their delivery. A number of women however, mentioned the alienating effect that the use of epidurals and caesareans had on the process of becoming a mother. Such clinical interventions caused mothers to feel detached from the birth which in turn detracted from their experiences of delivery (Cartwright 1979, Shaw 1974).

**Mothers: Partners or Participants**

The attitude of those caring for a woman during birth appears to have an influence on respondents attitudes towards the process of becoming a mother. Positive comments were made, for example, about the care received from midwives in general (Oakley 1979; Macintyre 1981), and especially about midwives who were in charge during the birth itself. Mothers placed particular emphasis on the personal relationship that often developed during labour between themselves and their midwife, which was highly valued. The helpfulness of midwives in trying to give women as much *control* as possible over the process was also mentioned, together with the detailed explanations and encouragement that the labouring

women were typically given which, in turn, made mothers feel that what was happening was neither frightening nor stress inducing (Kitzinger 1975; Macintyre 1977).

However, not all mother/midwife encounters were deemed to be positive, although when mothers expressed dissatisfaction with the care provided by hospital staff (either doctors or midwives) this was typically because staff were perceived of as uncaring and difficult to communicate with (Oakley 1979, Reiley 1977). Hence women appear to be more satisfied with their birthing experiences if they feel that the person who is caring for them places them at the centre of events and provides information and reasonable choice about how to give birth - and this appears to be the case irrespective of the carer's role or gender.

Table 4:4 Attitude to Sex of Doctor

| | (Oakley 1979, p305) | (Boyd and Sellers 1982, p130) |
|---|---|---|
| Preference: | | |
| Female Doctor | 23% | 11% |
| Male Doctor | 21% | 8.0% |
| Don't mind | 55% | 81% |

The importance of having staff who listen to what the women themselves are saying and who explain procedures and biological changes is a theme which typifies the attitude of many women to their care during labour and delivery. There is widespread agreement (c.f. Oakley 1979; Cartwright 1979; Winterton Report 1992) that irrespective of whether one examines the use of monitoring devices, the administration of pain killing drugs and the pattern of care experienced, women who are unclear about what was happening to them report more feelings of panic and a greater loss of control than women who feel informed and confident.

In summary therefore, feelings of ignorance on the part of service users were noted as being particularly stress inducing, with the consequence that respondents felt tense during their labour and delivery. Although many women said they were happy to be in close proximity to high-tech facilities (should the need for such arise during the course of their delivery), a striking feature of women's experiences of intra partum care, in common with the antenatal period, concerns their need for the provision of clear information from medical staff about the general nature of the processes involved. This in turn relates to women's need to feel that they have some control over the process of birth, and are not treated as merely bodies attached to machines.

## Post Natal Care - Reflections, Recovery and Routines

As the Winterton Report (1992) notes, less research has been conducted on the post natal period of maternity care then on the preceding antenatal and intrapartum phases - a situation which appears to have been brought about by the almost inordinate attention that has been given by clinicians and policy makers alike to the issue of how one can reduce infant mortality. This is especially true since the inception of the NHS and the subsequent emphasis which has been placed on the importance of the assessment of "risk" during pregnancy (as we have seen in Chapter 2). Not surprisingly therefore, much of the medical research literature "...has relatively little to say about postnatal care of the mother compared to..other issues considered...[and] postnatal care does not have a sufficiently high priority" (Winterton Report 1992, page li). Rather more surprisingly on the other hand, although social science research, and in particular, feminist research, has examined women's responses to motherhood after the birth of their baby (Graham and McKee 1980; Macintyre 1981), even these types of study tend to limit their focus to a relatively short period after delivery, the longest period being five months in the case of Oakley 1979 and Graham and McKee 1980.

Much of the research on postnatal care emphasises that the immediate post partum period is seen by many women as an important time for "bonding" to occur between mother and baby (Graham and McKee 1980, Kitzinger 1989). It is during this period that mothers (particularly first time mothers) learn how to care for their baby and a relationship begins to develop between mother and infant. If strict ward routines are imposed in hospitals, the effect on the mother/infant relationship can be negative. The dissatisfaction of women (usually in larger obstetric units) with the imposition of such ward routines, together with the effect that this has on their own, possibly fragile, state of mind is a particularly strong theme within the research literature on hospital-based postnatal care:

> Mother J: I got this horrible feeling that there was something wrong with the baby. I kept thinking oh I'm sure they're not telling me, I'm sure there's something wrong with him...and then I asked if I could see it and they said no, it was in the nursery or something. And that just convinced me that there was something wrong with it...I got to the point where I didn't want to have anything to do with him (Oakley 1979, p133).

> Mother K: When you have just had a baby you should be left to get on with it. I was told off for talking to our son. If our babies cried in between feeds they were put into the nursery, even at visiting times when the husbands were there (Boyd and Sellers 1982, p161).

The *birth* of a baby is often seen by many people as the focal point of pregnancy. It is not especially surprising therefore to find that the postnatal phase is often perceived by mothers themselves as an anti-climax. A large proportion of women are often in physical discomfort from both the birth itself and from bodily changes (such as engorged breasts, loss of bladder control, hormonal changes) and from the effects of interventions such as episiotomies, caesareans. (Winterton 1992).

During the immediate postnatal period therefore, women may need time in which they are allowed to adjust to their recent experience of birth, a period in which service delivery is flexible. But research suggests that this need is not met. Graham and McKee, for example, point out that a large number of women are dissatisfied with the post natal routines that they experienced within hospitals. Furthermore, the information that is provided during this time does not adequately prepare mothers for life at home with a new baby, since "...where women did seek advice from medical personnel they found that the advice given was unsatisfactory or incomplete" (Graham and McKee 1979, p23). They also note that the "...full extent of [women's] physical state of tiredness or debilitation [is] only realised on going home and attempting household chores [and] baby care routines etc...[and] one of the most common after effects of the birth...was that of exhaustion and fatigue" (Graham and McKee 1979, Volume 6, p26 - 29). Such findings are not uncommon, since Macintyre's study (1981) emphasised the significant role that practical support had to play in assisting mothers in the early postnatal period.

The experiences of women following birth in the early 1990's appears to be broadly similar to the picture outlined above, as a recent study by Glazener et al indicates that:

> ...most women (85%) experienced at least one physical or psychological problem [following the birth of their baby] in hospital; 33% experienced major complications such as bleeding or high blood pressure; 73% complained of relatively minor problems such as tiredness...87% of all women required pain relief in hospital. At home, 87% of mothers experienced at least one health problem: major problems such as bleeding or high blood pressure occurred in 46%; and 78% complained of relatively minor problems...(Glazener et al, 1992, p 4) "

Since it appears that many women face considerable physical (as well as mental) health problems during the post natal period, it is extraordinary to find that research on the postnatal phase of the maternity care cycle is, as the recent

parliamentary review of maternity care services observes, "surprisingly scant" (Winterton Report, 1992, page xlviii). Most disturbingly, one of the few studies which has examined the long term health problems of women found that these were directly associated with the clinical method of managing the process of birth itself. MacArthur et. al's study concluded, for example, that there were;

> indications of correlations between chronic backache and the use of epidurals; between chronic headache and neckache and general anaesthesia and caesarean section; between tranquillisers given during labour and pain in the legs; between the use of inhalation anaesthesia and fatigue; between pethidine [a pain killer administered in labour] and neckache, weakness in the legs and tingling in the hands; and between caesarean section and post natal depression (MacArthur et al 1991, quoted in the Winterton Report 1992, page xlix)

The authors go on to conclude that the "...popular model of a healthy, fit woman able to care for her baby is the exception. Most women are tired, in pain, depressed or unable to cope well" (MacArthur et al 1991, quoted in the Winterton Report 1992, page lii). Whilst Tew's pioneering critique of the scientific validity of the clinicians "discourse of risk" not only undermined the credibility of the argument based on mortality risk (to mother and infant) of a home birth but also hinted at the potential for increased levels of morbidity arising from institutional confinements, this line of enquiry has been generally neglected until comparatively recently.

This pattern of both poor physical and mental health amongst women during the period following birth is not altogether surprising when one examines the qualitative research undertaken by feminist critics of modern maternity care during the 1970's and 1980's. Although these early studies were somewhat limited in their scope (empirically and temporally), such research nonetheless indicates that many women not only had health problems to contend with following birth but, in addition, many experienced difficulties in adjusting to and coping with their new role:

> Mother I I used to be a person in my own right. Now all I am is somebody (or something) to feed, wash and change her. In between feeds I am just here to clean the house, wash clothes and feed the rest of the family. I feel unattractive and tired...(Boyd and Sellers 1981, p189

Such a major change in both the social circumstances and daily routines of women's lives brought about by motherhood typically exacerbates feelings of social isolation, especially over time. Thus, whilst only 18% of mothers in the First

Months of Motherhood Study reported that they felt isolated one month after the birth of their baby, by five months postnatally this figure had risen to 44% (Graham and McKee 1980). Oakley (1979) suggests that feelings of social isolation and monotony within women's live may potentially increase over time since as the baby gets older so new visitors get less and help from within the conjugal unit decreases. Given the emotional disturbances which women generally experience following the birth of their baby, and the subsequent need for women to be able to talk over their experiences and discuss their problems, it is during the post natal period in particular that the mother (especially the first time mother) requires information and support as a basis for re-assuring her that everything is "normal".

It would appear that maternal dissatisfaction with modern maternity care services arises at virtually every stage of what might be called the "maternity care cycle". The major sources of women's dissatisfaction over the delivery of intrapartum care centre on the alienating effects induced by an impersonal atmosphere, the inflexibility of routine hospital practices and the lack of information or consultation about medical procedures and techniques used during labour and delivery.

Dissatisfaction with the maternity services is by no means universal and a number of women spoke very highly of the care that they had received during the birth of their baby (Macintyre 1981; Oakley 1979). However, when mothers were satisfied with the maternity care that they had received (whether in a smaller maternity unit or in a large hospital obstetric unit), and regardless as to whether their baby was born healthy or not, the features of the service which were seen to enhance the personal experience were those of an understanding, personal approach, an informed dialogue between the mother and those caring for her and a sense of maternal control over events wherever and whenever was possible. In other words, such care consisted of those very aspects of modern maternity care which, as far as the majority of mothers were concerned, were honoured more in the breach than in the observance.

**Summary**

Maternity care policy in the UK in the latter part of the twentieth century has been primarily concerned with the issue of 'risk', but especially the risk of infant mortality. The reaction of women service users to the modern system of maternity

care which has developed as a consequence of this policy indicates that women are often highly critical of this form of care. Although the specific concerns which women express about the nature of the care provided for them vary at each of the three different stages of what can be termed the maternity care 'cycle', overall the broad areas of concern remain the same at each stage. As an extensive corpus of research demonstrates, women users of modern, post-war, hospital-oriented maternity care services experience a fundamental lack of *control* over the process of 'becoming' a mother. Any sociological assessment of the nature of modern maternity care must therefore examine the potentially problematic relationship between the discourses of risk and control, an issue to which we now turn in chapter 5.

# Chapter Five

## Risk and Control : A Dialogue of the Deaf ?

### Introduction

As the foregoing discussion indicates, the development of modern maternity care in the UK has been driven by a particular discourse or worldview, the 'discourse of risk', which principally represents the opinions and judgements of the *providers* of such services. By contrast, the worldview or discourse developed by the *users* of such services emphasises the importance of a quite different set of considerations. The central purpose of the present chapter is to examine the problematic nature of the *relationship* between these discourses.

### Risk and Control: the Competing Discourses of Modern Maternity Care

The difference between the clinical orientation to birth, and women's approach to pregnancy, labour and delivery can best be understood as deriving from the different world-views or ideologies of obstetricians on the one hand and pregnant women on the other. In other words, the acknowledged spectrum of potential beliefs about pregnancy and birth can largely be encompassed by two (opposing) paradigms - those of a medical model of birth on the one hand and a natural/holistic approach to the process of becoming a mother on the other. Oakley and Graham (1981, p9) for instance, argue that "...doctors and mothers have a qualitatively different way of looking at the nature, context and management of reproduction" and their apparently common goal of a successful outcome is defined differently.

What Oakley and Graham refer to as the obstetric "frame of reference" views reproduction as a professional, specialist subject, whereby doctors are experts (and women, by implication, are not), and pays particular attention to the selection of largely physical criteria of reproductive success with women typically viewed as maternity "cases". As Oakley points out, it is this paradigm which "...has been central to the whole development of medically dominated maternity care" (Oakley 1980 7-49). The importance of the existence of specific types of "knowledge", which are utilised by different groups or individuals to "bracket" the acceptable limits of any debate about maternity care is illustrated by the conflict of opinion between professionals and clients as to the relative appropriateness or importance of the different elements of maternity care (Comaroff 1977). The 1978 Council for

Science and Society (CSS) Report highlighted the fact that the inordinate degree of influence exercised by the obstetric perspective over the organisation and delivery of services had led to the development of a system of care which failed to either recognise or meet the perceived needs of the users of maternity care services. Moreover, the extent to which such ideological dominance represents a conscious or explicit choice on the part of the medical profession itself is perhaps most explicitly revealed by the Short Report's observation that;

> ...the understandable preferences of mothers in regard to place of delivery may not be compatible with the requirements for the maximum lowering of perinatal and neonatal mortality (p 59)

- and this despite extant research (reviewed in Chapter 3) which called into question the scientific validity of the claim that 100% institutional confinements could be justified solely on the grounds that it reduced the risk of infant/maternal mortality to a minimum. The dominance of the obstetric frame of reference in the field of maternity care is not surprising of course, given the respective degree of influence which obstetricians and mothers have had in determining the organisation and development of maternity services. As Kitzinger points out,

> ...in any culture, those with the power to define the meaning of birth also write the script for how it is to be handled and how the different participants should behave. In a technological culture, doctors define birth, while women experience it (Kitzinger in Roberts, 1992, p63)

The origins of this obstetric "frame of reference" can be found in the wider context of contemporary medical practice.

**The Development of Modern Medicine: a clinical gaze**

The emergence within medicine of a bio-mechanical metaphor for the body has its origins in the rise of rationalism which has come to dominate all branches of modern day medical practice (Freund & McGuire 1991). The application of such a bio-mechanical approach to maternity care has been subject to some slight modifications, although key elements of the original metaphorical thinking still remain. As Arney notes for instance, following World War II "...the body was no longer looked upon as a machine [but]...instead became a system [and] all events in a woman's life became important obstetrical material worthy of study...every aspect of birth became more carefully controlled" (Arney 1982, p8). Notwithstanding these more subtle variations on or departures from the original outlook, medical thinking is still strongly influenced by the bio-mechanical

metaphor. The author of an article in the February 1989 issue of Life for instance, observes that

> If we think of the human body as a kind of machine, doctors of the future will be like mechanics, simply replacing those parts that can't be fixed (p54-55)

Whilst it might be argued that, in a modern context, the role of obstetrician may take the form of a "supervisor" of technology rather than a "mechanic" who is responsible for fixing bodily malfunction, obstetricians remain highly skilled and "their training stresses the acquisition of the most sophisticated technical knowledge and expertise that can be brought to bear on the birthing body-machine" (Davis Floyd 1992, p49). The continuing dominance of this bio-mechanical "frame of reference", particularly in comparison with the alternative view of childbirth as essentially a "natural" event or the holistic approach which found favour amongst some sections of the midwifery profession (c.f. for example The Association for Radical Midwives), has been highlighted by physicians, medical anthropologists and sociologists alike (Corea 1985; Ehrenreich and English 1973; Leavitt 1986; Mendelson 1981; Oakley 1984; Martin 1987; Spallone 1989; Wertz and Wertz 1989), many of whom argue that the approach which has been adopted by the medical profession has convinced women of the "dangers" inherent in pregnancy and childbirth. Pregnancy is not an illness, but is a natural biological state. The fact that within all societies some women experience physical symptoms and complications during pregnancy and birth has led to a situation, in most modern societies, whereby *all* women are subjected to the same general bio-mechanical model of medical care of the kind which is commonly applied to the field of acute/chronic illness as a whole.

In understanding the conceptualisation of childbirth from this medical perspective, a number of features of the "orthodox" medical view of the human body can be identified (Carlson 1975; Illich 1976). Firstly, the notion that the human body is an imperfect mechanism and as such "requires" medical intervention provides a broad justification for the clinical "interventionist" approach of modern obstetrics. Secondly, it is typically assumed that the outcomes of clinical interventions are clearly identifiable (such as a reduction in perinatal mortality) and the effects of such interventions make a positive contribution to outcome, a supposition which has itself been subject to criticism (Tew 1991).

Since the supposed causal relationship between several improvements in medical techniques and their assumed benefits for the health of the individual have been

widely questioned (Illich 1976, McKeown 1965, Tew 1990) one might reasonably infer that the presumed beneficial influence of maternity care services should not be taken for granted. Indeed whilst modern medical procedures may confer many positive benefits, it is possible that such practices may induce harmful side-effects as well (Tew 1990, Stewart 1981, Hemminki 1983, Van Enk 1987). Furthermore, as Illich (1975) also suggests, the effects of an over-reliance on professional as opposed to personal forms of knowledge may well have led to a situation where lay knowledge and lay defined "needs" are seen to be either suspect or inferior. That is to say, our capacity to look after ourselves and a belief in our own knowledge and understanding of health may in fact be threatened by the tendency to rely solely on "experts".

As the rates of hospitalised birth have risen, and obstetricians have become increasingly involved in the provision of routine maternity care, the medical model of childbirth - the view that a birth can only be said to be proven "uncomplicated" after the event - has displaced the traditional view that pregnancy is a natural state and birth a natural occurrence. As Nash and Nash (1979) point out, obstetricians and politicians alike have increasingly adopted an attitude which routinely calls into question the capabilities of a woman to give birth without medical assistance, thereby providing justification for an increase in the proportion of hospitalised births and the high rates of intervention. Since women during the 1960's and 1970's were increasingly told that the hospital was the "safest" environment in which to give birth, it is perhaps no surprise to find that the policy of locating virtually all births within a hospital or "medicalised" setting initially met with lay acceptance.

The absence of overt criticism of such a policy from the point of view of its principal recipients, women, is by no means unproblematic however, and research undertaken by Hall et al suggests why criticism of the maternity care services may have been slow to evolve. During a study of innovations in antenatal care they found that overall levels of satisfaction with care were relatively high, since pregnant women appeared to assume that whatever arrangements they had experienced were the best arrangements possible:-

> [The]...data suggests that pregnant women - and the same may be true of other health service users - are fairly uncritical and assume that whatever care they are receiving has been well thought out and is probably the best there is. These women tend to accept and be satisfied with whatever care arrangements they experience and to prefer them to alternative possibilities. They were conservative in the sense of saying *"what is must be best"* (Hall et al, 1985, p 198).

However, when questioned about specific aspects of such care, women tended to be negative about "innovations" in either care patterns or specific treatments unless they had experienced them directly themselves.

Obstetrics, unlike other medical specialities, does not deal with what might be called "genuine" pathology in the majority of cases it treats and there are certain features of the maternity services which place the majority of those who use maternity services in a rather different situation from that which typically applies to the users of other hospital services. For example, in the case of maternity care, admission to hospital for birth is usually planned and is not, for the majority of women, a medical "emergency". Furthermore, given the gestation period of 9 months, women not only have time to organise their admission to hospital but may develop strong feelings on how they want to give birth. Satisfaction with and attitudes towards giving birth in a hospital environment may depend therefore on women's own views about the nature of pregnancy, birth and motherhood, in addition to the way in which she is regarded by others (eg; medical staff).

Since becoming a mother is commonly acknowledged as a "life event" (Oakley 1979,1980, van Gennep 1966, Davis Floyd 1992) which entails significant change in several role relationships, the events surrounding pregnancy, labour and delivery are likely to be seen as highly charged - both emotionally and personally - by women, their family and friends. In addition, aside from any expected changes in role relations, a number of studies also indicate that a positive or negative experience of the process of birth may affect a mother's relationship with her newly born child during the immediate postpartum period and beyond, and may therefore affect the very process of role change itself. (Oakley 1979, 1980, Oakley and Graham 1986, Kitzinger 1978, Ball 1989; Gordon 1990, Jordan 1983).

Modern maternity service provision, and specifically obstetrics, is especially vulnerable to criticisms raised by the natural childbirth and holistic health movements. Advocates of such programmes argue that the principal assumption should be that a pregnant woman is inherently "well", in contrast with obstetrics which, they argue, insists on conceptualising her as "ill" and which emphasises the necessity to "manage" women's bodies throughout pregnancy and birth (Zander and Chamberlain, 1984). That women themselves are often exposed to such 'conflicting paradigms' via professional and lay contacts during pregnancy has, it is argued, led to women being unsure of which perspective to adopt (Comaroff 1977, Macintyre 1981)

Although it is generally acknowledged within the obstetric profession that pregnancy is a state of health and not an illness, in practice the relative weight given to such a concept is generally slight. William's tome "Obstetrics" (1989), for example, designates (approximately) 900 pages to potential *abnormalities* during pregnancy and birth and simply includes the following brief summary to "remind" trainees that;

> the expectant mother has been commonly treated as if she were seriously ill, even when she was quite healthy. All too often she has been forced to conform to a common pathway of care that stripped her of most of her individuality and dignity...Too often the expectant mother has felt that her fate and that of her baby were dependent not so much on skilled personnel but on an electric cabinet that appeared to possess some great power that prevailed above all others (Cunningham et al 1989, p6)

In the course of her anthropological research in the USA, Davis Floyd notes that "...for the majority of modern practitioners, technology and birth are inseparable" (Davis-Floyd 1992, p55), a view substantiated by the majority of the obstetricians in her study who felt that the abilities to relate to and interact effectively with patients were not as important as the possession of technical skills. As one junior houseman commented, "...anybody in obstetrics who shows a human interest in patients is not respected. What is respected is an interest in machines" (Davis-Floyd, p55). In justifying the increased use of technology within hospitals, a senior obstetrician observed that the underlying reason why expensive, high technology equipment was utilised so extensively within hospitals was primarily due to the problems of time management. From his own point of view, he felt;

> ...totally dependent [on] fetal monitors...they free you to do a lot of things. I couldn't practice modern obstetrics without them. I couldn't sit over there with a woman in labour with my hand on her belly and be in here seeing twenty to thirty patients a day. You couldn't see the volume of people..(Davis-Floyd,1992 p55)

Accordingly, the modern medical ethos surrounding the process of birth relies heavily on the "processing" aspects of birth management rather than on the quality of the individual experience. As another obstetrician commented;

> ...There's no room for niceties around her. We just move 'em right on through. It's hard not to see it like an assembly line...the labouring woman was someone you worked *around,* rather than *with.* (Davis-Floyd 1992, p55)[my emphasis]

The obstetric view of a successful pregnancy and birth is therefore largely defined (in purely clinical terms), as "...the perfect baby. That's what we're trained to

produce. The quality of the mother's experience - we rarely thought about that" (Davis-Floyd 1992, p57). Indeed these sentiments were echoed during the course of my own research by a Senior Hospital obstetrician who commented that "I'm not concerned whether women in this hospital find birth an orgasmic experience. All I'm concerned about is [the problem of] dead babies " (October 1993).

Whilst a live, healthy baby is of course a key indication of a successful pregnancy and birth as Arney (1982) comments, following the re-location of birth out of the home and into the hospital (large bureaucratic institutions which are predominantly designed to cure pathological illness), a situation emerged whereby "...everyone - women, husbands, or significant others, and obstetricians - got caught up in [technological] monitoring's "web of power" and so became more and more alienated from the event and experiences of childbirth" (Arney, 1982, p9). Although many healthy babies may have been produced from such a system of maternity care, other criteria of success which focus on the emotional and psychological aspects of birth (which are of great importance to women) were implicitly ignored - which, as critics of the maternity care services have claimed, had a profoundly negative effect on many women's experience of becoming a mother (Reference Chapter 3)

Hence, critical concern about the medical model of childbirth has focused attention not only on the de-humanising process of hospitalised birth itself, but also on women's experiences of and attitudes towards pregnancy and childbirth within a wider social and cultural frame of reference.

**Divergent opinions**

The major areas of dissent between the obstetric profession on the one hand and the users of the maternity services on the other centre on a number of potentially disparate perceptions about the very nature of pregnancy and childbirth itself (Comaroff 1977). More than 40 years ago in their annual report the RCOG and the Population Investigation Committee (1948 page vi) noted that;

> the maternity services cater in the main for healthy women going through a physiological process. Their needs are more complex than those of the sick where the clinical aspect is all important.

Despite this apparent professional recognition that women utilising the maternity services have needs which go beyond purely clinical considerations, the principal focus of maternity care has continued to be that of a reduction of (primarily)

perinatal mortality. In the process of recording medical details and in relating these to a single outcome measure (that of a live birth), critics have argued that the medical profession attached great store to certain actions/procedures (i.e.; clinical intervention). Consequently, medicine has ignored the importance that a woman attaches to her relationship to those caring for her and her sense of self during the birth experience have typically been overlooked (Kitzinger 1992; Oakley 1980,1984; Welburn 1980). A "woman centred" model of childbirth thus began to emerge from this debate, which raised a quite separate set of issues and questions from those addressed by a "medical frame of reference" - as the following table (Oakley & Graham 1981) illustrates.

Table 5:1a Different Frames of Reference

| **Principles of the Medical Frame of Reference** | **Principles of the Maternal Frame of Reference** |
|---|---|
| Male centred | Female centred |
| Woman = object | Woman = subject |
| Body = machine | Body = organism |
| Dr=knowledgable, Mother=ignorant | Mother=knowledgable (preferences /informed choice/attitudes/feelings) |
| Pregnancy & birth inherently pathological | Pregnancy and birth inherently normal |
| Doctor = technician Baby=product | Midwife=nurturer |
| Safety of foetus is more important than the emotional needs of the mother | Safety and emotional needs of the mother and baby are of equal importance |
| Importance and supremacy of technology | Importance of people and the sufficiency of nature |
| Labour=mechanical process | Labour=an experience |
| Environment = unimportant | Environmental Ambience = crucial |
| Medical intervention usually necessary | Progress of birth not charted, intervention not usually necessary |

or as Davis Floyd (1992, p47) summarises:

| | |
|---|---|
| Science<br>Technology<br>Patriarchy<br>Institutions | Nature<br>Individuals<br>Families<br>Women |

The principles which inform a "medical frame of reference" not only underpin the "discourse of risk" but, in terms of their dominant influence over maternity care service provision, can also be said to represent the more general process of the "medicalisation" of modern life (Williams and Calnan 1996)

Conrad and Schneider (1980) suggest that medicalisation can occur on a number of different levels, all of which are evident in relation to the provision of maternity care services: conceptually, when a problem is "defined" in medical terms; institutionally, when the medical profession itself defines as "legitimate" a programme or problem which a medical organisation has decided to focus its attention upon and finally, diagnostically, at the level of the doctor / patient relationship, where a doctor provides his/her "treatment" for a "problem".

Whilst there is general consensus of opinion regarding the definition of medicalisation, as Williams and Calnan (1996) point out "...writers differ considerable regarding its causes" (p95). Friedson (1970) regards the process as a product of what might be termed the "professional imperialism" of medicine, whereas Illich (1976) sees it as a product of the much broader processes of industrialisation and bureaucratisation - which are themselves driven by a quest for formal, but not necessarily substantive, "rationality". Navarro (1975,1986) and Taussig (1980) on the other hand, emphasise the impact of dominant class interests whilst Conrad and Schneider (1980) cite the important influence of a variety of interest groups and agencies beyond a simple class analysis model. Crucially, feminists have emphasised the important role played by the phenomenon of patriarchy in the process of medicalisation - especially of course in the field of modern maternity care and reproductive technology (for example, Spallone 1989; Corea 1985(a), 1985(b); Koch and Morgall 1987; O'Brien 1981).

According to Stacey (1993, p53), the term 'patriarchy' is used by feminists "...to analyse the systematic organisation of women's oppression" and therefore gives conceptual form "...to the nature of male dominance in society". Patriarchy is, however, a concept whose fortunes have fluctuated markedly during the development of contemporary feminist thought. In what is often referred to as the 'first wave' of modern feminism (approximately the 1940's and 1950's), the term was originally used in a relatively restricted way to describe the power of the 'father' as head of the household. Post 1960s' feminism, by contrast, has used this term to refer to what Stacey describes as "...the systematic organisation of male supremacy and female subordination" (1993, p57).

The use of the concept in this later, more 'general' manner has however created its own set of difficulties. To begin with, this more general orientation led to a plethora of definitions and applications in an attempt, no doubt, to make sense of the idea in a 'substantive' context. This in turn generated a chorus of criticism. Certain writers (eg, Millett 1970) began to operate with the idea that male dominance over women was an essentially 'universal' feature of 'society'. This, inter alia, contradicted more 'particularistic' uses of the term 'patriarchy'. The description of certain households forms as 'patriarchal' rather than 'matriarchal' for instance, is underpinned by the assumption that the phenomenon of 'patriarchy' ought to be thought of as culturally and historically relative - and therefore presumably variable between time and place.

The generalising, but also contradictory, usage of the term led to criticisms that it was, inter alia, too nebulous to be of any explanatory value (Beechey 1980, and Rowbotham 1982). Barrett recalls her own early rejection of the concept, but, on reflection, comments that the term may be regarded as a useful 'marker' for feminist thought. This indicates that Barrett acknowledges "...the independent character of women's oppression and avoids explanations that reduce it to other factors" (Barrett 1980, p13). Post-modern feminism appears to refuse to confer even this more limited legitimacy on this use of the term. Pollert (1996) dismisses the notion of 'patriarchy' as an example of modernist theorising which is "abstract", "mechanistic", "reductionist" , circular, and in almost every sense "bad". More problematically, modernism involves the construction of 'grand narratives' (of which patriarchy is an example par excellance) which Pollert (and other post-modern feminists, for example Flax 1990; Hekmaan 1991) see as non-reflexive and most importantly 'masculine' 'rationalisations'.

Hence, whilst the notion that modern maternity care is 'gendered' constitutes a key element in feminist critiques of women's experiences of this type of care, the use of the specific concept or term 'patriarchy' in the context of maternity care is problematic. In general terms however, modern maternity care is nevertheless seen as a site within which conflicts of gender are intrinsically bound up with the organisation and delivery of maternity care services.

Although the medical frame of reference, and specifically the discourse of risk, has dominated policy making in the field of maternity care, it would be misleading to suggest that this perspective has escaped from criticism, either from within or

outside of medicine. As has been shown in Chapter 3, important critiques of the internal validity of the discourse of risk, judged on its own terms, emerged during the 1970's and 1980's and representatives of service users were vociferous in their criticism. However, this had little material effect on the long term development of policy which has, until recently, continued to be driven by the concerns of the "discourse of risk".

**The rise and fall of midwifery**

It is also important to stress that not only has the medicalisation of maternity care affected the experiences of women service users, but the organisational changes which have accompanied this process have also adversely affected the role and position of certain key, largely female, groups of service providers - most notably midwives (Robinson 1990; Bent 1982; Towler and Bramhall 1986). The rise of modern maternity care also represents the rise of modern, male dominated, obstetrics and the decline of domiciliary midwifery. The development of modern maternity services has resulted in a shift in the physical location and orientation of the activities of a large proportion of midwives from the community to the hospital. Concomitantly, this has altered the relationship between midwives and clinicians, bringing midwifery more directly under the influence of obstetricians. The development of medicine in the post war period in particular, witnessed growing tensions and conflicts between not only the providers of maternity services and women users, but also between different gendered groups of service providers themselves (Donnison 1977; Stacey 1988, Davies 1995, 1996). Although these tensions and conflicts centred on issues concerning the very nature and aims of modern maternity care, such struggles do not appear to have manifested themselves to any great degree as major public debates during the principal phase of maternity care policy development in the 1970's and 1980's. Most importantly, midwives have themselves been divided in their attitudes towards modern maternity care. Some midwives are content to work within a modern, obstetric environment, whilst others may hold stronger views about the autonomy of their work (Walton and Hamilton 1995). The creation of the Association of Radical Midwives (ARM) - a pressure group within midwifery who advocate a *more* holistic approach to maternity care - illustrates the complexity of the tensions and conflicts which surround modern maternity care.

## Individuality of Thought: Commonality of Experience

In comparing a maternal or woman-centred frame of reference with the medical model, it is important, of course, to stress that such a frame of reference should be regarded more as an "ideal type" rather than as an empirical description of the dominant tendency in most women's thinking about or attitude towards maternity care. To begin with, at the level of the female service user, women typically hold differing beliefs about pregnancy and birth, which may or may not stand in opposition to the medical model (Comaroff 1977; Davis Floyd 1992). Davis-Floyd argues that;

> the single factor that most influences the conceptual outcome of a woman's birth is the degree of correspondence between the technocratic [medical] model...dominant in the hospital and the belief system she herself holds when she enters the hospital (Davis-Floyd 1992,p155)

This is naturally a highly complex issue. The way in which individual women respond to pregnancy and childbirth and the differing "frames of reference" that they themselves work within, vary according to such factors as their own personal internal beliefs about womanhood, motherhood, health and illness together with the degree of control which they feel they are able to exercise over their own health - all of which are likely to be influenced by variations in social circumstances (Calnan 1991, Blaxter 1990).

Furthermore, amongst the largely feminist critics of maternity care, one must also recognise important differences in emphasis, interpretation and explanation, reflecting different schools of thought or perspective within the broad church of contemporary feminism. This is apparent in a number of ways and raises several important questions about 'the discourse of control' perspective. Whilst most critics appear to agree that modern maternity care has what is often referred to as an "alienating" and "de-humanising" effect on women (Doyal 1979; Scully and Bart 1978; Martin 1987; Oakley 1980; Cartwright 1979, Arney 1982), the precise meaning of this and the potential implications of such an analysis for future action are less clear[1].

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[1]As a further illustration of the essentially reductionist nature of arguments which attempt to introduce the concept of alienation into the analysis of the gendered nature of maternity care, O'Brien (1981, 1989) argues that reproduction has consequences for the alienation of both women *and* men. She suggests for example, using a Marxist framework, that in childbirth, women 'labour' and thus transform biological reproduction into a human or social activity. Men are only involved in the initial act of creation and not in the social process of gestation and delivery. Consequently, men are alienated from the process of reproduction. Accordingly to O'Brien, men attempt to

As used principally in Marxist theory, the term is typically used to refer to the separation or "alienation" of the individual from his/her own fundamental human nature or "species being". Applied to feminist discussions of society and gender however, the use of such a reductionist and "realist" idea does however present several major problems of a philosophical, theoretical and methodological nature. Most obviously - and even when one allows for the fact that feminist theory has become increasingly diverse and resonates with most theories of social order and/or social change - the suggestion that the differences between male and female behaviour and attitudes can be reduced to ineluctable differences in their basic nature is highly problematic - not least of course because a key feature of much feminist thinking stresses what Giddens has called the "plasticity" of sexual identity and sexuality. The meaning and implication of the term "alienation" as a means of describing women's experiences of modern maternity care is an issue which has to be addressed therefore in any such appraisal of the nature of such care.

Most recently, in perhaps one of the most radical expressions of this outlook, Kitzinger - who stresses the importance for women of understanding modern maternity care as the ideological expression of "patriarchy"- appears to advocate a relatively radical "closure" of maternity care from men which promotes enhancing the role of the midwife and seeking to re-locate the place of birth from the hospital to the home (Kitzinger 1994). A re-emergence of domiciliary midwifery would, moreover, represent the gendered shifting of professional control from obstetrics to midwifery, and would also reflect a wider process of empowering women within a community context.

By contrast, the work of Oakley and others, though no less critical of the "patriarchal" nature of modern maternity care appears to seek some degree of rapprochement with modern maternity care, exploring ways of reforming, rather than simply rejecting all aspects of the contemporary practice and organisation of maternity care outright, in line with more liberal tendencies within contemporary feminism. Recently, for example, in seeking to develop a more woman centred form of maternity care, Oakley (1992) makes specific reference to the needs of pregnant women in key "high risk" categories and examines ways of how these can be met within the broad structure of current health service provision.

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overcome their alienation by developing new reproductive technologies which allow them to gain control over this process.

This difference of emphasis is crucial since it raises the vital question about the nature of the discourse of control and a woman centred frame of reference. On the one hand, this could be represented as a largely ideological conflict, of a fundamentally gendered nature, which needs to be resolved at an organisational level (through a process of significant service reorganisation) for essentially ideological reasons. Whilst the organisation of maternity care undoubtedly requires one to consider the ideological influences within which the development of policy and practice has been framed as an issue in its own right, any review of modern maternity care must also examine a related question of equal significance. Namely, does the nature of modern maternity care, organised as it has been within a "medical" frame of reference, carry with it any health "costs" for women ?

Women users of maternity services have not only been described as typically "alienated", for example (though, as has been discussed, there has been little conceptual discussion of this key term) but have also commonly been referred to as "stressed" by their experience of using maternity services. Since stress is commonly regarded as an important source of ill-health (both physical and mental) the possibility that modern maternity care may have an adverse effect on the health of women (measured for example, at the level of maternal morbidity) is as critical an organisational issue as that of patriarchal dominance per se. If, in other words, the organisation of modern maternity care has an adverse effect on women's health (however measured), as distinct from the positive effect claimed by the discourse of risk argument, this constitutes a major problem in itself - the influence of patriarchy on modern maternity care not withstanding (Footnote 2).

Whilst such an idea might seem to be inherently implausible in view of the high levels of *general* satisfaction recorded by "consumer surveys" of medical care (including maternity service provision) (Which 1992), this would be to accept the validity of such results in an uncritical / unreflective manner. Certainly, the extensive body of largely ethnographic or qualitative research conducted by feminist critics suggests a very different story - although by the very methodological nature of such work it is difficult to establish systematic empirical evidence that the "controlling" aspect of modern maternity care has a negative influence on women's health.

Theoretically, the notion that inequalities in social control are associated with inequalities in health, at the level of both adult morbidity and adult mortality, has

found expression in a number of recent studies and discussions (outside of the field of maternity care) of the social determinants of health inequalities. The Black Report (1980) demonstrated that inequalities in health could be accounted for in terms of the influence of 'social' factors, whilst the earlier work of Marmott et al (1978) represents the development of a general theoretical model of health inequalities which is based on the assumption that the relationship between freedom and constraint/control and choice is a central determinant of health and illness[2]

At a theoretical level therefore, there is clearly a need to examine the role of the *social organisation* of modern maternity care as a potential *determinant* of the health status of women service users. In so doing, there is also a need to examine and define the nature or concept of control, both as it has emerged from the critical appraisal of research about maternity care and also as a general, explanatory concept.

In referring to women user's experience of "control", it is apparent that researchers typically refer to two broads dimensions of the nature of maternity care services. In the first instance, women users generally complained about the impersonal, rule governed aspect of maternity care services, particularly hospital based care, which downplays the personal and emotional (or 'affective') dimension of the experience of pregnancy and birth - in other words the broad organisational "context" or "form" within which maternity care is delivered. Such a bureaucratic approach is typified as unemotional and unfeeling, a dimension of modern medicine in general which Davies (1996) sees as reflective of a male rather than a female attitude to the nature of social organisations per se.

Women users also complained about another dimension of the "controlling" aspect of modern maternity care which refers to what might be called the "content" rather

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[2] In the work of Tew (1990), one also finds reference to the idea that modern maternity care may well increase the level of infant and/or maternal morbidity (irrespective of its effect on mortality) but for rather different reasons. She suggests that in seeking to reduce the risk of mortality, modern maternity care increases the level of clinical interventions, especially during delivery. This in itself, increases the risk of ill-health post birth since increasing the level of, surgical interventions, for example, carries with it health consequences for the individual Similarly, the increased use of drugs to induce labour may also have a negative effect on infant/maternal health - due for example, to the side-effects which occur in the case of virtually all drug regimes. However, this particular approach to the question of whether (and in what way) modern maternity care affects ill health is not directly related to the central issue of whether the organisation of maternity care per se affects women's health by restricting women's control over their own bodies. In other words, one needs to examine the psychosomatic effects of maternity care and not simply the physical effects of interventions.

than the "context" of service provision, especially the fact that choices (eg, alternative forms of care regime or the use of interventions) are often made on behalf of women by service providers, without the active involvement of the service user. The key issue here concerns the provision, or otherwise, of relevant and intelligible *information* so that pregnant women can make an "informed choice" about such issues. Related to this, women were also concerned about the lack of opportunity to discuss such choices in order to discuss the merits of the various care options on offer.

Accordingly, a number of important questions need to be considered, concerning the relative importance of the "context" and "content" aspects of control for understanding women's health:

(i) are each of these two dimensions of control equally significant both in terms of women's attitudes to different aspects of service provision and in terms of their impact on women's health - or is one aspect or dimension more important or influential than the other ?

(ii) is it the case that a high degree of control by professionals could be exercised in predominantly one area (eg; content rather than context) rather than both, and if so, what might the possible consequences of this be for women's health ?

(iii) if the problem of control within maternity care focuses principally on the issue of the context within which such services are delivered, does this imply, following Davies's analysis, that the main question that needs to be addressed is the possibility of "re-gendering" the organisation of the service. Davies suggests that the bureaucratisation of medical care in general reflects an essentially masculine attitude or approach to the organisation of medical services through the emphasis on formality, hierarchy and rule following. She argues that this essentially masculine emphasis on "impersonality" creates a form of organisation which fails to reflect women's more informal and personal approach to issues of organisation.

(iv) if on the other hand, the problem of control is seen to focus principally on the issue of the content of service delivery, is the potential re-gendering of maternity services still the paramount consideration - or do issues of service content raise questions of a different kind. For example, could the quality of service content be improved *without* a re-gendering of the service?

Problems of "control" associated with the "content" of maternity care services have been exacerbated by the rapid growth in reproductive technologies which has accompanied the development of modern maternity care practice - and is one of its distinctive features. It is important however, to recognise that any attempt to examine impact of maternity care on the long term health of women must, especially if one is interested in the impact of technology within this field, assess the nature of control itself directly. One cannot assume that variations in the level of technology form an adequate substitute or "measure" of control. The relative quality of the content of the service which is provided could vary, for example, between two hospitals which operate at the same level of technological sophistication (and therefore provide the same degree of technological choice to the service user), which illustrates the need to conceptualise and examine the concept of control in a valid, reflexive manner.

At a more general explanatory level, Oakley and Rajan's research (1990)[3] on the relationship between reproductive technology and women's health seems to operate with the implicit assumption that "technology" determines individual / organisational behaviour. Whilst such an assumption once characterised the work of a certain school of organisational theorists - most obviously embodied in the early work of Woodward (1965) - such ideas were rapidly superseded by the adoption of more general explanatory concepts. Woodward herself prefigured this change in her later work, where she began to see organisational behaviour as the product of "control systems", rather than organisational "technologies". A later generation of writers then contributed to the further development of this concept by underlining the culturally defined nature of such control systems (Pettigrew 1973) which came to be seen as embodying relationships of "authority and power" (Clegg 1989).

Since there is a need to examine both the notion and impact of "control" within maternity care on women's health, this also suggests the need for a type of research design which is uncommon within this of enquiry. To begin with, if one assumes that modern maternity care may have negative consequences for the health of women users, one needs to design research which allows one to examine the

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[3]Interestingly, Oakley and Rajan (1990) in a study of the relationship between maternity care technology and "postnatal unhappiness" found only limited evidence of an empirical connection between the two and note that their findings "confirm those of some previous studies and contradict others" emphasising the diversity of research data within on this particular issue.

question of possible relationships between levels of control (as perceived by the individual service user) and health outcome. This has two particular implications.

Firstly, it is the quality (or otherwise) of the care provided up to and during the process of birth which appears to be regarded as crucial in terms of the impact of modern maternity care on women. Hence, the consequences of such care will manifest themselves during the postnatal period. However, as was pointed out earlier, research into the postnatal phase of maternity care has been limited in terms of both its scope and the length of time involved. Any attempt to examine the potential long-term "effects" of service provision on the process of becoming a mother must extend analysis over a much longer period of time. Secondly, since research is required which will provide a systematic assessment of the effects of both antenatal and intrapartum care over an extended postnatal period, neither a small scale ethnographic study nor a simple "one-off" survey design would be sufficient to meet the design requirements of such a project.

**Summary: Discourses on Maternity care - A Dialogue of the Deaf ?**

The current chapter has examined the relationship between what, until the late 80's, were the two principal discourses or worldviews about the nature of maternity care. It is clear that these two discourses represent viewpoints or forms of thinking which are, in several key respects, diametrically opposed to each other, as the work by Comaroff (1977) and Oakley and Graham (1981) vividly illustrates. Whilst the 'discourse of risk' operates with a very narrow conception of the aims of maternity care policy and an equally narrow clinical view of the nature and causes of health and illness, the 'discourse of control' invokes a radically different set of considerations. At the most fundamental level, the 'discourse of control' is concerned with health conceived in a broader sense, encompassing the idea that health is something 'positive', which can therefore be 'improved', rather than something which is defined in wholly negative terms as the absence of disease. Applied to maternity care, this more positive view of health sees pregnancy and birth as essentially 'natural' conditions and processes, which maternity care should be 'assisting'. As a product of its highly interventionist character, modern maternity care is typically described by feminist critics in particular, as 'alienating", although as has been noted, the precise meaning of this term is rarely defined or explained. This is especially important, since the meaning conventionally ascribed to the concept of alienation from a Marxist tradition of thought, suggests that any attempt to incorporate this concept into a specifically

feminist-inspired critique of some aspect of modern life faces a number of potentially difficult philosophical/methodological problems. The 'materialist' notion of alienation, as used in a reductionist manner in Marxist theory, appears to at odds, for example, with feminism's conventional view of sexuality and gender relations as a product of social forces which are culturally and historically relative.

In any event, at an empirical level, feminist research into maternity care seems, in practice, to be referring to more general notions of 'stress', as distinct from the concept of 'alienation' defined more precisely by Marxist theoreticians as the denial, by social forces, of one's innate 'species being'. Since, feminist research typically seems to suggest that women experience stress as a consequence of their involvement (as users) in modern maternity care, one can also infer, on psychosomatic grounds, that this may be harmful for their health. The key issue is not necessarily therefore, whether women are 'alienated' from modern maternity care (whatever that means) in some general 'ideological' sense. Rather, the more precise issue which research needs to focus on is whether the increasing lack of control which is apparently associated with the process of becoming a mother within a modern system of maternity care, does indeed have harmful, stress-related, consequences for the health of the individual. In other words, contra to the claims of the 'discourse of risk', research needs to consider the potentially even more iconoclastic question, *'Does modern maternity care make women ill ?'*

Utilising sociology's rapidly developing understanding of the relationship between health, illness and society (especially the virtual explosion, during the 80's and 90's, of research examining the impact of the structure of social inequality on health) Chapter 5 has presented an analysis of the organisation of modern maternity care as a socially constructed phenomenon. Derivatively, such forms of organisation can be regarded as embodying various forms of social inequality, based on relationships of power and authority, not only between user and provider but also between different groups of provider (for example obstetricians and midwives).

A central issue facing the sociology of modern maternity care is to examine the manner in which the social organisation of such care impacts on the health of its women users. A key assumption here is that the very system of social control embedded in the organisation of modern maternity care is likely to be 'unhealthy'. In a literal sense, the feeling that one is not in control of one's own body is likely to be a source of stress to the individual, especially when that person is in the

process of simultaneously undergoing a major physical and social change in their life - viz. having a child *and* becoming a mother.

The largely feminist-inspired literature which uncovered women's concerns about this issue of control within maternity care, typically refers to two particular aspects of such control, which the thesis terms the 'context' and the 'content' of control. Any empirical study of the above question must therefore examine this issue of control in terms of both dimensions. Most importantly, as feminist research also suggests, any study of the nature of social control in the area of maternity care must consider the potential influence of patriarchy as a dimension of such control, in respect of either its 'context' or its 'content'. The suggestion by some feminist critics that the organisation of modern maternity care is structured along patriarchal lines clearly raises fundamental questions about the prospects for changing the organisation and delivery of such a form of health care.

To summarise therefore, as far as the 'discourse of risk' is concerned, the modern system of maternity care has been created (theoretically at least) to reduce 'risk', but specifically the risk of death. The 'discourse of control', by contrast, implicitly raises the question of whether this very same system of care may have harmful consequences for the health of its women clients or service users, by *increasing* the risk of a morbid if not a fatal outcome. Most importantly, the potential that modern maternity care may have for increasing the risk of infant or maternal morbidity is not necessarily simply a product of increased clinical intervention. Rather, the increased risk of morbidity may well be a consequence of the social organisation of modern maternity care itself, a form of organisation which has been crucially influenced by the power of patriarchy.

In order to subject such a hypothetical assumption to empirical scrutiny, it is necessary of course, inter alia, to examine morbidity for a reasonably lengthy period after birth. Consequently, it is essential to design a research project which examines the impact of antenatal and intrapartum care on the health of women users over an extensive part of the post-natal stage of the individual's maternity 'career'.

Before moving on to consider how one might design a research project capable of addressing these key issues about the nature of modern maternity care in general, it is clear, however, that at least within the UK, any research into such issues must also consider an important additional matter.

Despite the fact that research in the field of maternity care in the 1970's and 1980's emphasised the need for a systematic study of the degree to which modern maternity care may have a harmful influence on women's health, this alternative "discourse of control" had little effect on either the medical profession or the government of the day. Indeed, during the 1970's and much of the 1980's, the "discourse of risk" continued to dominate thinking within the NHS, and therefore acted to 'define' the central terms of the debate on policy and practice.

The late 1980's however, witnessed what appears to be a remarkable sea-change in the 'official' outlook of central government on this issue, a change which gives an added impetus to the questions which the discourse of control raises. This new impetus, provided by both the emergence of a new view of the relationship between NHS service providers and service users in general and also by a major review of maternity care services, appears to embrace many of the criticisms of past decades. For a number of general political reasons therefore, during the 1980's the UK witnessed the emergence of what is arguably an entirely new "discourse" on maternity care - a discussion of the nature of which forms the principal interest of the next Chapter.

# Chapter Six

## A Discourse of Choice? - The N.H.S. Reforms.

### Introduction

As the preceding discussion has indicated, the development of UK maternity care policy and practice has been marked by a tension or conflict between two discourses or worldviews; the discourses of 'risk' and 'control'. The former of these has been the dominant force driving the development of maternity care for most of the latter half of the twentieth century. Recently however, this situation has begun to change. During the 1980's, a new political outlook emerged from central government which appeared to challenge some of the most basic assumptions about the principles upon which health care in general had hitherto been organised. This change in outlook subsequently led to what is now conventionally described as the 'reform' of the NHS in the late 1980's, early 1990's. This process of reform has wide ranging implications for the organisation and delivery of the whole spectrum of NHS services, although some areas of service provision have been more directly affected than others. In the early 1990's, as part of what appears to be the on-going development of this general programme of reform, maternity care services were themselves subject to an additional specialist process of review.

The current chapter presents an analysis of these recent policy initiatives. The thesis argues that both the general reform process and the specific attempts to reform the organisation and delivery of maternity services represent a new form of 'discourse' about both health and maternity care - a 'discourse of choice'. This discourse has what might be described as an important 'subtext', a 'discourse of cost', which some critics of the NHS reforms (C.f. eg Paton 1992) regard as representing the true 'text' or philosophy behind the reforms. Irrespective of whether one views the reforms as representing a 'discourse of choice' or a 'discourse of cost' (and arguably the reforms reflect both concerns) in the case of maternity care services the emphasis on "choice" figures strongly in recent official policy statements.

The central, distinctive purpose of the present chapter is to outline and examine the nature of this 'discourse of choice', and in particular its' relationship to the discourses of 'risk' and 'control'. Such an analysis, and the implications for maternity care research have not to date, been undertaken elsewhere.

**The Winterton Report and Maternity Care - A Policy Volte Face ?**

In April 1991, a committee of enquiry was established by central government, under the chairmanship of Nicholas Winterton, MP, with the brief to review maternity care policy and practice. The initial report of this inquiry (subsequently referred to as the Winterton Report) was published in February 1992, and one of its' earliest comments signals a fundamental change in the attitude of government towards maternity care policy and provision. In a statement which appears to register an ominous note of warning to the medical profession in general, Winterton observed that the committee was not only stimulated into conducting its enquiry into maternity care by its awareness of the fact that a major review of policy and practice in this field had not been carried out for some time, but also as a consequence of

> " ...hearing many voices saying that all is not well with the maternity services and that women have needs which are not being met."
>
> (Winterton, 1992, page v )

Significantly, the committee pointed out that whilst such discontent may seem paradoxical in view of the continued fall in perinatal mortality and the very low levels of maternal mortality, one had to bear in mind that

> "...although avoidance of death is very important, it cannot be the only determinant of satisfactory maternity services."
>
> (Winterton, 1992, page v)

In a number of additional comments which signal the main thrust of the committee's thinking on maternity care, the report also observes:

> "Becoming a mother is not an illness. It is not an abnormality. It is a normal process which occurs during the lives of the majority of women and can indeed be seen as a manifestation of health." (Ditto above)

-and -

> "For all these reasons we made normal birth of healthy babies to healthy women the starting point and focus of our inquiry." (Ditto above)

The publication of the Winterton report represents a landmark in the development of maternity care in the UK for a number of reasons. To begin with, Winterton questions the validity of a number of key assumptions which have underpinned the development of maternity care policy and practice during the post-war era - viz. the

'discourse of risk' or the 'medical' frame of reference. Furthermore, it does so by principally relying on the opinions and work of those who developed a critique of the discourse of risk (i.e.; Tew, Campbell and Macfarlane) and those who promulgated a 'discourse of control.'. Although Winterton produces its own specific ideas about how maternity care may be developed, the close links between Winterton's critique of the problems surrounding maternity care and the critique provided by the 'discourse of control' are striking. A clear sign of this is provided by the way in which the work and names of many of the principal contributors to the discourse of control appear as major 'authoritative' sources for Winterton's own critique of the discourse of risk.

Tew's critique of the statistical validity of the argument that hospital confinements reduce infant/maternal mortality (a critique which challenged the scientific validity of one of the principle assumptions of the discourse of risk) is quoted at length, and given a critical but sympathetic airing during the report's rather trenchant re-appraisal of the scientific validity (or otherwise) of the 'medical' model of maternity care. (Chapter One of Winterton, 'Policy Developments in the Maternity Services'.) Similarly, in a later section of the report which deals with the central issue of how women define their own maternity care needs, (Chapter Two, 'What Women Want'), the opinions of such major critics of the medical model as Kitzinger (amongst others) are cited approvingly.

**Winterton's Critique of Maternity Care in the UK**

The extent to which Winterton was influenced by the discourse of control is perhaps most clearly demonstrated by its identification of the three common elements which typify the needs of women users of maternity care services. In the introduction to chapter two of the report, "What Women Want", Winterton notes:

> "...Our key measure of the success of the maternity services in terms of their effectiveness and appropriateness will ... be the response from those who use them. The way women respond to and express satisfaction with their experience of using maternity services is largely dependent on the extent to which they consider their needs are met sufficiently during the process. We therefore sought to establish what desires women express in terms of a responsive and appropriate maternity service and to compare this with what they actually experience." (Winterton, 1992, page xii )

Utilising evidence and opinions from a variety of organisations representing women users, from researchers, as well as interviewing women who were current

users of the service individually, Winterton identified three common themes. relating to women's needs.

(1) The need for continuity of care
(2) The desire for choice of care and place of delivery
(3) The right for women to be able to exercise control over their own bodies at all stages of pregnancy and birth.

The need for greater continuity of care was seen to have arisen due to the development of modern maternity care as a service within which intrapartum care (care during the process of birth) was provided almost exclusively within a hospital environment. Hospitals are themselves typically large, impersonal 'bureaucracies' and within hospitals, maternity care is often provided within large units which are themselves similarly impersonal and, as one mother commented to the committee, "... even hostile to mothers." (sic).

At both the antenatal and intrapartum stages of care, the report notes that women are commonly dealt with by a variety of different service providers (obstetricians, GPs, community and hospital midwives), and in a variety of settings. It was argued that this makes it difficult for women to establish a close 'working-relationship', so to speak, with those professionals caring for them. This in turn caused many women to feel that the whole process was very impersonal and it also created problems with communication, in that women reported being given different, and sometimes contradictory, advice. With the decline in the proportion of home births and the development of a policy which aimed to maximise the number of births occuring in hospitals, Winterton concludes that women's ability to make choices regarding the nature of care on offer and the degree of control which they had over their own bodies, was also affected.

As we have seen in Chapter 3 of the thesis, the needs identified by Winterton relate closely to the principal criticisms of maternity care highlighted by exponents of the 'discourse of control', even though the language and terms used are sometimes slightly different.

Thus the emphasis which the 'discourse of control' places on the impersonality of modern maternity care, the lack of information and choice available and the discontinuous nature of the care provided, (all of which underlie women's sense of a lack of control over the process as a whole), mirror almost exactly the concerns

of Winterton. This is further underlined by one of Winterton's major concluding comments. Amongst a welter of both wide-ranging and specific recommendations, one of its principal conclusions underlines the nature of the 'new' attitude to maternity care which the report as a whole embodies:

> "... the policy of encouraging all women to give birth in hospitals cannot be justified on the grounds of safety [and] ... it is no longer acceptable that the pattern of maternity care provision should be driven by presumptions about the applicability of a medical model of care based on unproven assumptions."
>
> (Winterton, 1992, page xciv )

**Strange Bedfellows?**

Not only, does the Winterton Report constitute a remarkable somersault in the official policy pronouncements on maternity care, but the wider political context which gave rise to Winterton is itself remarkable and worthy of comment since this raises several crucial and interesting questions about the possible motives behind this radical reappraisal of maternity care policy.

Without wishing to oversimplify the range of political and intellectual perspectives held by the large number of commentators who might be thought to constitute the 'discourse of control', one might reasonably characterise such critics as reflecting, in the main, what might be called a centrist or left-of-centre outlook, heavily influenced by feminist ideas. By contrast, the Winterton Report was commissioned by a government, who, in its attitude to the NHS in particular, was heavily influenced in its attitudes to health policy by 'libertarian' arguments which were decidedly 'right' of the political centre (Ham 1992, Paton 1992, Klein 1989).

A situation in which a libertarian right-wing government gives credence to and in fact actively supports the views and aspirations of a largely centrist / left of centre caucus of predominantly feminist opponents clearly demands comment and further analysis. How and why a radical re-appraisal of a major area of State policy could have been brought into existence by such seemingly strange bedfellows are questions which need to be answered, even though these questions are largely outside the remit of the current thesis. Certainly the first question - *how* did such an apparent 'alliance' of opinion emerge? - constitutes an important topic of research for analysts concerned with the process of policy formation. As far as the second question is concerned (*why* did such an apparent alliance of opinion emerge

between two very different political constituencies), it is clear that Winterton was not produced within a policy vacuum, at least as far as central government's attitude towards health policy is concerned.

In 1991 central government implemented a fundamental re-organisation of the NHS as a whole (set out in Working for Patients 1989). Rather surprisingly, Winterton hardly makes mention of these reforms, despite their undoubted relevance to its own deliberations. It is only in a later publication by an Expert Group on Maternity Care set up by Winterton, "Changing Childbirth" (1993), that explicit reference is made to the more general reforms of the NHS as a whole, which had in fact already been introduced (in April 1991) by the time that the Winterton report was published (1992). What is more, although "Changing Childbirth" couches its own recommendations in the 'language' of the wider NHS reforms, there is no discussion of any possible links between the rationale which lies behind the reform of the NHS in general and the deliberations of "Changing Childbirth" / Winterton on Maternity Care.

**Winterton and the NHS Reforms**

Despite the fact that neither Winterton nor Changing Childbirth discuss the possibility that the fundamental shift in maternity care policy and the equally iconoclastic 'reform' of the NHS as a whole may be related in some way, it is not especially difficult to discern, at an ideological level, what one could describe as an 'elective affinity' of ideas (using Weber's term) between the discourse of control, Winterton's critique of maternity care and the rationale behind the wider NHS reforms.

It seems plausible to argue that one of the reasons why a libertarian government might wish to champion policy changes which emanate largely from a pressure group with whom it would normally be at odds politically, is because it perceives a political advantage in so doing. This is especially true if it feels able to incorporate the concerns of such a group within the government's own policy objectives - however precarious or slight any attempt to create the impression of a degree of ideological congruence between such strange bedfellows might appear. As Habermas, amongst others, has pointed out, a desire to legitimise the actions of the state is a central feature of the modern political process (Habermas 1987).

Certainly, if one briefly examines the historical circumstances which led up to the development and implementation of the NHS reforms in general, together with the formal attempts to provide a political justification for this reform process, it is clear that the libertarian ideology which seems to underpin the reforms relies, amongst other things, on the notion of 'choice' as one of its principal sources of legitimation. As has been illustrated, the notion of 'choice' constitutes an important element of the debate which the thesis refers to as the 'discourse of control'. In other words, one of the reasons why a government might be prepared to initiate an iconoclastic change in maternity care policy, which requires it to embrace an outlook emanating from a group with which it appears to be at odds politically, is because such a change can be presented as ideologically consistent with its overall approach to policy-making.

The wider 'reforms' of the NHS, for instance, have their roots in an attempt, by central government, to change the nature of the relationship between civil society and the state (Harrison et al 1992). Within the area of health policy, the development of a modern system of "high-tech" health care provision, financed through taxation, has proved to be increasingly expensive, especially since the creation of the NHS (House of Commons Social Services Committee 1989, Ham 1992). The election, in the late 1970's of a new libertarian-inclined administration under Margaret Thatcher, subsequently led to a period of 'reform' of publicly-financed institutions, commonly referred to as a strategy of 'privatisation'. This major shift in government policy and practice was driven by a desire to cut direct taxation by cutting public spending and by an ideological conviction that 'privately' owned organisations, operating within a free market, provided goods and services which reflected more closely the needs and preferences of the 'consumer'.

In certain cases, organisations which had previously been publicly owned were simply transferred to the 'private' sector of the economy, normally through the creation of a 'rights issue' in which the notional wealth of the particular organisation was translated into 'shares', which were then made freely available on the stock market. In the case of the NHS however, although some thought does seem to have been given to its re-creation as a 'privately' financed system of health care, funded from personal insurance, this was rejected on the grounds that such a change would not necessarily improve its efficiency and effectiveness and might even be politically unpopular and expensive to implement (Paton 1992). Consequently, as an alternative to pursuing a policy of wholesale 'privatisation' of

the NHS, central government decided instead to concentrate on a radical overhaul of the structure and management of such services.

A central feature of this re-organisation or reform of the structure and management of the NHS involved the creation of a division between 'purchasers' of services and 'providers' of services (Working for Patients 1989). Prior to the reforms, District Health Authorities (the main 'operational' unit within the management structure of the NHS) had both managerial and financial control of health care services for a particular area. The NHS reforms redefined the role of the District Health Authority as the principal 'purchaser' of services for its local population. Hospitals and other providers of NHS services which had previously been financed and (directly) managed by District Health Authorities could bid to become autonomous units (Trusts). In order to secure an income, Trusts had to 'bid' to provide services from their DHA (and could offer their services to other DHAs). Hence a situation might be created where a number of Trusts are in direct 'competition' with other provider units for funding. The DHAs responsibility was to purchase those services which it deemed appropriate for the local population, with regard to both the cost and quality of such services, the conditions of which would be specified in the form of a 'contract' between purchaser and would-be provider.

Outside of the hospital sector, within the area of primary health care, GPs were encourage to register as 'Fundholders' (GPFH). This would allow them to hold 'budgets' on behalf of their patients (the money for which would be "top-sliced" from the DHA budget for the resident population) which GPFHs could then use to purchase services for their patients from other service providers, in a manner not unlike the role played by the DHAs at a much broader level. The scope of the GP Fundholders budget was initially restricted, however, to the purchase of a limited range of 'elective' (planned) hospital services (Working for Patients 1989).

Central government argued that this new reformed system would introduce 'quasi-market' mechanisms into the process of the funding and development of the NHS, with the effect that only those services which best suited the needs of patients would receive funding. In the jargon of the day, under the reformed NHS, "money would follow patients rather than patients follow money". It became the responsibility of the DHA to ensure that service providers would only receive funding if their services satisfied patient needs and DHAs were therefore required to establish mechanisms for determining such needs - mechanisms which had to involve patient opinion in the policy process (Local Voices 1992).

As one might expect, such sweeping changes became the focus of considerable criticism. One of the key criticisms of the reforms suggests that 'market forces' (in the shape of 'market mechanisms') cannot be applied to the delivery of health care since patients cannot be regarded as 'consumers' in the classical economic sense of the term. Furthermore, it has been argued by some critics (Stacey 1976, Neuberger 1990) that patients are not in a position to make informed choices about different forms of treatment or care available, since they lack both the appropriate level of 'knowledge' which would allow them to make such a choice (due to the complex technical nature of modern medicine), and are not the actual purchasers of their care.

Paton, in a detailed analysis of recent health policy initiatives, points out that the distinction between so-called 'public' and 'private' systems of health care can, in any event, be more appropriately understood in terms of a 'continuum'. In reality, Paton argues, a myriad of different health care systems exist, which involve a combination of various funding mechanisms together with a range of organisational forms, as a means by which health care can be 'purchased'. He also argues that *none* of the various systems of health care currently available approximate to the model of 'perfect competition', associated with the notion of a 'free market', since, in reality -

> " ... health care markets show impediments to effective competition both on the provision (supply) side and on the purchasing (demand) side, more than typical markets in goods and services."
>
> (Paton, 1992, page 57 )

He further points out that 'official' UK government thinking about the rationale behind the NHS reforms has itself been characterised by what he terms a degree of 'schizophrenia'. Policy discussions within government about the reforms have veered back and forth between official 'statements' - which appear to suggest that the reforms are designed to bring about a radical re-organisation of the NHS in the direction of a largely 'privately' financed system of health care - and other statements or declarations which see the reforms as simply a mechanism for increasing the efficiency of what is essentially a 'public' system of health care. Interestingly, when pressed in public to clarify the rationale or thinking behind the NHS reforms, a senior government minister observed that "of course health care cannot really be described as a market-place" (Kenneth Clarke 1996).

It is evident, therefore, that the rationale or justification for the reforms often appears to be the subject of some confusion, especially in terms of the question of whether the reforms may be regarded as an attempt to 'privatise' (however defined) the NHS or not. Nonetheless, official statements and pronouncements about the reforms, including the main government policy documents, consistently refer to specific central concerns or purposes, such as the concern about both service *efficiency* (typically defined in terms of service costs) and service *effectiveness* (even though 'official' discussions about the relative significance of these more enduring themes or concerns have not necessarily been consistent).

It is clear that the issue or theme of service efficiency, defined in terms of the need to contain (or even reduce) the burgeoning costs of the NHS, has been a topic of concern to governments of all political persuasions since the inception of the NHS (Ham 1992). This issue was certainly at the forefront of government discussions in the 1980's about the best way to 'improve' the NHS. This concern was signalled, in part, by the appointment of the Managing Director of Sainsburys, Roy Griffiths who was asked to assess how contemporary commercial thinking and practices might be applied to the field of health care. In the early 1980's, many DHAs were regularly over-budget and therefore over-spent. The Griffiths Report of 1983 called for better management of the NHS and introduced the concept of 'general managers' into the NHS, responsible for introducing 'resource management' procedures, annual monitoring reviews of operational costs and 'performance indicators'. Although welcomed by the government as a useful mechanism for changing the 'organisational culture' of the NHS in order to make it more cost-conscious, the fact that wholesale reform of the structure and management of the NHS was proposed by the government (in its 1989 White Paper, "Working For Patients") barely six years later indicates that the government had continuing concerns about the increasing cost of the NHS, notwithstanding the changes introduced as a consequence of Griffiths' Inquiry.

As indicated earlier, during the mid 1980's when the proposed structural reforms of the NHS were being debated, some consideration was given to the 'privatisation' of the NHS, and proposals for a private-insurance based system were mooted. The rationale behind this proposal involved a concern to reduce public expenditure coupled with the ideological belief that a 'private' system of health care would be more responsive to patient needs/preferences. Although the option of 'privatising' the NHS in this way was ultimately rejected for a variety of reasons, (some narrowly 'technical', others more overtly 'political'), it is evident from the very title

of the 1989 White Paper, "Working For Patients", that a concern to justify such changes at an ideological level, invoking the notion of patients interests, rights and choices, was placed alongside arguments about service cost containment and service 'efficiency'. Indeed, shortly after the introduction of the 1991 NHS Act which lead to the implementation of the structural divisions between service providers and service purchasers, several additional innovations were introduced which underlined the perceived ideological importance of 'empowering' patients. At a general level, the publication of "The Patient's Charter" in 1991 signalled an 'official' concern with the notion of patient's rights. Similarly, the publication of "Listening to Local Voices" (1992) indicated the importance of responding to the needs, views and preferences of local opinion, by obtaining feedback from service users as a formal aspect of the monitoring of service delivery -

> ...health authorities have a dual responsibility to ensure that the voice of local people is heard. Firstly they need to encourage local people to be involved in the purchasing process. Secondly, they need to ensure that providers take account of local views in their activities
>
> (Department of Health, 1992, p6)

Whilst the recent reforms of the NHS were clearly influenced by a concern with cost containment (or even cost reduction), alongside this 'discourse of cost' the reforms also embody, at an ideological level at least, what might be called a 'discourse of choice' - however central (or otherwise) this concern might to the overall political purpose or intention which lies behind the reforms.

In some respects, one might see these two broad, but not necessarily coherently integrated discourses or emphases as indicative of the 'schizophrenia' in government thinking about the general aims of health care planning, to which Paton refers. Equally, however, one could also regard these discourses of choice and cost as standing in a politically symbiotic relationship to each other. Thus an 'official' emphasis on the importance of enhancing patients' rights and patient choice within the NHS may be intended to make the government's concern to contain (or reduce) service costs appear less threatening to its electorate. Certainly, official references to the need for greater service 'efficiency' are frequently linked with statements about a concomitant concern with the need for greater service 'effectiveness', as though these two things are empirically correlated in a 'positive' direction.

Seen against this background, the sea-change in maternity care policy in the early 1990's - and particularly the prominence accorded to the 'voices' of those seemingly strange bedfellows from the 'discourse of control' - appears to be less inexplicable. At an ideological level - and irrespective of whether one regards this as contrived or genuine in intent - a central dimension of the NHS reforms in general (the 'discourse of choice') resonates to some degree with Winterton's critique of maternity care, which itself draws heavily upon key features of the feminist-inspired 'discourse of control'. The latter, for example, emphasises the importance of empowering women by giving them greater control over their bodies via the process of greater choice of maternity care. At an ideological level at least, the architects of the NHS reforms would appear, on the surface, to be sympathetic to such arguments.

Of course, the different strands of thinking within contemporary feminist thought are likely to stand in varying relationships to the discourse of 'choice', due to the assumptions which the different schools of feminist thought make about the cause of gender inequalities. Marxists feminists, for example, are arguably more likely to reject any attempt to enhance women's control over modern maternity care through the use of market forces. More radically inclined feminists on the other hand, may well reject any attempt to modify the workings of an organisation which they may see as ineluctably patriarchal.

Equally, one must also consider the extent to which, as Paton suggests, the principle motive behind the reforms is one of cost containment /reduction, or a genuine attempt to enhance so called 'consumer / 'user' choice. Even if the latter is deemed to be the case, the extent to which greater choice is possible is an open question , given that healthcare cannot easily be equated to that of a commercial commodity, the relative value of which cannot easily be judged by a potential consumer.

Whether or not one regards Winterton (and Changing Childbirth) as responding to the 'discourse of control', due to its resonance with central governments apparent concern to establish greater 'choice' and enhance patient power by its 'reform' of the NHS is a matter of judgement. However, both the wider NHS reforms together with the specific recommendations of Winterton and Changing Childbirth raise an important set of additional questions or issues for any sociological study of modern maternity care in the UK in the mid to late 1990's, aside from those posed by the 'discourse of control'.

**Maternity Care in the UK in the 1990's**

At the most general level, since both the wider reforms of the NHS together with the more specific recommendations of Winterton and Changing Childbirth each carry with them the intention to bring about 'improvements' in service provision, through the increased responsiveness of the NHS to patient's'/'consumers' needs. one would expect to see some indication of change following the introduction of such reforms. In the area of maternity care, one would expect to see evidence that women feel that they have more choice (and therefore more control) over the form of care available to them in the 'reformed', more 'market' or 'consumer' oriented NHS, compared with the 'old' style NHS, characterised by a more centralised system of control, with a 'top-down' set of planning procedures dominated by professional (specifically clinical) interests.

If so, such changes would have a sociological significance beyond merely the sociology of maternity care itself. At the most general level, changes of this kind would raise a number of fundamental questions about such macro-level debates about, to use Williamson's terminology, the value of 'markets' compared with 'hierarchies' (for example Professional or Non-Professional 'Bureaucracies') as a basis for empowering the individual (Williamson 1975;1980, Williamson and Ouchi 1983). Certainly, the general ideological assumptions which underpin the drive to "privatise" (wholly or in parts) the Welfare State as a whole as well as the NHS in particular is reflective of a wider debate between "left" and "right" about freedom and equity in modern societies.

Again at a macro-level, but this time specifically within the field of the Sociology of Health and Illness, one might wish to consider whether, and in what way, such changes might constitute evidence that institutional change within medicine can reverse the process of 'medicalisation'. Although the development of the 'discourse of control' is closely associated with the development of feminist thinking in general, this critique of the emergence of modern maternity care can also be regarded as part of the debate about the 'medicalisation' thesis of modern life. Hence if the NHS reforms as a whole and/or the specific policy re-orientation within the field of maternity care in particular appear to shift the locus of control from the service provider to the service user, should one regard this as evidence that the process of 'medicalisation' has been reversed by the introduction of 'market forces' into the production of health care services, and if so why ?

As far as the sociology of maternity care itself is concerned, one needs to examine the nature of modern maternity care within a 'reformed' NHS in order to assess whether there is any evidence that such reforms have had an impact on specific aspects of women's experiences of such care. Is there any evidence that the reforms have enhanced the degree of control which women have been able to exercise over all aspects of service provision in this field, or does the impact of the reforms appear to be more partial or localised in character - and if so, in what areas and for what reasons has change occurred.?

In order to address such a possible range of questions or issues about the nature of maternity care in the UK in the 1990's, in addition to those which were raised in the earlier appraisal of the 'discourse of control' (in chapters three and four), it is necessary to develop a more specific set of research questions, together with an appropriate research design and methodology, issues which will be addressed in the next chapter.

Before leaving this review of the discourses of risk, control and choice however, there is one final theme which demands separate attention, namely the question of the gendered nature of modern maternity 'care'.

**Gender, Maternity Care Policy and Practice and the NHS Reforms.**

The concept of gender is increasingly recognised as central to most, if not all, areas of sociological enquiry, and is of paramount importance to the study of maternity care, since research in this field has played a major role in the very development of feminist thought itself - not least because control over the process of reproduction has been seen as central to the issue of women's liberation within a 'patriarchal' society for many feminists (Oakley 1984,1985; Rothman 1989, Spallone 1989, Richardson and Robinson 1993, Hanmer 1993)

Furthermore, in both a literal as well as an ideological sense, the organisation of modern maternity care is itself gendered. With the increasing ideological dominance of the 'discourse of risk' and the consequent decline of domiciliary midwifery, control of the delivery and development of maternity care has become largely concentrated in the hands of a predominantly male-dominated clinical specialism, obstetrics, in an area of service provision where the clientele is exclusively female. The emergence of obstetrics as the clinical specialism which is primarily 'responsible' for maternity care also led to a gendered shift in the relative

power of specialist service provider groups. The emerging clinical imperialism of obstetrics, increasingly relegated midwifery to a subordinate or supporting role (Garcia et al 1990; Bent 1982), and midwifery is, of course, a largely female-dominated specialism.

The general critique of modern maternity care in the UK by Winterton and the specific proposals for change contained within Changing Childbirth, underline the importance of creating a more 'woman-centred' service. One of the central recommendations revolves around the idea that the organisation and delivery of maternity services needs to be what one might term 're-gendered'. This attempt to re-gender the service focuses on changing the relationship, not only between service providers and service users, but also between the different service provider groups. Particular attention has been paid to enhancing the role of the midwife vis-a-vis that of the obstetrician, so that the former comes to play a much greater role (and operate more autonomously) in relation to the latter. In many respects, although Winterton and Changing Childbirth stop short of calling for a wholesale re-instatement of domiciliary midwifery (accompanying what amounts to the rejection of the 'discourse of risk' as a guiding principle for service development), the desire to create what is in essence a more midwifery-led service is unmistakable - a move which itself has highlighted divisions within the midwifery profession between those who wish for a more autonomous role and those who are content with the current organisation of maternity care services..

Whilst it is clearly the intention to give midwifery a greater role in the development of modern maternity care than has hitherto been the case, neither Winterton nor Changing Childbirth provide what one might call a 'rationale' for this particular aspect of their critique of maternity care. Consequently, the potential implications of this new approach for the organisation of maternity care are less clear. As the overall intention is to make maternity care more 'woman centred', the implicit assumption seems to be that this objective is more likely to be achieved if the majority of maternity care is provided *by* women *for* women. Changing Childbirth sees this enhancement of the role of midwifery occurring principally in the area of 'normal' or 'low risk' pregnancies, where the more specialised skills and knowledge of the obstetrician are, it is argued, rarely needed. Whether this carries with it the implication that midwifery might also increasingly relocate its activities from the hospital to the home environment is less clear, though Changing Childbirth and Winterton both recommend that women should be encouraged to choose, where possible, the location of the birth. How obstetric practice might

respond or accommodate to such changes in practice is an issue which is rather glossed over, although the obstetric profession hass, like midwifery, witnessed widescale internal debates as to the future direction of maternity care (Chamberlian and Patel 1994).

Hence it is rather less than obvious how the new policy initiatives will in fact work in practice. As far as Changing Childbirth's specific ten 'indicators of success' are concerned, these more concrete proposals represent a rather limited step in the direction of empowering midwives, involving as they do a series of relatively minor changes in the detail of maternity care practice, alongside a few relatively gnomic comments about the need to enhance the role of midwifery viz;

Table 6:1 Changing Childbirth's 10 Indicators of Success

1. All women should be entitled to carry their own notes.
2. Every woman should know one midwife who ensures continuity of her midwifery care - the named midwife.
3. At least 30% of women should have the midwife as the lead professional.
4. Every woman should know the lead professional who has a key role in the planning and provision of her care.
5. At least 75% of women should know the person who cares for them during their delivery.
6. Midwives should have direct access to some beds in all maternity units.
7. At least 30% of women delivered in a maternity unit should be admitted under the management of the midwife.
8. The total number of antenatal visits for women with uncomplicated pregnancies should be reviewed in the light of the available evidence and the RCOG guidelines.
9. All front line ambulances should have a paramedic able to support the midwife who needs to transfer a woman to hospital in an emergency.
10. All women should have access to information about the services available in their locality.

The above 'indicators of success' clearly signal the desire to make the midwife a more important figure within maternity care. However, the specific means by which this should be achieved either involve a highly specific change in practice

(for example, that women should 'carry' their own clinical record from one consultation to another) or a general change at the level of care management, typically couched in rather vague terms and often accompanied by an unexplained 'qualification'. Changing Childbirth recommends, for example, that at least 30% of women delivered in a maternity unit should be admitted under the management of a midwife or that at least 75% of women should "know" their principal carer during delivery, although a definition of "know" is not provided.

The question which is not addressed in any detail concerns the impact on service delivery of the current, more restricted role of the midwife. In order to bring about effective change which not only empowers the midwife but in so doing also empowers her client, one needs to be aware of both the restrictions and the potential for change within current practice. Both Winterton and Changing Childbirth seem to imply that midwives rather than obstetricians are the group of service providers who communicate most effectively with the exclusively female clientele of maternity care services, but the scope for the further development of the midwife's role is seen to be restricted by the inordinate amount of influence and control exercised by obstetrics over the organisation of maternity care practice.

If so, then it is important to clarify the question whether the problem of communication between service provider and service user lies principally, or even exclusively, with the gender of the service provider *per se*, or whether the gender differentiation of specific types of service provider role (viz Obstetrician, Hospital Midwife) is also problematic.

If one assumes that the gender of the service provider is one of the principal issues affecting women's experience of maternity care then, presumably, one could argue that maternity care should be 're-gendered' across all the various service provider roles. In which case, one might expect Winterton to argue for the transformation of Obstetrics into a largely female-dominated profession, aside, for instance, from any recommendations which it might wish to make about the role of modern midwifery.

If, on the other hand, as Winterton and Changing Childbirth seem to suggest, the problem with maternity care is seen to revolve around the need to enhance the role played by a specific (even though largely female) group of service providers, the precise reasons as to how and why it is necessary to enhance or alter such a role needs to be spelt out. Is it the case, for example, that such a process of

enhancement is aimed at improving service delivery by widening the role of the hospital midwife so that she will have greater technical control over maternity care, or is the aim of such change simply to enhance the role of the midwife so that she becomes the principal source of information and advice for women service users about the management of maternity care?.

On a related issue, if it is the intention simply to make the midwife the official 'face' of maternity care, filtering clients' concerns to other service provider groups (for example obstetricians), is this simply because female service providers are seen to be better communicators because they are thought to be more caring and sensitive to women's needs and anxieties. Should one also assume that a more woman-centred service will require the role of midwifery to be enhanced so that midwives become technically more competent?. The degree of emphasis which is placed on the enhancement of the midwife's role in 'caring' for her clients compared with the degree of enhancement of the midwife's 'technical' or clinical skills represents an important area of potential ambiguity as far as the specific proposals for the reform of maternity care is concerned.

As has already been indicated in the review of the 'discourse of control', women service users complain about both the 'context' and 'content' of modern maternity care. Any attempt to 'empower' service users needs to consider such questions as to whether both dimensions are equally important (to women) or whether one dimension is more important than the other, and if so which one?.

The potentially wider sociological and theoretical significance of this aspect of the attempt to reform maternity care is underlined by the work of Davies (1995, 1996). Davies suggests that while the concept of gender has been largely defined as an 'attribute' (either behaviourally or attitudinally) of the individual, gender is increasingly being defined as a feature of a person's 'relation' to another. This is often signalled by a shift from the use of the term 'gender' as a noun to its' use as a verb. This relational view of gender underlines the fact that gender is situated within a specific set of historical and cultural circumstances, and involves binary-divisions of 'power', structured around gender-relations. Crucially, it also encourages us to examine the gendered nature of organisations and institutions as a product of both their formation and reproduction. Accordingly, the gendering of organisational life is to be regarded as an active process, during which gender relations may not only be sustained but also challenged and transformed. Applied to the discrete area of the sociology of health care professions, Davies argues that

this approach gives us a clearer view of the organisational dynamics of such institutions as the NHS, where gendered conflict between different specialist groups of service providers is prominent (Davies 1995,1996).

In contrast to the approach of feminist theorists of the professions like Witz (1992) who regard medicine as patriarchal by virtue of its attempt to restrict the entry of women into its area of competence, Davies argues medicine has established its patriarchal power (especially vis-a-vis the largely female 'semi-profession' (Etzioni 1969) of nursing) by deriving its notion of professionalism from essentially 'masculine' notions of 'work' and 'competence'. Professional competence, involves the possession of highly specialised knowledge by autonomous individuals who gain power/authority by controlling others through the application of this knowledge under specified circumstances. This is typically expressed in a very impersonal manner, as a means of establishing the impartiality (and therefore the universality) of the professional's judgement. Davies points out that these dimensions of 'professionalism' reflect key masculine characteristics such as the value which men place on individual autonomy, emotional control, and a desire for dominance in personal relationships. Since health care services must also display key 'feminine' characteristics, such as emotional disclosure and an interest in and concern for the "affective" element of human relationships, these characteristics are emphasised as valuable features of the different roles of other largely female groups of service providers (for example nurses) but in a manner which 'defines' them as beyond the concerns of 'professional' medicine.

Any attempt to enhance the organisational role of female service providers as a means of empowering female service users needs therefore either to widen the concept of professionalism in order to encompass the hitherto neglected 'feminine' features of service organisation and delivery, and/or to empower women service providers by, inter alia, enhancing the more 'conventional' professional education of such 'semi-professional' groups whilst, at the same time recognising their existing skills and qualities previously deemed not worthy of being designated as 'professional' in character.

Whether Winterton and Changing Childbirth provide the framework which would allow such changes to take place within the field of midwifery is open to question, precisely because they fail to address such issues, let alone attempt to provide solutions to them.

Finally, the extent to which the recommendations of both Winterton and Changing Childbirth imply the re-emergence of domiciliary midwifery, is an important separate topic, since this might well imply a greater degree of involvement in maternity care for non-professionals - viz family and friends. Some feminist critics (eg Kitzinger 1994) appear to view the latter as a key objective for the development of a more woman-centred form of maternity care - and in Kitzinger's case one which will, by its very character, enhance the general influence of women in this crucial area of role change, viz the process of becoming a mother. Other feminist critics of modern maternity care seem to operate with an implicitly more modest set of aims or objectives. This is reflected perhaps most clearly by Oakley's research on maternity care for high-risk mothers, where the intention appears to be more one of the reform of modern maternity care from within what is still a largely hospital-based system of service provision. (Oakley 1992)

**Summary**

In concluding this discussion of contemporary policy initiatives in the field of maternity care, it is clear that the aims and objectives of the specific policy changes advocated by Winterton and Changing Childbirth - as part of the wider 'discourse of choice' associated with the NHS reforms as a whole - are in need of greater clarification. However, the very fact that maternity care in the UK is now subject to the influence of these reforms adds an important dimension for any contemporary sociological examination of women's experiences of such care. The research issues which the discourses of 'risk', 'control', and 'choice' conjointly raise constitute the principal thrust of Chapter 7.

# Chapter Seven

## Researching the Process of Becoming A Mother in the 'New' NHS -

### Introduction

As the discussion in Section 1 has illustrated, the development of maternity care services in modern societies (and especially in the UK) can be characterised as a 'contested terrain', marked by a number of conflicts and tensions. These points of conflict are reflective, moreover, of problems with social order and social change in the wider society. On the one hand, the development of modern maternity care within the UK (and also, to some extent, in other western societies) can be regarded as a product of a 'discourse of risk', promulgated largely by the medical profession. Feminist critics in particular argue, however, that this has led to the 'medicalisation' of reproduction and especially childbirth as a result of the operation of 'patriarchal' forces within medicine. Women service users are reported as experiencing modern maternity care as 'controlling', de-humanising and therefore stressful. The emergence, in the late 80's, of a programme of reform of health care in the UK, inspired by libertarian ideas, aimed to provide service users with greater 'choice' of care. Since libertarianism and feminism are conventionally regarded as ideologies which generally stand in opposition to each other in several senses (notwithstanding the range of feminist thought), one might question whether the aims of the latter can be achieved (in part at least) by a programme of reform designed by the former?.

On the basis of the analysis presented section 1, the present chapter aims both to identify several key questions which contemporary research into the organisation of maternity care within the 'new' 'reformed' NHS needs to address, and to outline the type of research design and research methods required to examine such questions. In so doing, an outline description is also provided of the design of a study of a group of women's experiences of becoming a mother in the 'new' NHS. An analysis of the results from this study form the principal focus of attention for the remaining chapters of Section 2.

## The Development of Modern Maternity Care in the UK: Reprise.

As chapters two, three, four and five indicate, the development of modern maternity care in the UK raises a number of important (but neglected) sociological questions about both professional attitudes to health care and the gendered nature of organisational life within the health service. For example, whilst the discourse of control has highlighted the fact that women typically experience modern 'high-tech', hospital-focused, maternity care as 'alienating', the specific meaning and wider sociological ramifications attached to this term are unclear. As the discussion in chapter 5 indicates, this is especially problematic given the widespread use of this concept in other contexts, most notably in Marxist theory. It is important therefore to examine the issue of women's dissatisfaction with modern maternity care in more detail.

From the large body of research which has developed around this issue, one can distinguish at least two distinctive dimensions of modern maternity care, one of which has been described in earlier chapters as the 'context' within which such care is provided, the other as the 'content' of the care itself. It is necessary therefore to consider whether both of these two particular dimensions of maternity care are equally important potential sources of women's negative experiences of such care. Although most studies in the field refer to each of these two dimensions of the social organisation of modern maternity services, their relative influence on women's experiences of such care has never been systematically assessed. Research in the field suggests that the organisational 'context' within which modern maternity care is delivered is typically 'bureaucratic', in the sense that it is organised in a very rigid, rule-governed way. This in turn apparently creates feelings of impersonality as well as a form of organisation which is inflexible in its response to variations in individual circumstances - even at such a mundane or practical level, for instance, as the opening times of clinics (Oakley 1979, 1980; Kitzinger 1979; Macintyre 1981; Hall et al 1985).

Criticisms of what might be described as the 'formal organisation' of maternity care could be addressed without implying the need for change in the 'content' or technical nature of modern maternity care - although Davies suggests that such a bureaucratic, impersonal approach to the organisation and delivery of health

reflects an essentially 'masculine' outlook (Davies 1995,1996). In the case of modern maternity care, this 'masculine', impersonal outlook is reflected, one might argue, in the 'discourse of risk' which has shaped the very content or nature of such care. Criticisms about the 'content' of modern maternity care clearly refer to matters which lie at what might be called the technical 'core' of the practice itself and difficulties in this aspect of the organisation of maternity care raise fundamental questions about the very nature of such care. Critics stress that women often feel that they exercise little control over modern maternity services, due to the lack of information provided to users about the technical nature of such care (Cartwright 1979, Arms 1975, Macintyre 1981, Fearn et al 1982, Shapiro 1983, Kirkham 1983, Jacoby 1988, Davis Floyd 1992). Whether this kind of problem can be resolved by the development of an even more complex, high-tech, system of maternity care, using more sophisticated forms of communication based on information technology, for example, is a moot point. The development of increasingly sophisticated clinical techniques, as a consequence of a continuing process of technological innovation, may continue to outstrip any technologically-inspired improvements in the communication of information between service provider and service user.

The 'content' of maternity care therefore raises a fundamental sociological question - to what extent does the 'technology' of modern maternity care influence the form of *control* exercised by service providers over service users? In other words, what scope is there for changing the system of patient or client control independently of the technology of care?. Should one assume that the two are inextricably linked ? Would a change in approach or technique 'inevitably' lead in a 'deterministic' fashion, to a change in the way in which women service users are 'controlled' by service providers.

Interestingly, feminist critics of modern maternity care suggest quite different 'political' or organisational 'solutions' to such problems, depending, at least tacitly, on the nature of their own 'feminism'. Such feminist critiques can be broadly described as either relatively 'reformist' or 'radical' in outlook. Each carries quite different implications for future health policy and practice and each reflects broad divisions within feminist theory itself. In the case of Oakley (1992), for example, her most recent research suggests the possibility of changing modern maternity care by *modifying* certain aspects of current practice, at least in the case

of women who have a high risk of a preterm or premature delivery and/or a low birthweight baby. Hence her work suggests that a certain degree of improvement is possible, from 'within' the current, still largely hospital-oriented system of care. The work of Kitzinger, by contrast, (1994) suggests the need for a more fundamental re-structuring of such care, reflecting, implicitly, a different type of feminist agenda This includes the relocation of the place of birth from the hospital to the home for the majority rather than the few - a change which, according to Kitzinger, ought to be accompanied by a major shift in the relative importance attached to midwifery compared with obstetrics. This would in turn lead to a radical change in the very nature of the kind of maternity service on offer to the large majority of women users, creating a situation in which a service with an exclusively female clientele would then be almost exclusively staffed by women.

The importance of examining the way in which the different dimensions of the social organisation of maternity care affects women's experience of such care, is also underlined by the recent work of Davies (1996). In her study of both the 'professional' and 'bureaucratic' aspects of modern health care in general, Davies criticises earlier feminist analysis (e.g. Witz 1992,1994) which sees modern medical practice as 'excluding' female service providers (such as nurses) from the 'profession' of medicine. It is more appropriate, Davies argues, to regard such professional practice as dependent upon a symbiotic division of labour between aspects of service provision which are regarded as largely 'technical' (and predominantly delivered by male service providers, viz. doctors) and those which are regarded as 'caring' (and predominantly delivered by female service providers, viz. nurses). Although Davies believes that 'patriarchy' plays a significant role in the structuring of health care services, unlike earlier feminist analysis she suggests that this occurs more by a process of the subordinate incorporation of 'nursing' by 'medicine' rather by the professional 'exclusion' of the former by the latter.

Applied to the area of maternity care, Davies' work suggests that not only is maternity care gendered in a *literal* sense, around the division between obstetrics and midwifery, but it is also gendered in terms of the different *aspects* of care which each professional group is likely to provide to the service user. In other words, Davies' work indicates that midwifes and obstetricians are likely to play distinctive roles in relation to the two major dimensions of maternity care. Thus the 'contextual' aspect of care, which concerns the non-technical or 'personal'

aspects of care is likely to be regarded as 'female' whilst the more technical aspects of care, associated with its 'content' are more likely to be regarded as 'male'. For female and male read, broadly speaking, midwife and obstetrician respectively.

In addition to the above issues, one also needs to examine the question of whether the term 'alienation' has any explanatory value as a basis for understanding women's experiences of maternity care. Within class analysis, for example, this concept has a long and controversial history. (Swingewood 1984). As we have seen in chapters four and five, the ambiguous (and typically untheorized) use of this term within the field of maternity care also raises a number of theoretical and methodological issues which need to be addressed. At one level, the term often appears to be used in what might be described as an 'ideological' sense, in that 'alienation' appears to imply simply a lack or loss of 'control'. This loss of control is typically judged to be the product of the 'patriarchal' dominance of women within the sphere of maternity care. Consequently, the 'recovery' of such control loss could, theoretically, be seen as a largely 'political' issue, involving perhaps the 're-gendering' of maternity care (the transfer of control from men to women) for essentially 'ideological' reasons.

However, a large number of studies which refer to the 'alienating' effect of modern maternity care also refer to the 'stress' which such a system of 'care' often induces in its clientele. Hence it is clear that to continue to use the term 'alienation' in the relatively limited sense indicated would be to ignore a potentially even more important issue - namely, the question of whether modern maternity care, by inducing stress in its clientele, carries with it any health costs for women? In other words, is modern maternity care *'bad'* for women's health.?

The development of modern maternity care was originally predicated, of course, on the assumption or belief that such care was 'good' for women's health, since it reduced the risk of infant and maternal mortality - the central claim of the discourse of risk. If, however, the organisation and delivery of such care carries with it certain health costs in areas *other* than those of infant and maternal mortality (for example, in the areas of infant and maternal *morbidity*) then this is an important matter, since it raises fundamental questions about the very legitimacy of such a system of 'care', quite apart from the criticisms which have

been levelled at the scientific validity of the discourse of risk itself. In other words, modern maternity care may not only have been ineffectual in *reducing* the risk of infant and maternal mortality, but it may also have lead to an *increased* risk of infant and maternal morbidity. This is not due simply to the increased physical risks associated with the 'interventionist' character of modern maternity care. Rather, it more a question about the potentially negative effects on a woman's health of a perceived loss of personal *control* over her body during a period when she is experiencing a major physical and social change in her life.

Drawing upon conceptual insights from medical sociology in general, one needs to consider therefore whether the very process of what could be described as the 'medicalisation' of maternity care has had negative, though presumably unintended, health consequences. Certainly, the work of Marmott et al (1978) emphasises the importance of the individual's sense of social control over both work and non-work areas of life as a key determinant of health, a claim which reflects a growing awareness amongst researchers of the importance of psychosomatic processes as a major determinant of health and illness in general. Within the specific sphere of maternity care, Enkin et al's (1996) major review of research and "best practice" in this field highlights the fact that both sociological and psychological studies have provided 'strong evidence' of a link between 'social conditions' and post-partum depression. They also point out that researchers have sought and failed to account for post-partum depression in either biochemical or psychoanalytical terms over a long period of time, using a reductionist form of explanation which attempts to locate the problem 'within' the individual. (Enkin et al 1996, page 346).

Surprisingly, however, no researchers appear to have *directly* examined the more plausible possibility that the social organisation of maternity care itself (through its denial of 'control' to its clientele) may have long-term negative health consequences, even though one finds constant allusions to this possibility in much of the research in the field.

Any attempt to assess both the causes and likely consequences of women's dissatisfaction with modern maternity care in the UK must also, of course, take account of the potential impact on maternity care of both the recent general 'reforms' of the NHS, and the specific policy objectives of Winterton and

Changing Childbirth. The general aims of this process of reform, but especially the emphasis (sincere or otherwise) on 'consumer' or client choice, appear to broadly coincide with the aims of the 'discourse of control'. The implications of all of this for maternity care appear to involve:

(i) the possible reversal of the process of 'medicalisation' through an increased emphasis on the importance of lay preferences within the general reform process, and,
(ii) a re-gendering of maternity care services through, amongst other things, an increased emphasis on the importance of the role of midwifery as distinct from obstetricians.

**Research Questions**

As the preceding summary illustrates, the analysis presented in Section 1 raises, several major issues about the nature of maternity care. These in turn point to a number of more specific questions which any further research in the field needs to address.

At the most general level, the central question raised by the NHS reforms is whether such reforms have indeed 'worked' *in their own terms* by providing service users with greater choice. In the case of maternity care in particular, this question might be re-defined as a concern over whether such services are now more responsive to women's needs ?

This general question is, however, more complex than it might appear, since one also needs to consider how one might assess whether any such improvement in choice has occurred. The specific policy initiatives within the field of maternity care policy (viz. Winterton and Changing Childbirth) stress the need for such services to be more woman-centred, reflecting women's needs as defined by women. In which case, the question of choice has to be assessed, in the first instance, from the perspective and opinions of the service *user*. One cannot rely on the opinions of service providers as to whether improved choice had been delivered or not, in this situation.

Equally, if the libertarian-inspired programme of health care reforms has been successful in improving the degree of choice available to women users, has such an improvement occurred in all facets of the service? One needs to determine whether, from the services users perspective, improvements have occurred *across all 'sectors' of maternity care*, (i.e. care provided in hospitals and that which is provided in the community, in GP-based practices for instance). It is conceivable that the reform process may have brought change, but not necessarily across all 'sectors' of the service, since maternity care services are provided by different occupational groups, with different degrees of power and influences and therefore different interests (Zander and Chamberlain 1984; Chamberlain and Patel 1994).

One might, for example, wish to determine whether GP's who have deliberately 'opted-in' to the reform process and who now hold their own 'budgets' are more sensitive to women's needs compared within those GP's who have remained directly funded under a limited version of the 'old', pre-reformed system. Whilst maternity care services were not initially included as part of the specific reforms associated with GP fundholding[1], one might nonetheless consider whether the general 'ethos' of those GP practices which have volunteered to take part in the reform process at an early stage show greater awareness of all their clients needs, compared with non-fundholding practices - irrespective of whether the particular aspect of the care being budgeted for is itself covered by the new 'reforms'.

Secondly, one must also consider whether improvements have occurred *at all 'stages' of the maternity care cycle.* That is to say, at the antenatal, intrapartum and postnatal stages. Has any improvement in the degree of choice (and therefore control) afforded to services users occurred in a uniform manner at all stages of service delivery ? Have improvements taken place, for instance, at one (or two) of these stages rather than at all three ?

A third important dimension to consider is whether improvement has occurred *for each of the two major dimensions or aspects of such care* (i.e.; in respect of both the 'context' and the 'content' of maternity care). Are service users equally satisfied with their perceived degree of choice over both the context and the content of maternity services, or do they regard themselves as having more choice

[1] Shortly after the research on which this thesis is based was completed, proposals were introduced to include maternity care services as part of the GP fundholders scheme

over one aspect of care?. The NHS reforms may indeed have improved the choices available to 'consumers' or users, but the impact of the reforms may be partial rather than uniform, occurring more, for example, in the 'context' than in the 'content' of such care. It is interesting in this respect to recall the earlier reference to the work of Davies, which suggests that the context and the content of health care are, at the moment at least, broadly speaking the province of different occupational specialisms, doctors and nurses, reflecting the profoundly gendered nature of the organisation of medicine.

Apart from such questions about the extent of the changes which may or may not have occurred as a consequence of the NHS reforms, one also needs to consider the possible implications of any such changes in terms of their potential impact on the service user. Where women perceive their needs as being met, for example, does this have any consequences for their health?. Is the user's subjective perception of her own health related in any way, for instance, to her perception of the degree of choice and therefore control she has over the type of care available? A great deal of the research which has been described under the rubric of the 'discourse of control' implies that this may well be the case.

In addition to questions about the extent of any changes wrought by the reform process and the consequences of such changes at the level of the individual, one would also wish to determine how change has occurred. If the NHS reforms have indeed delivered a more woman-centred services, which is more in tune with the needs of its female clientele, has this occurred as a consequence of the 're-gendering' of service delivery.? For example, if women users in the 'new' 'reformed' NHS report themselves to be more satisfied with the choice of maternity care available to them, does this reflect the greater involvement of the midwife in the delivery of such care, compared, for instance, with that of the obstetrician?. Indeed, could the reform process have led to an improvement in service delivery, without the need for such role changes?

In order to examine the above research questions which form the principal focus of this thesis, it is necessary to design a project and select methods of enquiry which are appropriate to this task.

## Research Design and Research Methods

In 1992, a research project was developed in order to examine the key issues outlined above at an empirical level, with support from the NHS. Any study of the problems of modern maternity care has to examine the impact of service provision throughout the three distinctively different phases of what the thesis terms the maternity care 'cycle,' viz. the antenatal, intrapartum and postnatal phases. An important initial consideration in developing an appropriate research design therefore, was to create a project which would allow one to study women service users experience of maternity care at each of the different stages of this 'cycle'.

In contra-distinction to much (though by no means all) of the research which has been conducted in this field, where the use of qualitative methods predominate, it was decided at the outset that it was more appropriate to employ a structured rather than a qualitative approach to the study of the research questions listed above. This decision was influenced by a number of considerations related to matters concerned with both the focus and design of the research. To begin with, research into modern maternity care needs to examine both the 'context' and 'content' of such care in terms of users perceptions of the degree of influence they have in each of this two major dimensions over time. This requires one to carry out comparative analysis, which needs to be conducted in a systematic manner. Previous research has highlighted the importance of these two aspects of maternity care, but little attention has been paid to assessing the relative importance of the one compared with the other. The present study is also concerned with the issue of examining the possible 'health costs' of modern maternity care, especially within the changed circumstances created by the NHS 'reforms'. This in itself raises several complex questions of a theoretical and methodological nature, including issues of both method and design.

To begin with, if one makes the theoretical assumption that modern maternity care adversely affects the health of some or all women, then at a methodological level, one has to consider how such an effect or influence may be demonstrated. If one assumes that modern maternity care induces 'stress' in its clientele, which then manifests itself in the poor health of such clients and if one also assumes, as researchers suggest, that such stress occurs due to:-

(i) a lack of appropriate care during the period before birth (viz. antenatally) and

(ii) a lack of a sense of personal control during the actual process of birth itself (the intra-partum phase)

then the principal negative effects of such a system of 'care' would presumably become most evident during the *post-natal* stage.

However, as the thesis has pointed out, the long term post-natal phase of women's maternity career has largely been neglected by researchers, or simply defined for research purposes in terms of only a few days or weeks following birth. Winterton, for example, acknowledges that research into the post-natal phase of maternity care has been woefully neglected, which in part no doubt reflects the influence of the 'medical' frame of reference, and its associated discourse of risk, with its principal concern for the 'successful' delivery of 'live' births. It is clear, however, that any research project which wishes to study the impact of modern maternity care on its users must consider the potential consequences of such a system of care for a longer period of time during the post-natal period of the maternity care 'cycle'. Hence, not only should research in this field examine the impact of maternity care at all three stages of the cycle, but research at the post-natal phase in particular needs to extend over a much longer time frame than existing studies have conventionally been prepared to consider.

The discourse of risk discourages researchers from examining the post-natal phase of maternity care in any depth. The principal criterion of success or failure, as far as this 'discourse' is concerned, is that of infant *mortality*, the risk of which is greatest within the first four weeks following birth, whereas a concern with infant and maternal *morbidity* alters the comparative significance attached to the post-natal period. Ill-health, as a consequence of pregnancy and birth, may occur in many different forms, from the acute to the chronic and from the physical to the mental, and extend over many different periods of time, which only a lengthy examination of the postnatal phase in particular is likely to reveal.

To examine possible ill-health during an extended postnatal period, whilst at the same time attempting to compare the effects of the different 'dimensions' of maternity care on the health of women users (viz. the 'context' and the 'content'

of such care) suggests the need for structured methods of social enquiry, as well as the need for a longitudinal type of research design.

The development of a research project which is simultaneously structured in its method and longitudinal in design is comparatively rare within sociology, and there are few precedents or models to use as a guide - although after the present study commenced, two large scale studies examining maternity care provision have been undertaken, one in Wales, the other in Scotland (Dawson 1995, Turnbull et al 1996). Aside from the more 'positivistic' options of a 'full experimental design' in the shape of a randomised control trial -which was not appropriate for reasons which will become evident shortly - the one type of design which suggested itself was that of a panel study. Although panel studies are comparatively rare within sociology, the ESRC recently decided to support a large scale panel study as a key tool for the study of social change in Britain, acknowledging its value as a tool for sociological research (Rose 1993).

To date, the type of methods used to research the views and experiences of women users of maternity services have tended to fall into two broad categories:

(i) ethnographic studies, designed to obtain in depth, qualitative information about the process of becoming a mother (Oakley 1979,1980, Kitzinger, 1979, 1981, Kitzinger and Davis 1979, Graham and McKee 1980, Ong 1983, Rich 1977, Ehrenreich and English 1973, Corea 1979,1980,1985),

(ii) one-off surveys', often quantitative in design, typically designed to provide evaluative data on specific topics or for local health authorities / other organisations (Jacoby 1988, Porter and Macintyre 1984, Harrogate Community Heath Council 1979, Hillan 1992; Marteau et al 1988; Mid-Staffordshire DHA 1992, Newcastle CHC 1994, NCT 1996) .

Whilst such studies have produced a plethora of information about the process of becoming a mother, by their very nature research based upon such methods does not permit systematic comparisons of women's experiences of the provision of maternity care services, both (a) between different areas of service provision at the same point in time (for example, between hospital ante-natal care and community-

based ante-natal care) and (b) between ante-natal, intra-partum and post-natal care.

Hence, although qualitative studies of women's experience of maternity care have undoubtedly acted as a vehicle for the emergence of a major critique of such care, qualitative methodology does not appear to have developed to a stage where it is possible to utilise such an approach in order to create the type of structured or systematic type of research design outlined above - a problem which Burgess (1984), a leading advocate of qualitative methods, admits is the chief achilles heel of qualitative methods.

One of the key requirements of a more structured research design is that the methods incorporated within it will allow reliable systematic comparisons to be made within different social or organisational settings (for example, between hospital- based care and community-based care) both over time and at the same point in time - a methodological requirement which qualitative methods cannot currently meet. In contrast to qualitative approaches to the study of maternity care, survey methods allow for the systematic evaluation of the attitudes and experiences of a large and, if necessary, diverse group of respondents. "One off" cross-sectional surveys only provide what might be called a "snapshot" of a single cohort at a specific time and do not facilitate analysis of the measurement of change *over time* within a specific group or cohort.

By contrast, a panel study which uses structured methods as the basis for data collection is capable of providing the researcher with the ability to carry out systematic comparisons, both synchronically (at the same point in time) and diachronically (over time).

Although the use of panel studies is common place in the field of market research, and despite the fact that this method is utilised within the field of sociological research on a national basis (as illustrated by the establishment of the British Household Panel Study at Essex University) to date there is no known record of such a quantitative research design having been used by medical sociologists. (Weinberg 1992, Centre for Health Economics York 1992, Cartwright, 1986, Jones et al 1987, Dixon et al 1989).

As Rose, a member of the ESRC's Research Centre on Micro-Social Change, has pointed out, panel surveys begin in exactly the same way as any other survey. To start with, a sample of individuals is selected which is representative of the population from which it is drawn (in the same manner as for conventional 'one-off' surveys) and the panel members are then either interviewed or sent questionnaires enquiring into various aspects of their lives. Unlike conventional, 'one-off' cross-sectional social surveys, panel studies aim to *re-interview* as many of the sample again as is possible and are therefore longitudinal in character, tracking sample members across time (Rose 1993). Consequently, such studies aim in other words "...to study *social change*, as this is observed among the sample..."(Rose 1993, p2)

Panel studies are therefore concerned to trace the changing attitudes and beliefs of individuals over time and are well suited to the study of 'dynamic' or changeable behaviour generally. It is possible, of course, to conduct longitudinal research which appears to achieve the same outcome by comparing change over time for similar (but not identical) individuals, drawn from several cross sectional surveys conducted at different points in time, with newly selected samples at each temporal point. However, the similarity in outcome is more apparent than real and as Rose (1993, p6) observes "...cross sectional data produces little to help the analyst of social change".

Furthermore, the use of a panel study allows for the control of previously unobserved determinants of behaviour on which no data has been collected by other means (due to the inherent methodological difficulties in doing so); for example, the response of a specific individual with certain definable characteristics to a specific kind of change over time. In addition, one should also mention that panel data allows for the control of period, age and cohort specific elements. As described by Rose (1993) period effects are those which vary across a time period but are the same for all respondents at any particular time. Hence within the area of maternity care, such 'period effects' would equate to women's experiences at the antenatal, intrapartum and postnatal phases of their maternity career. Age specific elements are those which vary across age but are the same for all respondents of a particular age while cohort effects are those effects which are the same for individuals born in a specific time period but which otherwise differ

across respondents, such as the socio-demographic differences which might exist within a random sample of women users of maternity care services.

Finally and most importantly, panel studies facilitate the study of "...transitions between [different periods or] states in a way not possible where only cross-sectional data are available (Rose 1993, p3). Specifically, panel data permits the analysis or effect of what might be called "gross" or macro change (such as, for example, the changing status of hospitals under the NHS 'Reform' process) at the micro or individual level. As Rose (1993, p4) comments, such a methodology allows "deeper analysis of the incidence of conditions and events...over time...In turn such events can be examined for dynamic links with other factors" (Kemp 1991, Magnusson and Bergman, 1990; Social Science Research Council 1975). For the purpose of illustration, the comparative use of a panel study design and a 'repeated' cross-sectional survey design for the study of maternity 'careers' can be represented as follows -

Table 7:1 Types of Survey Design

| **Type of Survey Design** | **Unit / Cohort** | **Time Period** | | |
|---|---|---|---|---|
| | | Pregnancy | Birth | Postnatal |
| Cohort Sample (Panel) | A | A | A | A |
| Repeated Cross-Sectional Sample | X, Y, Z | X | Y | Z |

In summary therefore, the principal benefits of establishing a panel study for the study of women's experiences of the maternity care services are that such a method is:

(i) longitudinal,
(ii) compares the same individual over time,
(iii) tracks aspects of social change and
(iv) facilitates the study of change and causal inference

On a critical note, however, as Weinberg (1992, p38) points out, " ... two potential drawbacks have been suggested as occurring with panel research. The first is *attrition* [whereby] a panel will become depleted with time and attrition is likely to lead to a loss of representativeness of the panel if there is selective depletion. The second potential drawback concerns the possible *conditioning* of the panel - repeated contact may cause the members of the panel to change their attitudes and/or their answers. The members will no longer behave in a representative manner but as panel members..." - although Weinberg goes on to say that at the time of writing he could find "no published data to support either claim" (op cit.).

Indeed, as the Report from the 1985 British Social Attitudes Panel Survey points out, when considering the question of selective depletion, the various reasons for attrition cancelled each other out - i.e.; despite depletion, the sample remained representative over time. Consequently,

> "although attrition does occur within panels, selective depletion appears to be relatively uncommon. Furthermore, there appears to be little evidence of any notable differences between the attitudes and characteristics of individuals who agree to take part in panel studies, compared with those who agree to participate in single cohort studies. (C.f., e.g. the "Atwood" Panel, established in 1948 to study consumer purchases, and Bowles 1984). On the question of "conditioning", [the possibility that respondents attitudes change over time as a result of their involvement in such a longitudinal study] the British Social Attitudes study also noted that in comparing panel study data with cross sectional data from one-off surveys about related issues, the "attitudinal and behavioural profile of each group [survey and panel] were broadly similar'". (Weinberg 1992, p13).

Interestingly, one of the principal findings of the British Social Attitudes Survey was that, in some instances the response from panel members to certain attitudinal questions did indeed differ from those given by respondents in cross-sectional surveys. However, the report argues that panel members were more likely to give an *honest* response to particular questions. For instance, panel members were more likely to admit that they would pay 'cash' for work done, even though they knew that this was a tax 'fiddle', compared with respondents to cross-sectional surveys (from similar backgrounds to the panellists) who were more likely to

deny engaging in such 'deviant' behaviour, despite the fact that evidence from other sources indicates that behaviour of this kind is in fact commonplace.

Although nobody has sought to explain why panel members are likely to be more 'honest' about aspects of their attitudes and behaviour which might be judged as either 'deviant', radical or critical 'in public', it is possible that this type of research design may engender a greater degree of openness between researcher and research subject. The researcher's repeated involvement with or apparent 'concern' for the attitudes and experiences of the respondent (at whatever remove) over a period of time may generate a sense of 'commitment' and therefore 'trust' on the part of the respondent, compared with the latters more cautious response to a one-off enquiry, whether qualitative or structured in character,. Hence whilst panel studies have been seen to suffer from several methodological weaknesses, many of these supposed weaknesses often appear to be more imaginary than real, and the application of this methodology to the study of modern maternity care has a number of undoubted advantages, particularly when one wishes to examine the potential health 'costs' of such care, over time, at an individual level.

One key problem which has to be addressed, nonetheless, is that of attrition over time. However, in the area of maternity care research, even if, as in the case of the current project, one extends the post-natal stage of a panel study beyond the conventional few days or weeks covered by the majority of extant research in this field (say to a year or more) the period of time needed for the completion of the entire maternity care 'cycle' (from ante-natal to post-natal) is still relatively short, reducing further the problem of attrition.

A study by Brooks (1993) of the transmission of health information to women adds an interesting footnote to the above discussion, since it raises important questions about the comparative usefulness and validity of structured methods in general, issues which are especially relevant to any evaluation of panel studies which often employ structured methods of enquiry. Brooks critically evaluates the common belief that the use of structured methods of social enquiry produces more 'distorted' data, compared with less structured or qualitative methods, either as a result of the 'bias' introduced by the researcher in the formulation of questions (a criticism conventionally levelled at questionnaire surveys) or as a consequence of the reluctance of the respondent to disclose their 'true' feelings and opinions to an

'impersonal' form of enquiry. Using both a questionnaire survey and an interview survey to elicit 'sensitive' information about personal health matters from a sample of women, Brooks study achieved a substantially higher response rate from the former (68%) compared with the latter (26%), contrary to conventional expectations. Whilst Brooks does not provide any explanation of this outcome, it is clear that one should avoid simplistic assumptions about the relative reliability and validity of qualitative and quantitative methods.

In designing a panel study to examine women's experiences of maternity care which requires respondents to participate over a period of time and during which the respondent's will experience a highly personal and sensitive "life event", both the initial response rate and maintenance of the panel are matters of considerable importance for the success of the study as a whole. Consequently, in the light of Brooks's findings in particular, it was decided that questionnaires would be used as the principal research tool in the current study. It is perhaps also worth mentioning at this juncture that the frequently encountered assumption that questionnaire surveys *always* suffer from low response rates ignores the improvements achieved in this field, by recent advances in the development and application of various 'follow-up' techniques (Brooks 1993).

Quite apart from the specific methodological issues surrounding the use of panel studies, it is important to acknowledge the fact that the application of this type of research design to the area of maternity care, in combination with the use of highly structured methods of social enquiry as questionnaires, raises a number of important questions concerning the use of women as research subjects and the development of a feminist research methodology.

The emergence of feminism has been associated with a critique of sociological analysis at both a theoretical and a methodological level. As far as debates about feminist methodology are concerned, these have increasingly been couched at a very complex epistemological level, centering around the dichotomy between modernity and post-modernity, an intellectual focus of concern which is beyond the scope of this thesis. At the level of research methods, on the other hand, a detailed and well-established body of feminist literature exists which addresses much more concrete or practical questions, and which tends to concentrate on more direct matters, such as which methods are most appropriate for projects

involving women as research subjects. This is a matter of some importance, especially when one is proposing to use a *quantitative* or structured methodology to examine the experiences and views of a group of female service users in an area of research where the *qualitative* approach predominates. (Oakley 1979, 1980, Kitzinger 1979 in Kitzinger and Davis 1979, Graham and McKee 1980).

As Hockey (1993) notes, for example, much of the feminist-inspired health research undertaken during the 1970's and 1980's sought to redefine women's health by listening to women's accounts of their own experiences and to facilitate women in taking control of their own health. Nowhere is this more evident than in the area of research into women's experiences of and attitudes towards maternity care, a point underlined by Nicolson, who opines -

> "... feminist writers have paid sustained attention to the experience of being a woman and the ways in which motherhood impinges upon women's lives. Accounts of childbirth prior to the work of...Oakley tended to be either "medical" or to extol the joys and fulfilment of childbirth for the truly "feminine woman. Feminist writers, whilst not denying the pleasures of childbirth and the various experiences of childbirth explored the medicalisation of birth and the ways in which women's control...had been eroded (Oakley 1980, Nicolson 1988)". (Nicolson, in Richardson and Robinson (eds.) 1993, p220)

In general, the underlying rationale for the use of an ethnographic or qualitative approach to research by feminist writers is that such an approach allows the 'voice' of the research subject to be heard. Through the use and development of such qualitative methods, it is assumed that women will provide their own "authentic" account of personal events and experiences (and their reactions to such) rather than have any restrictions or limitations imposed on their thinking by the researcher, through his or her employment of more 'structured' or pre-determined forms of enquiry (Daly et al 1992; Smith 1975; Oakley 1980;1985; Roberts 1981, Jacoby and Cartwright 1990.). Furthermore, in examining women's experiences, beliefs and opinions, some feminist writers assert that it is necessary for women to be researched *by* women in order to avoid the bias associated with the very gendered nature of the "conflict" between men and women, itself a reflection of the unequal patriarchal structure of the wider society of which we are all a part.

Consequently, the questions raised by feminism's critique of 'conventional' (non-feminist) research methods go beyond the simple assertion that qualitative methods produce a more valid or unbiased account of the world as seen from the point of view the 'actor' or research subject, compared with quantitative methods which privilege the judgements of the 'observer' or researcher. Such a critique also requires us to consider the possibility that structured or quantitative methods may 'privilege' the influence of the observer or researcher within a society whose patriarchal structure has profound implications for the setting of the very agenda about what ought to be researched in the first place. Feminism's critique of 'method' raises not only the question of 'bias', but also the issue of 'power', as expressed, for example, in the possible exploitation of the research 'subject' by the researcher. Accordingly, given "...the centrality of personal experience within the women's movement" (Stacey in Richardson 1993, p50) it is no surprise to find that much of the feminist-inspired research on maternity care which emerged during the 1970's and 1980's was based on experiential, qualitative accounts of women's own experiences of pregnancy and childbirth.

Whilst such research undoubtedly highlighted a number of salient problems about the nature of "modern" maternity care services (criticisms which made an important impact on Winterton's critique of maternity care), any attempt to adopt ethnographic or qualitative methods as the key research instrument for the present project would have posed a number of major problems, many of which are themselves reflective of wider difficulties associated with the use of qualitative methodology in general.

As Burgess (1994) (himself an ethnographer) contends, ethnographic studies, whether in the form of one-off interviews or a series of observations, are typically what might be called "time specific", leaving aside any consideration of the relatively infrequently used method of 'participant observation'. Even though a researcher might devote a large proportion of time to a particular research 'subject' at any particular *point* in time, it is nonetheless extremely difficult to develop a comprehensive picture or description of the attitudes, behaviours and practices of that particular respondent, let alone provide an account of the underlying 'causes' of these, especially with reference to any changes in their character or pattern over time.

Generally speaking, due to the predominant use of qualitative methods in this area, a large proportion of the research into women's responses to maternity care involves a retrospective element which, as Rose (1993, p6) notes, also affects the calibre or validity of such information since "...the quality of retrospective data decreases the further back one wishes to take respondents [and]...moreover, the ways in which individuals' interpret their behaviour [are] coloured by subsequent events". As Rose also notes, whenever researchers engage in either participant observation or more specifically relatively unstructured in-depth interviews, *social interaction* occurs between the researcher and the subject which effects the responses of both the interviewer and interviewee to their common situation. Therefore, in examining the responses of a potentially diverse group of women about the experience of becoming a mother, using in-depth 'interviews', the question of the relative uniformity of the conversational stimuli used needs to be addressed. Some respondents might require additional information regarding the topic of discussion, whilst the actual language employed by the researcher might vary according to the way in which he/she interacts with the interviewee, all of which will affect the clarity, depth and type of information provided. Whilst some degree of idiosyncrasy of approach may be permissible and even desirable, during a wholly 'unstructured' interview, the requirement to 'generalise', as both Rose and Burgess acknowledge, requires the introduction of some measure of uniformity into the research process, which then brings in its train the kind of problems highlighted above.

Furthermore, Richardson (1993) points out that if the use of more open-ended qualitative methods is approved of on the grounds that it allows the 'authentic' views, opinions and experiences of a research subject to be known, especially in a situation in which the individual concerned is not only the subject of research but also the 'subject' of oppression, this does not necessarily lead to 'knowledge' which is liberating. Due to the complex nature of inequality, which ensures that women do not share or inhabit a common world of deprivation in which all are unequal to exactly the same degree, the world-view and preferences of one (subject) woman may not necessarily valorise (and therefore support) the world view and preferences of another (subject) woman. The influence of differences in class background or ethnic group membership, for example, may militate against any common or shared sense of purpose between the two.

Oakley (1980) has also emphasised that if feminists commit themselves to the exclusive use of qualitative rather than quantitative methods, this could have what she refers to as potentially 'sinister' implications, precisely *because* the distinction between qualitative and quantitative methods is commonly regarded as 'gendered'. Oakley argues that if quantitative methods really are 'masculine' tools of social enquiry, then, within a patriarchal society, the abandonment of such methods could have the effect of marginalising (by 'trivialising' in the minds of men) feminist research based wholly on qualitative methods.

More generally, within the context of a broader epistemological discussion of the relationship between actor and observer in contemporary social enquiry, such complex methodological issues cannot necessarily be resolved at the level of method (Popay and Williams 1994). Oakley, for example, emphasises the point that the distinction between qualitative and quantitative is itself simply a *theoretical* construct and that feminism ought to gain from the advantages of using both approaches in combination. As far as she is concerned, the principal issue of 'bias' (and therefore the potentially 'exploitative' nature of research) is not a matter of method but of ethics and 'informed consent'. The 'subjects' of a research project ought to be informed of both the objectives of the research and their 'right' not to participate (Oakley 1981, 1990, ).

In respect of feminism's concern about the way in which quantitative-based research may result in the creation of a research agenda which fails to reflect the concerns and interests of women, one might also point out that qualitative and quantitative methods can of course stand in a symbiotic relationship towards each other, *across* research projects (Reid 1994). Thus the research concerns or issues of a wholly quantitative project may nonetheless be largely informed by the outcome of pre-existing research projects utilising qualitative methods - which is essentially the case as far as the project currently being described here is concerned. Crucially, a wholesale rejection of the use of quantitative methods runs the very considerable risk that this may well inhibit the exploration of particular aspects of women's lives which are vital for understanding the determinants of women's well-being - a matter which proved a major consideration in the choice of methodology for the current project.

Finally, the financing and conduct of research into such matters is typically dependent upon the provision of public (often NHS) funding, as was the case in this research project. Such public bodies often demand 'results' rather than 'opinions'. Quantitative data is more likely, of course, to be seen by research sponsors as falling into the former than the latter category, and such funding reinforces the pressure to quantify.

**The Development of a Maternity Care Panel Study**

The following panel study of women's experiences of maternity care was funded by the NHS itself, after initial consultations with a District Health Authority in the South of England who were keen to establish a method of obtaining the views of the users of its maternity services, shortly after the introduction of the 1991 NHS reforms. Consequently, in the early part of 1992, a project outline was submitted by the two potential future directors of the project (one an academic, the other a senior medic) to the District Health Authority concerned and the Regional Health Authority within whose boundaries the DHA was located. This thesis is based on a "linked" PhD studentship which was used to fund the appointment of the project's sole research officer. Funding for the project was obtained from both the Regional Health Authority (through the Regional Purchaser Development Fund) and from the Department of Health NHS Executive (NHSE). Subsequently, the Local Health Authority's Ethics Committee gave the project ethical approval and formal support for the project was also given by the District's Family Health Services Authority (FHSA) and the local GP Advisory group.

Research results from this project constitute the principal focus of the discussion in Section II of the thesis. At a later stage in the development of the panel study, further funding was sought and obtained from the Regional Health Authority (with support from the Regional Manager of Midwifery Services) in order to evaluate a specific innovatory project in a neighbouring DHA, concerned with the development of 'team midwifery', an explicit objective of which was to create a more "woman-centred" maternity care service through the development of a midwifery-led form of care (in line with the recommendations of Winterton and Changing Childbirth). Key findings from this second project are briefly discussed in Chapter 13 of the thesis.

The creation of the panel study itself followed the general outline provided earlier. Questionnaires were administered to a single cohort of women at three distinct points during their maternity career - questionnaire 1 during pregnancy, questionnaire 2 shortly after birth and questionnaire 3 postnatally.

**Data Sources and Methods of Collection**

A single random sample or cohort of women users of the District Health Authority's maternity services was drawn from the antenatal patient database held by the local NHS Trust. The women who had been selected by this process were then asked to take part in a longitudinal study, which focused on the antenatal, intrapartum and postnatal stages of the maternity care 'cycle', and which required each individual to complete a questionnaire at each of these three stages of their own maternity 'career'.

The use of questionnaires was seen as the most appropriate research tool to use in these circumstances, for a variety of reasons. To begin, as indicated earlier, panel studies can lead to the establishment of a sense of 'trust' on the part of the respondent and may therefore lead to greater honesty or openness. The use of questionnaires may also enhance the initial response rate from the research sample by ensuring greater privacy compared with face-to-face surveys or in-depth interviews. Furthermore, since it was clear at the outset that the sample would comprise of mothers with young children, it was also felt that the use of questionnaires would be less intrusive and more flexible from the respondent's point of view. Most importantly, the rich resources provided by previous (ethnographic / qualitative) research were extensively utilised in the construction of the questionnaires themselves, underlining the point that the study was not developed in isolation from the extensive body of research which has already been conducted in this field.

In the planning stages of each questionnaire (that is to say prior to the design, piloting and dispatching of questionnaires during the ante-natal, intra-partum and post-natal stages of the study) extensive focus group discussions were held with women attending a number of ante natal and post natal clinics in the locality, in order to ensure that the questionnaires were clear in their focus and in their

language, and that the specific concerns and experiences of women within the district were taken into account.

In the first instance, focus group discussions were held to determine whether the content of the questionnaires was appropriate to women using the local services. Before each of the three questionnaires was designed, a list of possible topics was formulated (on the basis of, for example, local interviews with healthcare professionals and a review of previous research). This list then formed the loose basis around which the focus group discussions were held.

Six antenatal focus groups were held, drawn from across the locality, each having between 7-9 participants. In structuring the focus groups, it was decided from the outset to maintain some degree of homogeneity within the groups, and hold separate groups for first time mothers and second time mothers. This was due to the fact that "people are more likely to feel comfortable in discussions with others whom they perceive to be similar to themselves...homogeneous groups are more likely to generate an easy, free flowing discussion on a topic of shared interest" (Morgan 1992, p187). Of course, the composition of groups is always mixed (by socio-demographic characteristics, for example) although in the present study it was felt that the distinction between the experiences of first and second time mothers was of central importance. Since these groups were primarily used to outline and verify the topics for inclusion in the questionnaires - as opposed to being used for data gathering purposes - it was felt that pure homogeneity would have been almost impossible to attain within the confines of the project. Consequently, each group had women of different socio-demographic backgrounds, with the added benefit that no one group was omitted / over-represented. The discussions were of approximately 60 minutes duration, and were led by a single co-ordinator.

During the focus group discussions, a semi-exploratory position was adopted by the co-ordinator. Questions were put to the groups, and whilst discussion was allowed to 'free-flow' some degree of direction was maintained by the co-ordinator. No data from any of the focus groups was used in the analysis, the main purpose of the groups being that of ensuring that salient and relevant topics were included in the questionnaire schedules. Analysis of the focus group discussions also led to questionnaires being modified.

Different focus groups were established to consider the content and orientation of the second and third questionnaires, with the dichotomy between first and second time mothers being maintained. Once the questionnaires had been devised, these were then randomly piloted to groups of women attending for the regular antenatal / postnatal clinic sessions in order to ensure clarity of expression.

Whilst many of the responses to the questions on the questionnaire schedules were of a fixed-choice design, the schedules also allowed women to couch their responses in their own words in a number of key areas, through the use of 'open-ended' questions. Respondents were also positively encouraged to express their views freely on any issue they wished, at the end of the questionnaire - and this latter invitation did indeed generate some interesting and detailed responses.

In all the different ways outlined above therefore, various strategies were employed in the development of the research design in order to facilitate the involvement of women in the study in a positive manner, whilst at the same time creating a project which would be capable of addressing a number of key theoretical / explanatory issues which existing research in the field had failed to examine, notably the question of the potential health 'costs' of modern maternity care. At the same time, the research design also allows one to address broader issues concerning the relative effect of the recent reforms of the NHS in the field of maternity care.

Following Oakley's analysis, which suggests that the problems of bias and exploitation in the use of women as research subjects relates as much to the way in which they are initially recruited into a project, as to the actual project design and methodology employed, one of the most important ethical considerations addressed during the establishment of the panel was that of ensuring that all of the women who participated in the study did so on a voluntary basis. It was considered important to ensure that potential respondents were provided with as a clear a sense of the project's objectives and aims as possible, so that they would be in a position to give their informed consent, if they so wished, and they were also given the opportunity to *refuse* to take part in the study.

Such measures were adopted, inter alia, to circumvent the (recently criticised) assumption, implicitly made by some studies, that women are always willing to

take part in such research and are available to do so (Smith 1974; Roberts 1985: Brooks, 1993). Further ethical considerations addressed during the development of the project included those of patient confidentiality and anonymity, and the normative conventions for the protection of patient identification applicable to all NHS research were adhered to. Additionally, respondents were given information about the scope as well as the nature of the project at the outset (and especially the fact that participation involved the completion of a number of questionnaires) so that any decision made by the participant would be made in the light of her knowledge about the longitudinal nature of the project and her expected on-going involvement.

The question of attrition is of course a key issue in the use of panel studies and a decision has to be made, prior to the creation of such study, about the most appropriate way of responding to this kind of problem. Whilst some panel studies (such as the British Household Panel Study) seek to replenish the panel by bringing in individuals with the same characteristics as those who have dropped out it was felt that in a panel study of maternity care - which examines and compares contact experiences and attitudes within a specific time period (the maternity career) - any attempt to replenish the original sample in the way chosen by the larger national study would distort both the findings and the validity of the panel itself, since the maternity care study's sample size was much smaller and the time frame involved was much shorter. Accordingly, in order to retain as high a proportion of the original sample over the duration of the study, strenuous efforts were made to keep in contact with as many as possible of the women on a regular basis through the use of such techniques as a panel 'news-letter', send to women at regular intervals throughout the duration of the project and containing information relevant to them (such as clinic times, helpline telephone numbers promotions, free gifts (donated by Boots the Chemist etc). Mobility out of the area automatically meant that respondents could no longer be included in the study.

Although some measure of attrition is inevitable in the case of all panel studies, over a period of almost three years, of the original group of 282 women who completed the first questionnaire on ante-natal care, 200 remained to complete the third and final questionnaire on post-natal care, representing an overall attrition rate of slightly more than 28% . Subsequent analysis of the panel data did not,

moreover, produce any evidence of selective depletion, either in a demographic or attitudinal sense.

In establishing the panel of women users of the maternity care services it was decided in the first instance to select the panel members according to their GP (i.e.: a practice based sample) rather than a purely random selection of residents. This would theoretically allow for inclusion of patients from GP practices with contrasting characteristics (in respect of, for example the size of practice and its fundholding status) and would allow for some comparison to be undertaken according to such variables.

All GPs in the area (247) were sent letters informing them about the project and asking if they would be willing for their practice to be included in the study. Only one GP refused at this stage. The GP practices within the locality were grouped according to their location and an estimate was made of the number of panel members needed from each locality so that the proportion of panel members from a specific area was representative of the total number of women of child bearing age from that location (with the population figures being derived from census data). On the basis that a GP practice would yield, on average, 1.5 potential panel members (viz. women of child-bearing age) per 1000 patients on the GP list, GP's were randomly selected from each locality until the sample size reached 400. As a result of this process, 37 practices were identified from a total list of both 58 District practices located directly within the county boundaries and a further 8 District practices which 'straddled' two (or more) county boundaries, this 'sample' of practices constituting 56% of all practices, (N=66) within the District as a whole. The single GP practice which initially refused to take part in the study was not, in fact, randomly selected during this phase of the project and the non-participation of this practice did not affect therefore affect the outcome of the process of selection in any case.

The selection of GP practices was conducted in this way so as to minimise selection bias. By using a randomised method of identifying a potential sample of GP practices, the project sought, for instance, to avoid the kind of bias that might be introduced by simply contacting only those practices deemed, on the basis of their local reputations, to be 'pro-active' and therefore positively inclined to co-operate with such a project.

Having therefore established (i) the practices from which to derive the sample and (ii) the "quota" of women needed to establish the panel from each practice, the next stage in the development of the panel study was the recruitment of women users of the service. The selection of the actual sample of women users was conducted by a NHS practitioner, according to the ethical safeguards governing access to patient records. The personal details of pregnant women were obtained from the hospital antenatal database, which provided such information as patient names, their addresses, GP codes and hospital identification number. Since the vast majority of women users (99%+) attend hospital at some stage during their pregnancy (if only for a scan) the number of women who might be excluded by the use of such a method of sample selection is, in practical terms, extremely small, and the element of possible bias involved negligible. Using a table of random numbers, women were randomly selected from the hospital data-bases but only if their GP practice had itself been 'selected' for inclusion in the project. The women were then contacted directly in order to determine whether they would like to take part in the panel study.

The letter which was sent to this initial sample of potential panel members was piloted in a child health clinic prior to being circulated, in order to ensure that the aims of the project were communicated as clearly as possible and the implications of participation for the potential panel members were also clearly stated, so that all potential participants would have the opportunity to make an informed choice about whether to participate or not. Following a few minor alterations after the piloting stage and the establishment of a Freepost return address, this letter was sent to 400 women, asking if they would take part in a project aimed at examining women's experiences of and attitudes towards the maternity care services within the District. A reply slip was attached to the letter and women were asked to sign and return the "consent form" if they were prepared to take part in the study. Of the 400 letters sent out, 282 women agreed to take part in the study, representing a response rate of 70%, which compares favourably with the response rates of conventional face-to-face interview surveys conducted in this field. Each panel member was then sent the first questionnaire, asking them about their experiences of ante-natal care and their social circumstances.

Ideally, one would have wished to conduct a follow up of non-respondents (according to socio-demographic / service use characteristics, for example). Under the ethical guidelines governing patient confidentiality, this proved impossible within the scope of the current project. Following sample selection within the hospital, the questionnaires were sent out via a 'mail-merge' computer programme, linking respondents ID with their home address. Upon completion and return of the questionnaires, the only identification available to the researcher was the patients hospital ID number. Whilst this did allow some limited follow up of non-respondents (by address only), the lack of access to detailed patient information meant that post-coding and analysis of non-respondents by age, parity, GP, service use, past medical history was impossible.

In developing the questionnaires for each of the three main stages of the project (viz. pregnancy, birth and post-natal care) and in addition to the focus group discussions with women service users mentioned earlier, the views of both the DHA and health care professionals (GP's midwives, obstetricians, health visitors) were elicited through face-to-face interviews. At each of the three main stages of the project, the respective questionnaires were piloted at a number of ante natal and post natal classes run in the District. The questionnaires were modified following the initial pilot and the revised schedules were again piloted, when necessary.

The first questionnaire (referring to women's experiences of ante-natal care) was sent to panel members in the late autumn of 1992, and a follow up letter and questionnaire was sent to those who had not responded after a three week period.

In order that the questionnaire on labour and delivery was as close as possible to women's birth experiences, the second questionnaire was drawn up sent to panellists shortly after the birth of their baby - circa. March 1993. Of the 282 women who responded to the first questionnaire, 237 replied to the second questionnaire.

Whilst the emphasis of much sociological and medical research has predominantly focused on ante natal care, labour and delivery and the immediate post-partum period, one of the main aims of the panel study was to examine the impact of childbirth of the long-term morbidity of mothers. Consequently it was

decided that a number of months would be allowed to elapse before the third (and final) questionnaire on postnatal care and experiences was sent out. In order to sustain interest in the panel in the meantime, two newsletters were sent to women between the second and third phases of the project providing general information about the panel., helpline / useful local information, promotions (the panel newsletter was sponsored by Boots the Chemist, who donated vouchers to give to panellists) etc. and asking respondents to inform the project researcher if they were due to change address. The final postnatal questionnaire was sent to all panel members (N=282) early in 1994, 200 of whom returned the final questionnaire.

**Method of Analysis**

The questionnaires which were returned at each of the three stages of the panel study were entered on to a data-base which was then interrogated using SPSS for Windows. The principal statistical tool used was that of the test of significance, specifically chi-square, reflecting the nature and level of measurement of the data-base itself. The construction of a data-base from a panel study which utilised structured methods of data collection provides an opportunity for statistical comparisons to be made both,

(a) diachronically or longitudinally, between one 'stage' of the panel (for example, antenatal) to another (for example, postnatal), as well as,

(b) synchronically, that is to say, comparatively between different aspects or 'variables' of a data-base established at the same 'stage' or point in time.(For example, the antenatal data-base alone).

**Summary**

Based on the analysis presented in section 1, the current chapter has sought to highlight the major sociological issues which research into the impact of the NHS reforms on maternity care needs to address. In addition, the chapter has also provided an outline of the principal type of research design which was developed in order to investigate the issues and questions raised by this discussion, a panel study.

The remaining chapters of this section of the thesis discuss the empirical findings of the panel study. Chapter 8 outlines the characteristics of the sample and then subsequent chapters focus on the response of panellists to care provided during pregnancy, birth and postnatally (with Chapter 13 presenting data from an evaluation of an innovative project in a neighbouring locality).

# Chapter Eight

## The Social Background of Panel Members

### Introduction

One of the principal aims of the preceding chapter was to highlight several key research issues concerning women's experiences of maternity care within the 'new', 'reformed' NHS. Chapter 7 also considered the type of research design which needed to be developed in order to examine these issues or questions at an empirical level. The characteristics of the principal research tool adopted by the thesis, a panel study design, were then outlined and discussed.

The current chapter provides an account of the social background of the sample of respondents who were selected to take part in this panel study and discusses the methodology used to assess women's maternity care preferences.

### The Age, Marital Status and Ethnic Background of Panel Members

As indicated in Chapter 7, the panel sample was selected at random from NHS antenatal records and the first stage of the panel study, focusing on women's experiences of antenatal care, comprised 282 respondents. The mean average age of these respondents was 29 years, with one third under the age of 27 and approximately 1 in 10 over the age of 35. The majority of the sample (84%) described themselves as 'married', and for 76% this was their first marriage. The proportion of unmarried mothers amounted to 12% of the sample, whilst the remainder (3.5 %) described themselves as divorced or separated.

On the question of ethnicity, 10% of the sample described themselves as belonging to non-white ethnic groups, a proportion which corresponded almost exactly to the 1991 census estimates for the county from which the sample was drawn. Interestingly, all respondents who described themselves as belonging to non-white ethnic groups also described themselves as 'fluent' English speakers, which is almost certainly a reflection of the character of ethnic communities in the locality, the majority of whom have been established in the area over a long period of time. It is possible that the less fluent members of

local ethnic groups are under-represented in the sample, although this may also be a general problem in recruiting would-be respondents on to a panel study, irrespective of their ethnic background. Panel studies are relatively time-consuming and require respondents to provide information on more than one occasion. Women service users who are generally less confident in their ability to express their opinions, may therefore be over-represented amongst those who refused to participate in the study. This is, naturally, a difficult issue to resolve with any degree of certainty and has to be viewed, in any event, as part of the wider issue of the 'representativeness' of the panel sample and its fitness for the purpose for which it has been selected.

The extent to which any 'sample' can be said to be 'representative' of a particular 'population' or sampling 'universe' is, of course, both an important and complex matter for a number of reasons. To begin with, it is clear that the relationship between the character or nature of the individuals involved in a particular research project and the general aims of that project are always a key consideration in itself. If, for example, one were to deliberately select a certain 'type' of service user as a basis for studying the impact of the NHS reforms on women users, then this would need to be justified in terms of the theoretical aims of the project. Otherwise, this would conventionally be regarded, prima facie, as an attempt to introduce an element of 'bias' into the research process. The panel study sample was, of course, randomly selected and most importantly appears to be 'representative' of the county 'population' from which it was derived, at least in terms of certain key demographic and social aspects of this population. However, the very character of the population of the county raises a number of potentially important theoretical and methodological issues about the 'representativeness' of the study as a whole and the extent to which one can therefore 'generalise' from it, which merit further discussion at this particular juncture.

**The Class* Composition of the Panel Compared with the Class* Composition of the Local Population (*By Head of Household's Occupation)**

The county within which respondents to the panel study reside is located within Southern England and was one of the few English counties to experience a growth in population between the 1981 and 1991 censuses. This was primarily due to an influx of young and typically married 'professional' households, attracted by the creation of job opportunities in the new 'sunrise' industries of information technology and the like. Accordingly, using the Registrar General's Social Class Classification Schema, the census for 1991 indicates that the county population comprises a high proportion of households classified as either RGSC I (Professional/Higher Managerial) (9.3% of all economically active heads of households) and RGSC II (Semi-Professional / Middle Management)(33.8% of all economically active heads of households). Overall, the majority of household heads (53.2%) are employed in 'white-collar' or non-manual jobs, whilst the majority of 'blue-collar' or manual workers are in occupations described by the Registrar General as 'skilled'. Broadly speaking, therefore, the county may be described as one in which 'middle class' households predominate. As the following table illustrates, a similar observation can be made about what might be termed the 'class' composition of the panel sample - although several caveats need to be added at this point.

Table 8:1 Class Composition of the Panel Sample (according to husband / partners occupation) compared with the Class Composition Of the County within which the Panel Members reside.

| Registrar General's Occupational Class Of Head of Household. | Panel Sample | County Population |
|---|---|---|
| I | 13.4% | 9.3% |
| II | 34.5% | 33.8% |
| IIInm | 7.4% | 10.1% |
| IIIm | 22.5% | 26.4% |
| IV | 3.5% | 12.1% |
| V | 1.1% | 3.9% |
| | (Remainder unemployed / did not provide information) | (Unemployed:5%) |

## Women and Class Analysis: The "Conventional View" Controversy

As the debate initiated by Newman illustrates, the classification of the position of *women* within the class structure of late modern societies is a subject of some controversy (Newman, 1980). In a review article covering a number of books on class, Newman, commented that it was 'most remarkable' that major research studies in this field continued to ignore the topic of gender when analysing class inequality. What Newman referred to as '...the fact of the missing millions' of women excluded from studies of social stratification (Newman 1980, pg 633) became the subject of a fierce debate.

One of the central protagonists within this debate, Goldthorpe, defended what came to be known as the 'conventional' view of the relationship between women and class (Goldthorpe, 1983). This view maintains that the class position of women should be defined as equivalent to that of their husbands, using the latters occupation as the principal indicator or measure. According to Goldthorpe, it is the *family* rather than the individual which forms the basic unit of social stratification and the position of families within the class structure is articulated essentially via the occupational position or status of the 'head' of a family (viz. a woman's husband or partner). Inter alia, critics of this view argued that a large number of families or households are increasingly characterised by, and reliant on, 'dual incomes', as a consequence of the fact that husbands and wives are often both employed. This renders the classification of a family's class position solely by the occupation of the husband potentially misleading. By ignoring the contribution of wives or female partners, critics argue that the 'conventional' approach gives a false impression of the true 'life chances', to use a Weberian concept of class, of such families or households. Additionally, within such dual income households, the actual occupational category or grade of the wife may also be different to that of the husband, making the actual classification of the occupational class position or status of the household difficult to determine as well. More generally, the 'conventional' approach to class analysis renders women 'invisible' within the study of social stratification. (C.f. e.g., Dale et al, 1985, Heath & Britten, 1984, Stanworth, 1984)

The debate on women and class analysis, initiated by Newman's original comment, ranged over several years and the detailed ebb and flow of the debate is too involved to reproduce here. In what could be regarded as something of a concluding comment by key proponents of the 'conventional' view, Erikson and Goldthorpe conceded that, at the very minimum,

> ...It is clearly conceivable that the proportion of conjugal families in which the wife has the greater involvement in, and commitment to, the labour market will increase ... It may also be that the class position of married women as defined in terms of their own employment will in general become a more powerful determinant of their class awareness, social imagery, political partisanship etc.; and further, perhaps, that cross-class effects, both within families and on the socio-political characteristics of their members, will take on greater significance than they would presently appear to possess. (Erikson and Goldthorpe, 1988, pg 550)

In one sense therefore, the degree to which it is appropriate to classify women's class position by the occupational standing of their husband or partner is a matter of empirical enquiry. From the point of view of the thesis, the principal theoretical point of concern is whether differences in the class position of women in the panel sample (however defined and measured) are likely to affect the attitudes and behaviour of panel members. If so, this raises the question, 'will women from different class backgrounds respond differently, for example, to any changes which are initiated within the 'new' NHS as a consequence of the process of 'reform'?.

Of course, one must decide at the outset, precisely what one means by such a term as 'class'. Some critics argue that the 'conventional' view of the women and class debate - such as the research of Goldthorpe et al's Social Mobility and Class Structure in Britain (Goldthorpe et al, 1980) - is flawed because its' concept of class fails to take adequate of the type of class divisions addressed by a Marxist analysis. In general however, the general character of the debate seems to operate with a largely tacit Weberian conception of class, which is to say that one's class position has a major influence on one's 'life chances'. Since this can be interpreted in narrow economistic or financial terms, it is important to recognise the fact that Weber's original discussion of the nature of social stratification in 'modern' societies also referred to the importance of

'status' divisions, reflected in differences in 'life styles'. (Gerth & Mills 1946) Although the terms class and status are regarded by Weber as separate analytical entities, he recognised that in practice, class divisions and status divisions often coincided or overlapped. In such situations, the division of a society into separate classes did not simply imply a system of stratification based solely on financial considerations, but the division of the society into distinctive groups or communities, membership of which had a powerful influence on an individual's attitudes, behaviour and outlook (Goldthorpe et al 1969).

Applied to the current research, if one were to assume that women may be differentiated in this way, according to their class position (irrespective of whether this is regarded as being determined by their partner's occupational standing or by some other strategy) then the attitudes and response of individuals from different class backgrounds to major changes in their social world are likely to vary significantly. For example, if we follow Goldthorpe and Lockwood's original classic discussion of the relationship between social class and individual's social and political outlook or beliefs about the nature of social order and social change, individual attitudes toward change may be accommodating, hostile or neutral, depending on class position (Lockwood 1966)

Equally, the way in which individuals respond to the personal challenges and opportunities provided by any particular aspect or form of social change (including, for instance, the opportunity to exert a greater degree of influence or control over some aspect of their life) may differ according to class background (McIntosh 1989, Oakley 1979). However, one must also recognise the possibility that whilst class differences may indeed influence the outlook and behaviour of women, the relationship between class divisions and gender divisions is complex, although this area itself demands more attention. Although individual women may behave differently from each other due to differences in their class background, this does not necessarily imply that the attitudes and behaviour of men and women from the same class background will be similar. (Abbott, 1987)

## The Level of Economic Activity of the Panel

As far as the present research project is concerned, the important question to determine is whether there are indeed marked differences in the class background of the panel sample and if so, do such class differences appear to have any bearing on women's reactions to potential change in the area of maternity care provision ? Arguably the most straightforward way of prosecuting this question is to begin by examining what Lockwood (1966) refers to as the 'market' and 'work' situation of our respondents. In so doing, however, one immediately encounters a major problem. The issue of whether one should determine women's position in the class structure by relying solely on the occupation of their husband or spouse is especially problematic for the thesis since a high proportion of respondents were not employed at the time of the first stage of the panel study (since women are entitled to statutory maternity leave and their occupational characteristics typically undergo substantial change during the transition to motherhood (Jacobs 1997)

## The Incidence of 'Cross Class' Households in the Panel

Of the 282 women who agreed to take part in the panel study, only a minority, some 108 respondents, were in paid employment during the first stage of the study. The existence of dual-income households is potentially significant for a variety of reasons. The existence of a second income boosts the household's resources, of course. Additionally, in so-called 'cross class' households, where the woman is in a higher occupational class than her husband or partner, it is likely, even allowing for gender inequalities in wage/salary rates, that the woman will be making a large and perhaps even the major contribution to the family budget.

The majority of the women in the panel sample who were employed were employed in non-manual jobs and this was true in the case of households where the man or putative household 'head' was in either a non-manual or a manual job themselves (92% and 70% respectively). Interestingly, the specific incidence of 'cross-class' households was entirely restricted to those in which the putative male 'head' of the household was employed in a manual occupation. Of the 28 women in the sample who were employed and whose

partner or husband worked in a manual occupation, 20 of these women were employed in non-manual occupations, 15 in the Registrar General's social class II. Indeed, such cross-class households account for almost 1 in 4 of all those households which might otherwise be classified as manual or, more loosely-speaking, 'working-class' if one were to rely on a form of classification based solely on the occupational status of a woman's partner or husband.

On the basis of this more fine grained analysis of the likely class position of the panel members, the picture which appears to emerge is one in which a large proportion of the sample (almost 6 out of 10 respondents) can be classified as either non-manual or 'cross-class'. The significance of this for the thesis in general is that the sample may be described, in broad terms, as predominantly 'middle-class'. This in turn may have certain implications for the way in which such panel members respond to any changes or opportunities for exercising greater choice over the type of maternity care which the newly 'reformed' NHS provides. One might assume that 'middle class' service users may demonstrate a greater degree of confidence in responding to such changes or opportunities compared with women from lower class origins. If this is a legitimate assumption to make, then one might also infer that if the NHS reforms have indeed acted to provide service users with greater 'choice', then one should be able to provide evidence of any such improvement in the quality of such health care services in the experiences of this type or group of service user.

**The Concept of 'Prototypical' Research Samples**

A similar inference was made by the authors of the famous "Affluent Worker" study, when they deliberately attempted to select what they termed a 'prototypical' sample of survey respondents in order to subject the 'embourgoisement thesis' to a critical test. (Goldthorpe et al 1969) Their idea was to select a sample of workers whose social circumstances were theoretically thought to be most propitious for the emergence of particular attitudes and behaviour. As far as the thesis is concerned, a parallel assumption might be made about the panel sample. If the NHS reforms are effective in 'empowering' service users, this is arguably most likely to be apparent amongst articulate, assertive 'middle class' individuals who are used to

vigorously pursing their interests and preferences. Indeed, as Jackson and Marsden's classic study of the relationship between class culture and educational achievement in the fifties, "Education and the Working Classes" indicated, even 'cross- class' households show evidence of such distinctive 'middle-class' cultural traits. (Jackson and Marsden, 1966) Jackson and Marsden argued, for instance, that a high proportion of children from seemingly 'working-class' backgrounds who passed their 11+ exams and entered 'selective' secondary education in the fifties were actually the product of 'cross-class' backgrounds. Hence although the fathers (male heads of households) of such children were employed in manual occupations, a high proportion of their mothers were either occupationally 'middle class' in terms of their own family of origin or employed in a non-manual occupation. Described as 'submerged' middle class households, Jackson and Marsden suggest that such 'cross class' circumstances lead to a situation in which key middle class cultural traits (including, for example, a commitment to what they term 'deferred gratification') come to have a disproportionate effect on the behaviour of the offspring of such relationships. This interpretation seems to find some confirmation in more contemporary studies, such as Zipp and Plutzer's examination of social class, gender and class identification in the U.S.A. (Zipp & Plutzer, 1996) Whilst their study provides general support for the 'conventional' assumption that a husband's class position has a greater effect on class identity within a household than the wife's class position, they note that in certain situations (most notably those involving 'cross class' households) the wife's class significantly modifies or reverses the expected class leanings of the household based on the husband's position.

In attempting to assess whether the panel sample can be regarded as 'prototypical' or not, one has to be cautious in extrapolating from data concerned with individual attributes (such as the individual's occupation or the occupational character of her household) to assumptions about individual attitudes and behaviour. When one looks in more detail at further individual attributes of the sample, together with additional information about variations in individual attitudes, beliefs and behaviour, the impression produced of the sample's class position, based largely on occupational or economic criteria, needs to be qualified.

## Home Ownership, Car Ownership and Health Inequalities

In what is almost certainly a measure of the resources of the households of which they are a part, rather than of the resources of individual panel members, the large majority of the sample described themselves as both 'owner-occupiers' (77%) and 'car-owners' (88%). Not only does this confirm the general impression that the sample is predominantly middle class in character, but this additional evidence is important in its own right for a slightly different reason. As the findings of studies like The Black Report (Townsend and Davidson, 1982) and Townsend and Mortimore's study of health and poverty in the North East of England indicate, class inequalities and health inequalities are intimately interrelated phenomena. Consequently, when one discovers that the sample is not only largely middle class in an occupational sense, but panel members also display a high level of both car and home ownership, one may also reasonably infer that the majority of the sample are likely to be relatively healthy as well. This is potentially very important.

## On the Relative 'Prototypicality' of the Panel

The 'reforms' of the NHS are, at one level at least, associated with a drive to increase 'consumer choice' (Working for Patients 1989). In the area of maternity care in particular, so-called 'consumers' or service users who are fit and healthy (and generally from the higher social classes) are arguably less in need of the traditional kind of 'high tech.' maternity service, which the 'discourse of risk' sought to justify (Winterton 1992). Since the NHS reforms are intended to develop services which are more in tune with 'consumers needs' and the specific policy critiques of maternity care (viz Winterton and Changing Childbirth) underline the line the need for new forms of care in addition to the standard 'high tech' approach, the panel sample may be regarded as 'prototypical' in several senses. On the one hand, middle class individuals may be more assertive in articulating their needs and preferences (Cartwirght and Anderson 1981), and they may therefore be especially able to take advantage of any improvements in the degree of choice afforded to services users as a consequence of the reform process. On the other hand, as a predominantly middle class and therefore largely healthy group of people, such individuals may also be positively motivated to seek changes in the care

regimes provided for them, since the relatively standard, traditional, 'high tech' approach to maternity care, may not be particularly suited to their needs - which might be for a more low-tech and even domiciliary-based/midwifery led service (Oakley 1992).

**The Educational Background of Panel Members**

In assessing the degree to which the panel sample may be regarded as 'prototypical' vis-a-vis the central theoretical or explanatory concerns of the thesis, it is important to acknowledge that much of the foregoing analysis is based on relatively indirect measures or estimates of the characteristics of individual panel members. When one examines aspects of the character of the individual panel members in a more direct manner, the preceding observations require some qualification. This is most apparent when one examines the educational background of panel members, which constitutes a *direct* assessment of the individual or personal characteristics of respondents.

Whilst the majority of panel members may be judged to be middle class on 'occupational' grounds (principally the occupation of their partner), the educational background of the sample provides less convincing evidence in support of such an assumption, especially when class divisions are defined in social as well as economic terms. Just slightly more than half of the sample (52%) left full-time education at the age of 16. Only 5% of the sample continued in full time education beyond the age of 19 years, the remainder leaving at some point between their seventeenth and eighteenth birthdays. Evidence about the educational achievements of panel members therefore provides rather less convincing support for the assumption that the sample may be regarded as predominantly middle class in *both* economic and cultural terms.

Education may be deemed to be relevant to the assessment of class divisions in two general senses at least. To begin with, differences in levels of educational achievement are likely to have a major bearing on one's 'life chances' in the marketplace. Secondly, in a way which is analytically separate from the issue of 'life chances', though empirically closely related to the former, differences in levels of educational achievement are also likely to be associated with

differences in what educational sociology has termed 'cultural capital'. The latter does not simply imply, moreover, differences in the depth or breadth of one's 'knowledge' in a 'technical' or 'academic' sense, but rather 'knowledge' conceived of in terms of one's understanding of and therefore control over 'social' and 'organisational' processes (Young 1971) On the basis of their husband's or partner's occupational standing, in other words, the majority of women could be classified, broadly, as 'middle class'. On the basis of their own level of educational attainment the classification of the majority of the sample in this way is rather more problematic. Accordingly, the analysis in later chapters of the thesis, takes separate account of the potential influence on respondents experiences of both the respondent's class position and her level of educational achievement.

**First and Second Time Mothers**

In addition, since previous experience of maternity care services is also likely to have a major bearing on women's experiences of and attitudes towards such care within the newly reformed NHS, separate assessments are also made of the potential impact of the reforms on 'first time' mothers (FTM's, n= 123) and 'second (+) time' mothers (S(+)TM's, n= 159).

**The Health Beliefs of Panel Members**

Finally, in attempting to determine whether the character of the panel sample provides an appropriate basis for assessing the likely effectiveness of the NHS reforms, one must also take account of panel members attitudes towards the notion of 'health' itself. One needs to determine, for example, not only whether a particular group or sample of service users have the capacity, skills and motivation to capitalise on any opportunities for choice of care which the NHS reforms may present, but also whether such service users are interested in or assign any particular significance or priority to the maintenance of their own health. If one were to attempt to assess the impact of the NHS reforms on service delivery using a sample of service users for whom health is a matter of little concern, then this may lead to an under estimate of the effect of the reform process. This does not appear to be the case as far as the panel's sample of service users is concerned.

Although research suggests that women often see themselves as taking on a major part of the responsibility for maintaining the health of their household (Morgan 1980), it is evident that there are, nonetheless, substantial differences in women's lay conceptions of health and health behaviours according to variations in the individual's social background or circumstances.(C.f. eg Calnan 1987, Blaxter and Patterson 1982, The Black Report 1980) If one considers the nature of the health beliefs of panel members, it is apparent that, in keeping with the general 'middle class' nature of the sample, at least as defined in occupational/economic terms, health is a matter of some importance to the great majority of respondents.

The large majority of panellists (9 out of 10) strongly agreed with definitions of health which were both positive and holistic - viz. health is 'a state of physical, social and mental well-being.' Not only is health an issue of some importance in the lives of panel members, therefore, but they also regarded health as an issue which involves virtually all aspects of their lives. This result corresponds, furthermore, with the class composition of the panel sample. As the work of Calnan and others suggests, (Calnan, 1987) 'lay' conceptions of health which are both 'positive' and 'holistic' in character are especially common within the middle classes. Importantly, almost 9 out of 10 respondents felt that they could influence their own health. This latter point is particularly well illustrated by the pattern of what medical sociologists would term 'health behaviour' amongst panel members (Kasl and Cobb 1966).

**The Health Behaviour of Panel Members**

Two thirds of the sample reported that, when not pregnant, they took regular physical exercise on at least a weekly basis and 8 out of 10 would like to have taken even more exercise. Cigarette smokers were in a clear minority, of just 2 out of every 10 respondents and even amongst this group, only three respondents smoked more than 20 cigarettes a day. Even more significantly, 8 out of 10 of those respondents who did smoke reported reducing their pattern of smoking during pregnancy, showing a clear responsiveness to a major health education message.

By contrast, a much higher proportion of the sample drank alcohol. Only 2 out of 10 respondents described themselves as non-drinkers. However, only 13% of those who drank alcohol described themselves as 'regular' drinkers, the remainder classifying themselves as either 'occasional' or 'special occasion' drinkers. What is more, during pregnancy, more than 95% of the sample reduced their alcohol in-take, reflecting once again their awareness of and responsiveness to a major health education message. In a similar vein, almost the entire sample thought that diet was either very important or important for maintaining health.

**Summary and Conclusion**

This preliminary assessment of certain key characteristics of the panel sample, suggests that the sample as a whole is generally affluent, seemingly healthy and certainly very aware of, interested in and responsive to health matters. Accordingly the sample appears to be particularly appropriate for the purpose of assessing the potential of the NHS reforms to effect change in the quality of service provision, as judged from the perspective of the service user. Since the sample could be described as predominantly 'middle class' in character, one could assume that the majority of panel members are relatively 'healthy' and also, rather more speculatively, reasonably confident and articulate. This latter assumption about the socio-cultural nature of the panel sample is of great potential significance.

The principal interest of the thesis is in assessing the degree to which the NHS reforms have succeeded in 'empowering' women users of the maternity care services, by enhancing the choice of care available to such users. Since the panel is composed predominantly of women from a 'middle class' background, then, cateris paribus, one might reasonably argue that this type of research sample ought to be regarded as a 'prototypical' sample. That is to say, if the reforms of the NHS are likely to have any prospect of success, then evidence of the successful transformation of the NHS into a more 'consumer' friendly system of health care which delivers the kind of service which users prefer, is most likely to be found amongst middle class service users than amongst lower class groups of service user. As studies of practitioner-client patterns of interaction demonstrate, (Cartwright and O'Brien 1976; Stimson and Webb

1975, Jeffreys and Sachs 1983) 'middle class' client groups are generally more assertive and demanding than 'working class' clients and are therefore more likely to capitalise on any new opportunities for exercising greater choice and control over the health care services which are available to them. Derivatively, since the 'middle classes' are also likely to be healthier than their working class counterparts within the area of maternity care, middle class service users may be particularly motivated to seek alternatives to the 'high tech' form of care, justified by the 'discourse of risk' - since the latter is principally orientated towards the needs of less healthy, 'high risk' and therefore predominantly 'working class' service users. Certainly within the Panel sample, the incidence of mortality was below the national average, with just one infant death recorded within the first 6 weeks of birth. .

In most respects therefore, the social characteristics of the panel suggest that the sample can be regarded as a 'prototypical' sample, particularly suited to assessing the thesis' central research question, " Is the 'new' 'reformed' NHS (but specifically maternity care) better able to satisfy the needs or preferences of its service users than the 'old' unreformed NHS ?."

Of course the latter question requires one to determine;

(a) exactly what Panel members' maternity care preferences *are,* and,
(b) how one might assess whether these preferences are being met (or not, as the case may be) within the 'new' NHS,

- issues to which we now turn in the succeeding chapters.

# Chapter Nine

## Panel Members Experiences of Antenatal Care in the "New" NHS.

### Introduction

The previous chapter examined the social background of respondents and considered the possible implications of this for the exploration of the thesis's central research interests. Chapter 8 concluded by suggesting that, in several respects, the panel sample could be regarded as a 'prototypical' sample for the purpose of examining the impact of the NHS reforms on women's experiences of maternity care. That is to say, given the characteristics of the panel, if one cannot demonstrate that the reform process has been able to achieve its goal of 'empowering' service users amongst this type of service user, then this goal is unlikely to be achieved amongst service users in general.

The key methodological questions which the panel study has to address in examining respondents experiences of maternity care in the 'new' NHS are:

(a) how should one assess the maternity care needs or preferences of panel members ?

(b) how can one determine whether these needs or preferences are being satisfied or not within the 'new' NHS ?.

In the current chapter, the thesis develops a method of assessing women's maternity care needs or preferences which addresses such issues. This methodology is then used to make systematic comparisons of women's experiences across different *sectors* of maternity care provision.(e.g. community-based versus hospital-based services) Such sectoral comparisons are important since one cannot assume that any improvements which may have occurred as a consequence of the NHS 'reforms' will have occurred uniformly across every area or sector of service provision. Following an analysis of respondents experiences of antenatal care, the chapter then considers the potential impact of variations in respondents' social backgrounds and previous experience of maternity care on their experiences of antenatal care.

## The Assessment of Women's Maternity Care Needs and Preferences

Before one can attempt to evaluate panel members' experiences of antenatal care within the 'new' NHS, one must first determine what women want or expect from such services. As we have already indicated in chapter 4, researchers have explored the nature of women's maternity care needs and preferences, using a variety of methods, both qualitative and quantitative (Arms 1975; Oakley 1979, 1980; Kitzinger 1979; Graham and McKee 1979,1980; Macintyre 1981; Rakusen and Davidson 1982, Shapiro et al 1983) It is apparent that, at the most general level, women wish to exercise more 'control' over the process of becoming a mother within the 'modern' system of maternity care. Specifically, women have been shown to be dissatisfied with both the 'context' and the 'content' of such care.

As far as the 'content' of maternity care is concerned research suggests that the 'quality' of the information provided to women service users is a central source of concern. Similarly, the amount of attention given to the opinions and observations of service users by service providers and the degree to which women feel that they are able to make choices about the types of care/care regimes available to them, are also frequently mentioned as major sources of concern to service users. (Oakley 1979,1980; Graham and McKee 1980; Cartwright 1979; Jacoby 1988; Macintyre 1981 for example)

As far as the 'context' of maternity is concerned, such research also suggests that privacy is often lacking, especially within hospitals during pregnancy and the intrapartum stage of care. Consequently, hospital environments often feel like 'meat markets', where women have to wait long periods of time before being seen and are treated as 'bodies' rather than as people. Allied to this is the also frequently cited complaint that modern maternity care is provided in a very impersonal, regimented manner. Women also report that clinic and surgery opening times often seem to be devised for the convenience of the service provider than the service user. Finally women users of maternity care services are often dissatisfied with what they regard as the poor quality of the physical 'environment' in which maternity care is delivered.

Accordingly, the following dimensions of the organisation and delivery of

maternity care were incorporated into the panel study's questionnaire schedules - viz.

(i) the length of waiting times
(ii) the quality of the physical environment within which care is delivered
(iii) the degree of privacy
(iv) the quality of the information provided to the service user
(v) the convenience of clinic opening times
(vi) the degree of attention paid to the users comments by service providers
(vii) the degree of involvement of the user in choices about care.

In addition to these seven major areas of concern, the questionnaires also addressed particular issues associated each of the three specific 'stages' of the maternity 'cycle' viz. antenatal care, intrapartum care and postnatal care. Apart from women's general needs and concerns, research has highlighted a range of issues or problems which occur at the various stages of the 'cycle' and which also have an important bearing on the degree to which women may feel that they are in 'control' of the process of becoming a mother. At the intrapartum stage, for example, the degree of physical freedom which service providers allow women during delivery is a feature of care regarded by many women as an important aspect of the quality of the care being provided (Cartwright 1979). At the postnatal stage, by contrast, such issues as infant feeding, infant health and infant development all figure prominently as key areas of concern (Oakley 1979, Boyd and Sellers 1982).

Having identified both the general maternity care needs and preferences of women service users together with some of the more 'stage-specific' issues or concerns highlighted by extant research on women's experiences of 'modern' or 'pre-reformed' maternity care provision, one is then faced with the problem of how one might assess whether these needs are being 'satisfied' or met within the 'new' NHS.

**Assessing the Degree to which Women's Maternity Care Needs and Preferences Have been Satisfied within the "New' NHS**

The use of patient or consumer 'satisfaction' surveys as a means of soliciting lay opinion about medical care is relatively common-place within public organisations like the NHS. As several critics have pointed out, however, the reliability and validity of the findings of this type of survey have been questioned at several levels. Attempts to determine whether or not service users are 'satisfied' with the *general* or overall 'quality' of the service they receive tend to show that the majority of people and patients are happy with the service they receive (Fitzpatrick, 1984, Reid 1994). Fitzpatrick comments that such evidence " ... sharply challenge[s] any simplistic notion of a profound and widespread disenchantment with modern medical care." (Fitzpatrick, 1984, pg. 162).

However, when satisfaction surveys focus attention on *specific* aspects of medical care, much higher levels of patient *dis*satisfaction are recorded. (Fitzpatrick, 1984, Williams & Calnan, 1992, Reid 1994) The level of criticism or dissatisfaction identified by such surveys has also been found to vary according to the way in which questions are asked. Less critical responses are elicited when 'open-ended' questions are used, than when more direct and specific questions are asked. In addition, aside from the specific 'operational' criticisms mentioned above, a fundamental criticism has also been levelled at the concept of 'satisfaction" itself. In their review of patient/consumer surveys, Locker and Dunt, conclude that

> " ... it is rare to find the concept of patient satisfaction defined and there is little clarification of what the term means either to researchers who employ it or respondents who respond to it." (Locker & Dunt, 1978, pg. 282)

Indeed, Williams (1994) suggests that since lay conceptions of health and illness are complex, lay beliefs about the value (or otherwise) of medical care cannot be expressed simply in terms of the degree to which the individual is satisfied or dissatisfied with such care. Whether or not this really is the case is a moot point. The relative complexity of lay beliefs does not in itself *intrinsically* prevent one from asking whether a service user is satisfied with the medical care they are

receiving or not. The real point is that one wishes to know, in addition, is precisely what it is that the user is unhappy *about.*

The principal difficulty one encounters here is that the degree to which the service user is aware of his or her own needs - and, consequently, the extent to which they are able to determine whether or not those needs are being met - is in part a function of their relationship with the service provider. As both Stimson and Webb's study of the consultation process in General Practice and West's study of the interactions between doctors and parents of children with epilepsy illustrate, patients' views about the nature of their condition and, consequently, their evaluation of the medical care provided to them, fluctuate over time as they reappraise their experience of the consultation process in the light of changes in their symptoms. (Stimson & Webb, 1975, West 1976 )

Finally, Calnan points out that satisfaction surveys typically suffer from what he terms a 'managerialist bias'. Potentially critical questions which may cause the service providers some concern or embarrassment are often avoided by such studies, especially questions which permit the service user to express his or her views about the relative competence of the service providers(Calnan, 1988).

In the light of these problems with patient/consumer satisfaction surveys, Williams and Calnan suggest that "... the nature of lay thought in this area calls for more detailed qualitative, or ethnographic research; studies that are likely to yield far richer insights and do justice to the complexity of the issues involved." In the meantime, they suggest that satisfaction surveys are likely to be of only limited value, until "... they manage to free themselves..." from these conceptual and methodological problems. (Williams & Calnan, 1996, p15-16) Williams & Calnan also note that qualitative or ethnographic studies of lay experiences of modern medicine are rare - with the notable exception of feminist research on women's experiences of medical care and technology and sociological research on chronic illness (Ong and Shiels 1991).

In a number of respects, Williams and Calnan's analysis seems to throw the baby out of the window with the bath water. One can make a strong case for the value of researching the complex nature of lay beliefs about health and illness in greater detail, using qualitative and ethnographic research methods. But this

remains a separate issue from the problems surrounding the use of the concept of 'satisfaction' in the evaluation of service users needs and service producers effectiveness. Taken at face value, Williams and Calnan's observations appear to rule out of consideration the general question of whether service users are satisfied with the kind of medical care provided for them. The point at issue is not whether one should attempt to examine lay evaluations of care using either qualitative / ethnographic or quantitative / structured methods. The real question is whether one can effectively address the problems associated with the use of the concept of patient satisfaction, so that questions about patient's perceptions of the relative effectiveness of health services can be investigated.

As Williams and Calnan's review indirectly acknowledges, in the case of maternity care it *is* possible to identify the specific dimensions of women's maternity care needs and preferences with a reasonable degree of confidence, due to the extensive body of research which already exists on this topic. What is more, much of this research is retrospective in character. Although the act of reflecting on and recalling past experiences poses its own methodological problems, (Burgess 1984) the identification of users needs and preferences *after* the service user has received such care has certain advantages. The criticism made by Stimson and Webb (op cit.) and West (op cit.) that any attempt to determine whether a patient's needs are being met or satisfied by the service provider, using a patient satisfaction survey, may be vitiated by the fact that service users needs can change as a consequence of their experience of receiving health care services is an important point. The identification of patients needs and preferences, using research which reviews the patient's experiences after the care has been delivered, helps to overcome this problem. To begin with, this approach allows one to identify needs and preferences in a generally reliable and valid way. Following the identification of such needs/preferences, one can then proceed to assess the degree to which women service users believe their needs are met or satisfied by the service they receive, in a direct and specific manner, using either an interview schedule or a questionnaire.

By using existing research into women's maternity care needs and preferences in this way, the panel study is able to address many of the criticisms levelled at previous attempts to apply the concept of satisfaction to the question of whether services users needs are met by the medical/health care they receive. One over-

riding difficulty still remains, however. A central problem with the use of the term 'satisfaction', mentioned earlier, is that its meaning and use is rarely ever defined. To put this another way, the concept of 'satisfaction' is 'untheorised'.

One way of approaching this problem is to begin from the position that our understanding of the concept of 'satisfaction' is as much a question of understanding the way in which it is *used*, as it is of *defining* its 'meaning'. A valuable point of reference here concerns the work of the American organisation theorist, Tannenbaum.

In his work on inequalities within organisations, Tannenbaum developed a measure of the structure of inequalities within organisations, using the concept of a "control" graph or curve. (Tannenbaum, 1968) A "control" graph or curve attempts to show the comparative degree of control or influence which different groups within an organisation exercise over a key set of organisational decisions. Tannenbaum suggests that in order to 'measure' the relative influence or degree of control which the membership of each group is able to exercise over decisions, it is necessary to make two separate types of assessment. To begin with, an assessment has to be made of the extent to which the membership of different organisational groups or strata are *'satisfied'* with the influence or control which they have over these various areas of decision-making. At the same time, Tannenbaum argues, it is also essential to assess the level of *importance* or significance which the membership attaches to a specific issue or area of decision-making. Whilst individuals or groups may report that they are 'satisfied' with the amount of control or influence that they have over a particular issue or area of decision-making, the issue or decision itself may be a matter of comparatively little or no importance them, or conversely a matter of great importance. Tannenbaum points out that in order to assess whether or not a particular group feels that it is able to exercise some influence or control within an organisation, one must therefore consider both the issue of *satisfaction* and the issue of *salience.*

Tannenbaum's work suggests that any attempt to assess the extent to which women's maternity care needs or preferences are being met / satisfied by the newly 'reformed' NHS must take account of the relative importance or 'salience' which the service user attaches to these different needs or preferences. Although

research indicates that women service users have a range of different maternity care needs and preferences, this does not necessarily imply that women rate each need or preference as of equal importance. One might also reasonably assume that the relative ranking of such needs or preferences by the individual may well be affected by variations in the individual's social circumstances or background. Accordingly, the panel study makes a comparative assessment of both the extent to which panel members' were *satisfied* with the degree to which their maternity care needs or preferences were being met by the 'new' NHS, *and* the relative importance or *salience* which panel members attach to these needs or preferences.

In order to answer either question, however, one must begin by examining the pattern of utilisation of maternity care services by panel members, since this clearly affects the potential reliability and validity of service users evaluation of such services.

**Panel Members' Pattern of Use of GP- Based Antenatal Care**

The first point of contact with NHS maternity care services for the majority of women typically involves a visit to their local GP, having either confirmed that they are pregnant (through the use of a home testing kit / chemist test) or as a means to determine their own initial evaluation of this matter. Women's experiences of GP-based antenatal care often constitutes the initial stage of what is ultimately a lengthy process of further engagement or involvement with the NHS. In order to assess the relative validity and reliability of panel members' evaluation of the antenatal care which they received, it is important to determine the point at which initial contact with the antenatal services was first established, as well as the subsequent pattern of service utilisation. Women who register their pregnancy at a relatively advanced stage of conception and/or attend antenatal clinics on an infrequent basis are likely to produce a less reliable/valid evaluation of the quality of the service on offer, compared with service users who register and attend on a more frequent basis.

Bearing in mind the relative inexperience of the panel in relation to pregnancy and motherhood, (approximately 4 out of 10 panel members were 'first time' mothers at the time they were making use of the antenatal services), it is not

perhaps surprising to find that over half of the sample (61%) had seen their GP by the time they were 8 weeks pregnant, with a further 29.4% visiting their GP before the 13 week of pregnancy. In practice, however, there proved to be little difference between first and second time mothers concerning the point at which women first see their GP. The majority of both first time mothers (57.7%) and second (+) time mothers (56.0%) first went to see their GP 4 - 8 weeks into their pregnancy. This corresponds with the findings from a number of other surveys which suggest that the most common time for women to first go to their GP for antenatal care is usually before the 10th week of pregnancy (C.f. e.g. Graham and McKee 1979; Changing Childbirth in Newcastle upon Tyne, 1994) On this basis, the pattern of behaviour of a clear majority of panel members appears to be relatively conventional or 'normal', as the following table illustrates in more detail :-

Table 9:1: Number of Weeks into pregnancy when panel members first visited their GP

| Time of First Visit to GP (weeks pregnant) | % of Panel (n=282) |
|---|---|
| under 4 | 2.8 |
| 4-8 | 57.8 |
| 9-13 | 29.4 |
| 14-18 | 6.7 |
| 19-23 | 1.8 |
| more than 23 | 1.1 |

Almost 6 out of 10 respondents contacted their GP practice within the first 8 weeks of their pregnancy, and this proportion had risen to almost 9 out of 10 of the panel by the thirteenth week of pregnancy. The level of utilisation of GP-based antenatal care, as judged by the frequency of use, also proved to be relatively high, as Table 9:2 (overleaf) illustrates.

During the period of their pregnancy, two thirds of the panel saw their GP on 5 or more occasions. Community midwifery services were used by panel members to a slightly greater extent with nearly 4 out of 10 (37.6%) of respondents seeing their midwife between 5 and 8 times and approximately 3 out of 10 (29%) seeing their midwife more than 9 times during the course of their pregnancy. Such a

pattern of service utilisation coincides with the findings of Hall et al's study of ante natal care which noted that " ... the great majority of women attend [for ante natal care] early, regularly and assiduously... [as] most believe that in principle ante natal care is important for the progress of the pregnancy and the health of the baby ..." (Hall, 1985, p23)

Table 9:2 Frequency of panellists visits to GP and Midwife during their Pregnancy

| How many times seen | % of panel who saw GP | % of panel who saw midwife |
|---|---|---|
| 0 - 4 | 35.1 | 33.0 |
| 5 - 8 | 40.1 | 37.6 |
| 9 - 12 | 13.8 | 19.1 |
| 13 - 16 | 7.4 | 6.0 |
| 17 + | 3.2 | 3.9 |

Blaxter and Patterson's study of the pattern of health care utilisation amongst a 'working class' sample respondents in Aberdeen suggests that it would be unwise, however, to regard the pattern of utilisation of health care services as something which is unrelated to the influence of the individual's social background. (Blaxter & Patterson 1982) In general, panel members seemed to utilise GP-based antenatal care services to a reasonably high degree, and in a manner which almost certainly reflects the cultural influence of the majority of panel members' middle class origins. This relatively high level of use of GP-based antenatal care by the panel as a whole is important. It indicates that the reliability and validity of evaluations of this sector of antenatal care by panel members is likely to be high, since any such evaluations reflect the direct use of these services by a majority of the panel over a relatively long period of time.

**Panel Member's General Evaluation of GP-Based Antenatal Care**

Panel members were initially asked to describe their overall level of satisfaction with GP-based antenatal care in general. A third of panel members (35.5%) reported that they were "very satisfied" with such care and a further half (51.1%) that they were "fairly satisfied". This result corresponds reasonably closely, moreover, to the findings of an earlier study by Hall et al (1985, p93) (illustrated

below) which was conducted during the period before the NHS reforms were implemented :-

Table 9:3 Overall Satisfaction (%) with GP based antenatal care

| | Hall et al (1985) | Panel Study (1992)* |
|---|---|---|
| Very Satisfied | 52 | 35.5 |
| Fairly Satisfied | 32 | 51.1 |
| Mixed Feelings | 15 | 9.5 |
| Fairly Dissatisfied | 1 | 3.9 |
| Very Dissatisfied | 0 | 0 |

(* Antenatal Stage)

As the above comparison indicates, at a general level at least, a large proportion of service users appear to be reasonably happy with GP-based antenatal care, both before and after the implementation of the NHS 'reforms', even though the proportion of those who are 'very satisfied' with such care is undoubtedly lower amongst the 'post-reform' panel sample. However, such findings may reflect a common tendency for users of health services to respond in a positive manner whenever asked to indicate whether they are satisfied with the *general* quality of the care they received (Fitzpatrick, 1984, Williams & Calnan, 1992) Studies of consumer appraisal of any kind of service, but especially of professional services such as medicine, are dogged by the problem of low consumer expectations, and in the UK, by the tendency towards a "resigned acceptance", although such attitudes do appear to be changing. (Mason 1989, Martin 1990, Calnan et al 1994; Williams and Popay 1994) Furthermore, although the overall level of "satisfaction" with the quality of service provision often appears to be high, such results frequently "mask" considerable levels of *dissatisfaction* with *specific elements* of the delivery and organisation of such services, as pointed out earlier in the current chapter. (Fitzpatrick 1984; Williams & Calnan, 1992; Reid 1994).

Consequently, respondents were asked not only about both their *overall* levels of satisfaction with the quality of the GP-based antenatal care that they had received but also about their degree of satisfaction with *specific* features of such care (outlined earlier in the present chapter) using a five-point scale, ranging from 'very satisfied', 'fairly satisfied', 'neither satisfied nor dissatisfied', 'fairly

dissatisfied', to 'very dissatisfied'. Given that there may be some reluctance on the part of service users to be 'critical' of service provision, the distinction between 'very' and 'fairly' satisfied may be more important than it might at first appear. Overt or 'strong' critical responses are likely to be rare.

**The Degree of Panel Members' Satisfaction with Specific Features of GP-based Antenatal Care**

The responses of the panel to a series of specific questions about particular aspects of GP-based antenatal care indicates that panel members were satisfied with certain features of such care more than others. The aspects of such care which were viewed in a generally positive light included, for instance, the quality of the physical environment in which such care was provided, the degree of privacy provided and the perceived convenience of clinic opening times. When asked about the physical 'environment' at their GP surgery 3 out of 10 (29.2%) of panel members said that they were "very satisfied" with this, with a further 51.1% indicating that they were "fairly satisfied". Similarly, more than a third of respondents indicated that they were "very satisfied" with the levels of privacy afforded to them when they visited antenatal clinics, and a further 56% said that they were "fairly satisfied" with the privacy they were given. The convenience of antenatal clinics also elicited an apparently high level of approval from the panel. More than three quarters of the panel were positively satisfied (either "very satisfied" or "fairly satisfied") with the times at which such antenatal clinics were held, whilst only 6% of respondents expressed any form of dissatisfaction.

In contrast, the response of panel members to questions about the length of time they had to wait, the quality of the information provided to them, the degree of attention paid to their own comments / concerns by service providers and the degree to which they felt that they had been involved in decisions about their own care, were considerably less favourable. In the case of waiting times, for instance, only 1 in 5 respondents (19.9%) said that they were "very satisfied" with the waiting times that they encountered, the majority of respondents (47.9%) indicating that they were "fairly satisfied". However, 15% of panel members were overtly dissatisfied (either "fairly dissatisfied" or "very dissatisfied") with the length of time they had to wait. When asked about the length of time women had to wait, 4 out of 10 (41.4%) reported that they were

seen within 15 minutes of their appointment time, with a further 40 % indicating that they had to wait between 15 and 30 minutes. The remainder of the panel reported waiting times in excess of 30 minutes after their appointment time before being seen.

Respondents' views about the quality of the information provided to them are even more negative, with a quarter of the panel describing themselves as either 'neither satisfied nor dissatisfied', 'fairly dissatisfied' or 'very dissatisfied', and only one quarter of the panel (25.1%) describing themselves as 'very satisfied'. This particular result confirms the findings of several 'pre-reform' surveys of antenatal maternity care services, which indicated that many service users feel that this aspect of the delivery of modern maternity care service provision fails to meet their self-perceived needs. Hall et al comment that in their study -

> " ... women sometimes found that their questions about the pregnancy, or any anxieties they expressed...were met with placatory comments or injunctions [by service providers] "not to worry" which they found far less reassuring or helpful than a direct answer would have been. Some women were made to feel silly for having asked questions." (Hall et al, 1985, p23)

One mother in Oakley's study described in her own experiences of this particular problem in the following graphical manner -

> " ... the doctor has a quick feel around and he says "right, we'll see you in 4 weeks time. And that's it, in and out in a couple of minutes. Well, I suppose they know what they are doing: if there was anything wrong they would have said so. I haven't had any bad treatment...but I suppose they get so many people, when they say their bit at the end it's all automatic, like parrot, no tone in the voice. They say it off pat...there's no personal touch at all. You're just a body to them..." (Oakley, 1979, p28)

More recently, an OPCS survey (Mason 1989) suggested that there was an unmet need among women for further information and advice. Over half the women (55%) in the OPCS study said that during pregnancy they would have liked more chance to talk to someone for advice and 50% of mothers wanted substantially more information on all aspects of childbirth.

Despite the emphasis placed, at a national level, on involving women in decision about their care and providing information which facilitates informed choice, it is apparent that the situation outlined by the recent House of Commons Health Committee review of maternity care is reflected in the attitudes and experiences of many panel members. The Winterton report (1992) observes

> " ... many women do not have access to as much information as they feel they need...in order to make effective choices, women need basic information, and sometimes this is not even available to Community Health Councils...too often [women] experience an unwillingness on the part of professionals to treat them as equal partners in making decisions about the birth of their child." (Winterton Report 1992, page xvii)

The significance of this problem is further underlined by a review of NHS maternity care services undertaken by the Audit Commission in 1997. This concluded that " ... a substantial number of women are not satisfied with the information that they receive." (p20). Indeed, whenever evaluations of the organisation of health care in general are carried out, service users as a whole are typically dissatisfied with the limited amount of information which they receive from service providers (Byrne and Long 1976, Shapiro et al 1983).

The extent to which panel members had been involved in choices about their treatment or pattern of antenatal care was also a source of dissatisfaction. Less than one quarter (22.7 %) of the panel said that they were "very satisfied" with this aspect of GP-based antenatal care, whilst 3 out of 10 respondents (31.7%) felt unable to express any degree of positive satisfaction with they way in which they were involved in their care.

A similar outcome is recorded in a national survey conducted by MORI, the results of which suggested that " ...discussions between women and professionals about the choices available for both antenatal care and delivery were limited" (NHSE, West Midlands 1996, p18), whilst a recent review of maternity care services by the Audit Commission found that service providers discussions with women regarding care options were inadequate in 61% of cases (Audit Commission 1997, p20)

Finally, on an issue which is closely related to the degree to which service users

are involved in choice about their care, 1 in 10 (10.1%) were actively dissatisfied with the limited notice taken of their own comments/opinions by GP`s and midwives and 1 in 5 (17.7%) were neither positive nor negative in their response. Only slightly more than a quarter of respondents (27.7%) reported that they were "very satisfied" with this aspect of GP-based antenatal care.

## The Satisfaction of Panel Members' Maternity Care Needs/Preferences and the Concept of Salience

Panel members are clearly more satisfied with some aspects or features of GP-based antenatal care than with others. It might therefore be assumed that those aspects or features of such care with which the panel members are most 'satisfied', fulfil the 'needs' or 'preferences' of the service user. This is, however, a more complex issue than might initially appear. Studies which rely solely on the concept of 'satisfaction' as a basis for determining whether the user's needs/preferences are being met, ignore a crucial additional issue or question. This concerns the degree of importance or salience which users attach to certain features of the service which they receive, an issue highlighted in an earlier reference to the work of Tannenbaum on organisational analysis. However, as Poole & Peccei (1979) point out, Tannenbaum's application of the concepts of satisfaction and salience to the study of inequalities in organisations is of limited value, due to the highly 'positivistic' assumptions which underpin his method of analysis. The core concepts of satisfaction and salience, on the other hand, have a more general explanatory utility and applicability and are potentially of much greater value or worth. Poole & Peccei also point out that the *relationship* between the concepts of satisfaction and salience is under-theorised in the context of Tannenbaum's analysis. The relationship between the two concepts is complex. There are, I would argue, several possible relationships between these two concepts, each of which results in a differing degree of influence / control on the part of the individual - viz.

(1) High Salience combined with High Satisfaction = A High Degree of Influence/Control/Choice experienced by the Actor (Respondent)

(2) High Salience combined with Low Satisfaction = A Low Degree Influence/Control/Choice experienced by the Actor (Respondent)

(3) Low Salience combined with High Satisfaction = ? Satisfaction of 'presumed' needs of Actor / service user by others, perhaps?

(4) Low Salience combined with Low Satisfaction = ? An 'irrelevant' area from the Actor / Respondents perspective?

Whilst combinations 1 and 2 appear to readily explicable examples of inequality within organisations, combinations 3 and 4 are much more difficult to theorise.

Combinations 1 and 2, for example, can be accounted for using a 'zero-sum' conception of 'power' (Mills 1956). Where the actor / respondent is able to achieve or realise his/her preferences then this could be assumed to reflect their ability to get their own way, if necessary in opposition to the contrary intentions or preferences of another individual or group - for example the service provider (and vice-versa). Of course, a 'non-decision' making conception of power (Backrach and Baratz 1963) might suggest that the actors' priorities may be limited through a restriction of knowledge about the range of alternatives available - a restriction achieved by the deliberate withholding of information on the part of others (for example; information concerning the comparative risks of home and hospital deliveries). Certainly, combination 3 is difficult to theorise, since this might be thought to imply that the needs / priorities of service users are being determined by others, and that this also represents the 'non-decision making' concept of power. However, the fact that low salience is attached to a particular issue indicates that the actor / service user refuses to accept that the issue is of any real importance.

Not withstanding these potentially complex issues of interpretation, in the context of the current study of women's experiences of maternity care in the 'new' NHS, the addition of the concept of salience to the study of women users degree of satisfaction with the responsiveness of the new regime to their needs raises a number of important additional issues. The identification of these issues would have been difficult, if not impossible, if one had to rely solely on measures

of service users degree of 'satisfaction' per se.

## The Degree of Importance (Salience) Attached by Panel Members' to Specific Features of GP-based Antenatal Care

In the case of respondents attitudes towards waiting times, for example, whilst only slightly less than 1 in 5 respondents are 'very satisfied' with this aspect of GP-based care, over one third of panel members described waiting times as "very important", with a further 49.3% indicating that waiting times were "fairly important". As Appendix I illustrates, second time mothers rated waiting times as more important than first time mothers (which may be accounted for by second time mothers additional childcare considerations). Such attitudes re-enforce the findings of earlier studies, in which women criticised the length of time that they had to wait in antenatal clinics. Many felt that the whole antenatal experience was impersonal and " ...like a cattle market production line". (Rakusen and Davidson 1982; Oakley 1979; Reid and McIlwaine 1980). Conversely, whilst nearly 8 out of 10 respondents were either "satisfied" or "fairly satisfied" with the environment at their GP surgery, only 15.6% said that they thought that this was a "very important" aspect of service provision.. Nearly 3 out of 10 (28.8%) respondents rated such a feature as fairly unimportant. In other words, a high level of recorded satisfaction with any particular feature of maternity care does not necessarily imply that that aspect of care satisfies some highly valued need or preference.

A detailed consideration of the degree of importance or salience ascribed to other features of GP-based antenatal care underlines this point further. For instance, only 13.8% of the panel regarded clinic times as "very important" , but almost three quarters reported themselves to be very or fairly satisfied with this aspect of the service. Half of the panel thought that clinic times were "fairly important", whilst 3 out of 10 respondents did not hold any opinion on the subject and 3.2% felt that the issue was "fairly unimportant". Such a response may of course reflect the tendency for a high proportion of women in the 1990's to receive antenatal care whilst still in paid employment. The timing of clinics may present relatively few problems for the majority of attendees since they have a statutory right to time off whilst at work to attend routine antenatal care.

On the relative importance of the provision of information to women by medical personnel during the antenatal phase, by contrast, three quarters of the sample (75.9%) said that this issue was "very important", and a further 21.6% indicated that this feature of service provision was "fairly important". On the other hand, only one quarter of the panel described themselves as 'very satisfied' with the element of the service, whilst a further quarter expressed active dissatisfaction. As the Winterton Report points out, for the great majority of women, the provision of information is clearly a cornerstone of "maternal need" during pregnancy, an issue which is in turn closely associated with the degree to which women feel able to make " ...fully informed choices about their care, their carer and their place of birth." (Winterton Report, 1992, page xix)

As with the provision of information, mothers also rated the importance of being involved in discussions about the choice of care very highly indeed. Two thirds of respondents (66%) said that this was a "very important" feature of GP based care, whilst a further 28.7% reported that this was "fairly important". Once again however, only a relatively small proportion of the panel (less than one quarter) described themselves as very satisfied with an issue which was clearly of some considerable importance to a large majority of panel members. The significance of maternal involvement in choices regarding care has been well documented by previous research into this field, as Kitzinger notes ;

> " ... women who feel that they can retain control over what is happening to them...who understand the options available and are consulted...are much more likely to experience birth as satisfying than those who are merely at the receiving end of care, however kindly that care...life events may be endured as processes over which one has no control, or perceived as experiences in which one is a decision-maker and active participant."(Winterton Report, 1992, page xvi)

The majority of research in this field has established that pregnant women often appear to experience antenatal care as a stage of maternity care which is typified by a lack of information in several key areas (Oakley, 1979, 1980; O'Brien and Smith 1981, Macintyre 1981; Graham and McKee 1979,1980, Kirkham 1983, OPCS 1989, Jacoby 1988). The implications of this are spelt out in the Winterton Report, whose authors observe, " ... even the most articulate and assertive women may have difficulty achieving maximum choice in their contact with the

maternity services." (Winterton Report 1992, page xv)

In considering the extent to which panel members felt that their own views and concerns were given consideration during their antenatal clinics, the panel study revealed that nearly two thirds of respondents (64.5%) indicated that this issue was "very important" to them, and an additional 31.9% said that this was a "fairly important" matter. However, only 27.7% described themselves as being very satisfied with this aspect of their care. This particular result recapitulates the findings of several pre-reform studies of maternity care. Such research illustrates that only a slight majority of women feel that their preferences are respected in practice. As recent research in Newcastle-upon-Tyne (1994) found, only 55% of service users (n=216) expected that their own care / treatment preferences would be taken account of by service providers. Additionally, the Newcastle survey also highlighted the fact that as mothers re-use the maternity services as second (+) time mothers, the extent to which they feel that their preferences will be acted upon decreases. 66% of first time mothers indicated that they thought their preferences would be followed, compared to just 54% of second (+) time mothers.

The issue of privacy would appear, prima facie, to be an important aspect of care as half of all panellists said that this was a "very important" feature of service provision. Indeed, a further 41.5% of panellists indicated that privacy was "fairly important". This is especially interesting since this is the *only* dimension of care assessed by the panel study where needs or preferences defined as especially salient or important by the service users appeared to have been satisfied by the service providers.

**Panel Members' Evaluation of Specific Features of GP-based Antenatal Care: Satisfaction and Salience Compared By Ranked Position.**

From the responses of the panel regarding GP based antenatal care, it is apparent that if one *ranks* those elements of service provision according to whether the users of the service are very satisfied with them and compares the results with the ranking of the same service features according to salience, considerable disparities emerge as the following table illustrates.

TABLE 9:4 Respondents Evaluation of GP Based Antenatal Services: The Comparative Rank Order of Satisfaction and Salience / Importance (ranking of % response)

| | | % Very Important | % Very Satisfied |
|---|---|---|---|
| (i) | Information | 1 | 4 |
| (ii) | Choice in Treatment | 2 | 5 |
| (iii) | Attention Given | 3 | 3 |
| (iv) | Privacy | 4 | 1 |
| (v) | Time Waiting | 5 | 6 |
| (vi) | Surroundings | 6 | 2 |
| (vii) | Clinic Times | 7 | 7 |

One of the principal features of panel members' attitudes towards GP-based antenatal services within the "new" NHS concerns the apparent "mismatch" between the key priorities of women users, and the extent to which these are met or satisfied. As the above table clearly demonstrates, the ranking of women's most salient needs/preferences stands in an almost inverse relationship to the ranking by degree of satisfaction. Respondents are relatively *dissatisfied* with those aspects of the service which they regard as of *greatest importance* to them (most notably information provision and choice in care). Conversely they are either relatively *satisfied* with some aspects of GP-based care which are of the *least importance* or significance to them, or *dissatisfied* in areas which are of relatively *low* importance.

If one compares the relationship between satisfaction and salience over each of the 7 aspects of care listed above then, in respect of information provision, attention given to one's own concerns and opinions and the degree of women's involvement in care choices (i.e.; those aspects of service content) the level of salience is *higher* than the level of satisfaction. In the diagrammatic representation of the relationship between salience and satisfaction presented earlier, this reflects a situation of *low control* for the service user, in a relatively unambiguous way.

As far as the remaining aspects of GP-based antenatal care are concerned, all of which concern the *context* in which antenatal care is delivered, the only aspect of which appears to satisfy panel members' needs concerns relates to the level of

privacy provided. In this case, a *high* level of satisfaction is combined with a *high* level of salience, which, theoretically could be said to reflect a situation of *high control* for the service user, the issue of 'non-decision making power' not withstanding.

As pointed out earlier, at a theoretical or explanatory level, this is a complex relationship, which is susceptible to a number of different interpretations. At the very least, one might argue that in respect of the *context* in which care is delivered (particularly the physical environment and privacy), service providers may well be attempting to satisfy 'needs' which they presume, incorrectly, are of some importance to service users. Interestingly, a Consumers Association national survey of GP services in general, suggests that GP's and patients hold somewhat different priorities in respect of service provision. (Steele 1992). GPs are inclined to stress the importance of the 'context' (physical and temporal) within which their consultations took place, and it is in this area that improvements in modern maternity care services are most apparent. Patients, on the other hand, are more inclined to stress the importance of the 'content' of such services.

The key elements of GP-based *antenatal* care which were identified by panel members as areas in which their needs or preferences are not met - information, choice and communication - resemble the findings from earlier 'pre-reform' research on antenatal care. Hall et al's study, for example, discovered that -

> "...women's response to antenatal care [is] characterised by...disappointing experiences [particularly a] lack of information or advice and poor communication." (Hall et al, 1985, p34).

Furthermore, panel members' experiences of hospital-based antenatal care in the 'new' NHS replicates almost exactly their unsatisfactory experiences of GP-based antenatal care. Indeed, respondents overall level satisfaction with hospital-based care was significantly lower than their overall level of satisfaction with GP based antenatal care ($p=0.05$).

## Panel Members' Pattern of Use of Hospital-Based Antenatal Care

The large majority of respondents (87%) attended hospital antenatal clinics for a number of routine appointments during the course of their pregnancy, although 1 in 10 said that they had visited hospital for an ultrasound scan only. In the case of the majority of the panel therefore, the responsibility for the delivery of antenatal care was 'shared' between GP clinics on the one hand and the local hospital on the other. Almost 4 out of 10 panel members attended a hospital antenatal clinic for the first time between 9 and 13 weeks into their pregnancy whilst a further 41.1% attended such a clinic approximately 16 weeks into their pregnancy. The majority of the sample (41.5%) reported using hospital antenatal services less than 4 times over the course of their pregnancy, with approximately 1 in 8 (13.8%) of panellists utilising such services on more than 8 occasions. Although the pattern of antenatal care is 'shared' between community-based and hospital-based antenatal services, panel members were clearly more involved, in a purely practical sense, in the activities of the former than the latter. This does not necessarily imply that respondents viewed GP-based care as more important however. Nonetheless, this seemingly greater level of involvement of women in GP-based care at the antenatal stage of the maternity care 'cycle' is rather surprising, given that intrapartum care (labour and delivery) is wholly hospital-based. At the initial point of entry into the maternity care 'cycle', panel members seem to spend most of their time interacting with service providers who have little *direct* involvement in the later stage of labour and delivery. Not surprisingly, in view of the foregoing, the panel's general level of satisfaction with hospital-based care was significantly lower than their general level of satisfaction with GP-based antenatal care.

## Panel Members' General Evaluation of Hospital -Based Antenatal Care

By comparison with the relatively high level of general satisfaction with GP-based antenatal care, where almost 86% of panel members reported that they were either 'very' or 'fairly' satisfied with such care, only slightly more than 6 out of 10 panel members (65.7%) described themselves as either 'very' or 'fairly' satisfied with their experiences of hospital-based antenatal care. This is comparatively low, especially when one considers the common tendency, referred to earlier, for service users express relatively high levels of general

satisfaction when asked about the service that they have received. (Fitzpatrick 1984). Whilst a third of the panel reported that they were "very satisfied" with their GP-based antenatal care, this figure falls to 16.5%. in the case of hospital-based antenatal care. Additionally, more than a third of respondents (33.2%) failed to express a positive opinion about the care that they received from hospitals during pregnancy, with almost 1 in 5 (19.2%) expressing active *dissatisfaction* with such care.

These results echo women's experiences of hospital maternity care in the pre-reform era, (e.g. Oakley 1979,1980; Kitzinger 1979, Hall et al 1985) as the following table illustrates, which compares overall or 'global' measures of service users satisfaction with hospital antenatal care from Hall et al's study and the Panel Study.

Table 9:5 Overall Satisfaction with Hospital Antenatal Care

| Satisfaction Scaling | Hall et al (1985) % Response | Panel Study (1992*) % Response |
|---|---|---|
| Very Satisfied | 40 | 16.5 |
| Fairly Satisfied | 43 | 49.2 |
| Neither Satisfied / Dissatisfied | 12 | 15.0 |
| Fairly Dissatisfied | 5 | 16.5 |
| Very Dissatisfied | 0 | 2.7 |

(* Antenatal Stage)

**The Response of Panel Members to Specific Elements of Hospital Based Antenatal Care**

Not only are panel members less satisfied with the overall (general) quality of hospital-based antenatal care compared with GP-based antenatal care, but levels of satisfaction with the provision of *specific* aspects of hospital care are also comparatively low, especially when compared with GP-based antenatal care.

Only a comparatively small proportion of respondents, for example, indicated that they were "very satisfied" with each of the specific aspects of the antenatal care that they received from their hospital, and a large proportion of the panel expressed dissatisfaction with several key elements of care.

Table 9:6 Respondents Satisfaction with Key Features of Hospital Antenatal Care (n=282)

| | Very Satisfied | Fairly Satisfied | Neither | Fairly Dissatisfied | Very Dissatisfied |
|---|---|---|---|---|---|
| Waiting Times | 2.5 | 19.1 | 15.6 | 36.5 | 19.5 |
| Surroundings | 5.3 | 44.3 | 29.8 | 12.8 | 1.1 |
| Privacy | 9.9 | 54.6 | 17.4 | 8.5 | 2.5 |
| Information | 16.3 | 39.0 | 17.4 | 16.0 | 3.9 |
| Clinic Times | 6.4 | 48.6 | 27.7 | 9.6 | 0.7 |
| Attention Given | 16.0 | 41.0 | 17.0 | 13.8 | 3.9 |
| Choice in care | 19.5 | 36.5 | 17.7 | 12.4 | 6.4 |

In a manner which closely replicates other 'pre-reform' surveys of NHS maternity services (Oakley 1979, 1989, Arms 1975, Cartwright 1979, Hall et al 1985), a principal area of dissatisfaction for panel members was the length of time spent waiting in hospital antenatal clinics. An OPCS study (Mason 1989) carried out immediately prior to the implementation of the NHS reforms, found that only 25% of women using hospital antenatal clinics regarded their waiting times as acceptable. Amongst the panel, the majority of respondents (40.1%) reported that they waited for more than 45 minutes before being seen, with a further 3 out of 10 (31,2%) waiting between 30-45 minutes. Only 1.3% indicated that they were seen within 15 minutes of their hospital antenatal clinic appointment time.

However, aside from the high level of dissatisfaction about waiting times at hospital antenatal clinics, which concerns the *context* in which the service is delivered, specific areas of overt dissatisfaction (where respondents were fairly or very dissatisfied) with hospital-based antenatal care relate largely to features of service *content.* For example, almost 1 in 5 respondents expressed overt dissatisfaction with the provision of information, the extent to which they were involved in care choices and with the attention that medical staff gave to their own concerns and views.

**The Importance (Salience) Of Specific Features Of Hospital Based Antenatal Services**

As far as the issue of salience is concerned, it is apparent that the major issues which were very important to panel members in respect of hospital antenatal care are :

* the provision of information (65.6% said this was 'very important))
* the extent to which women are involved in choices about their care (62.4% )
* the attention given by medical and nursing staff to what the women themselves had to say (61.3%).

By contrast the *context* in which such care was delivered, involving waiting times, opening times of the clinics themselves, the degree of privacy and the character or quality of the surroundings are rated far less highly. Less than 1 in 10 (9.6) panellists felt clinic times were very important, whilst only 12.8% said that the surroundings / environment were of high importance to them. Slightly more than one third of respondents (36.9%) rated waiting times as very important and 4 out of 10 (40.4%) said that privacy was a feature of high significance to them.

What is particularly striking about the level of importance or salience which panel members attach to specific aspects of hospital-based antenatal care is that their relative ranking, one to the other, is virtually identical to the assessments made by the panel in their assessment of specific aspects of GP-based care. That is to say, the quality of information provision, the degree of attention paid to respondents concerns and the degree of choice provided to service users are the three most important features of care (ranked 1, 2, and 3 respectively). The service 'context' (privacy, waiting times, environment and opening times ranked 4th 5th 6th and 7th). In evaluating respondents experience of these two forms of antenatal care (hospital-based and community-based), the principal difference concerns the lower levels of satisfaction with hospital services compared with GP based services. In the case of hospital-based antenatal care there is a noticeably higher level of dissatisfaction with the *context* in which such care is delivered, compared with GP-based care. Levels of satisfaction are lower in

respect of waiting times, privacy and surroundings in hospital than GP-based clinics. In the case of both GP and Hospital antenatal care however, the most notable or significant feature of respondents assessment of service delivery, concerns the particularly high degree of variance between salience and satisfaction in key areas of service *content* - information provision, level of involvement choice of care, attention given to one's own views.

**Respondents Experiences of Antenatal Tests / Scans Undertaken in Hospital**

All respondents indicated that they had at least one ultrasound tests during the course of their pregnancy and almost two thirds of the sample (65.4%) reported that they had had an alphafetoprotein (AFP) test (for spina bifida). Overall, the majority of women reported that they were either very satisfied (54%) or fairly satisfied (34.6%) with the information that they had been given regarding their ultrasound test(s), which may reflect a tendency for women to feel reassured by seeing their baby on a screen and being able to have a picture of the fetus - despite the fact that clinical opinion is divided as to the relative benefits of routine sonography (Enkin et al, 1995, p40-45).

However, when asked about specific tests, typically 'laboratory' tests involving notions of "risk" (eg.; amniocentesis, AFP test), it is clear that the majority of women require more information (possibly in a different format), than they currently receive. Of those who underwent an AFP test, less than a quarter (24.5%) were "very satisfied" with the information they had received and one fifth (19.3%) were actively dissatisfied.

Questions about women's overall level of satisfaction with the information provided about antenatal tests suggests that many women wanted more information about the tests that they experienced. Less than one quarter (21.9%) were very satisfied with the information they had received and 1 in 10 (13.5%) expressed dissatisfaction with this feature of antenatal care (with a slightly higher number of second time mothers expressing dissatisfaction with this aspect of care provision - 17.5% compared to 8.1% of FTM's). Such findings echo the results of several 'pre-reform' studies (Marteau et al 1988). Hall et al, for example, reported that "...49% of their sample had not been given as much information as they would have liked on...the results of any examinations and measurements [such

as]...the lie and position of the baby, the general progress of the baby, routine measurements (i.e.; blood pressure) special test results...".(Hall et al, 1985, p91) Enkin et al also note that women's experiences of ultrasonography in the 'new' NHS may be less than satisfactory, due to the fact that:

> "...the experience of having a scan, even if the findings are normal, can be unpleasant because of the uncommunicativeness on the part of the ultrasonographer. Some...may be put under professional constraints not to communicate freely with the women they are examining...uncommunicativeness can eliminate the potential psychological benefit of the examinations..."(1995, p43)

Whilst the majority of respondents in the current study *were* satisfied with their ultrasound tests, the problems outlined by Enkin may equally apply to the transmission of information on maters concerning fetal abnormality and / or 'risk'.

Before commenting on the broader implications of the evaluation of antenatal care which has been presented in this chapter, one final point which has to be considered is whether the foregoing analysis is likely to have been affected in any way by the social characteristics of the panel itself.

**The Panel's Evaluation of Antenatal Care in the "New" NHS and the Social Circumstances and Background of Panel Members**

A majority of panel members (53%) had one or more children prior to their current pregnancy. Do more experienced users of maternity care services respond in a significantly different way to such services compared with 'first time' mothers-to-be ?. If so, what effect does this have on the image of maternity care provision provided by a sample of respondents in which second time mothers are in the majority.? The relative priorities of first and second time mothers in the panel proved to be remarkably similar however, and the same was also true of the degree to which they are satisfied with antenatal care both at a general and at a specific level. (Appendix I) Hence, both 'first time' and 'second time' mothers thought that the *content* of antenatal care was far more important than the *context* in which such care was delivered, and both groups reported relatively low levels of satisfaction in areas which were of key importance to them, with less than 1 in

4 reporting that they were "very satisfied" with any aspect of the GP-based care they had received. The level of dissatisfaction was slightly higher amongst second time mothers than first time mothers in the three most important aspects of care (information provision, choice in care and attention given to their own concerns), but not to a significant degree.

This is not, arguably, all that surprising when one considers that since many first time mothers in the sample felt that the information given by service providers did not meet their self-perceived needs (evidenced by the relatively low proportion who were 'very satisfied' with this aspect of service provision), and given that they also felt that their opinions were not taken into account and they were not involved in choices about their own care regimes to the extent that they would, then they may be no better prepared for pregnancy and birth the second time around. It may also be the case that amongst women who have had previous experience of pregnancy and birth, their concerns, anxieties and questions do not diminish from one pregnancy to the next, since a second pregnancy is a separate entity in itself and may be a different experience both physically and socially. Whatever the reasons, it would appear that women's need for information on matters concerning pregnancy and birth does not diminish simply as a result of previous experience.

The only noticeable difference between the attitudes of 'inexperienced' and 'experienced' service users was in their attitudes towards hospital antenatal clinics. Second time mothers attached a greater degree of importance to waiting times than first time mothers (43.4% felt this was "very important" to them compared to 28.5%) - no doubt for the fairly obvious reason that, unlike first time mothers, second time mothers had to juggle childcare responsibilities during their pregnancy.

If anything, STM's were marginally more dissatisfied with the 'content' of hospital antenatal care than FTM's , though not to a significant degree. This may also reflect other deficiencies in the way in which services are delivered since, as one mother wrote in response to an invitation for comments on antenatal care

> "They [service providers] treat me as if I know it all...I might have been pregnant before, but this time I feel very different..."

Finally, although the social background of panel members was described in chapter 8 as predominantly 'middle class' in character, at least in economic terms, there are, nonetheless, notable variations in the class background of panel members. Such variations continue to exercise some influence on the individual's life chances if not necessarily on his or her life style, as The Black Report's study of class and health inequalities demonstrates. As the discussion of this topic indicated however, only a minority of panel members were in paid employment during stage 1 of the study. Consequently, one cannot examine variations in the class background of panel members directly, in terms of their own economic attributes or achievements for the majority of the panel. As an alternative, a detailed examination was undertaken of panel members maternity care needs and priorities according to differences in the educational background of panel members, since this is an important direct attribute of the individual and one often closely associated with occupational success, (Appendix 2) The most noteworthy outcome of this exercise was the remarkable degree of *similarity* in the maternity care priorities of women with different educational experiences.

**Summary and Conclusion**

The principal concern of the current chapter has been to evaluate panel members' experiences of antenatal care within the 'new' NHS. The primary motivation or interest behind this concern was to examine whether the NHS reforms have produced greater choice for service users in the area of maternity care. A review of research into women's maternity care needs in the 'pre-reform' era was presented in chapters 4 & 5 of the thesis. This review suggested that the service user's experience of modern maternity care, prior to the introduction of health care reforms in Britain in the 1990's, could be characterised as one in which the service user felt that she had little or no 'control' over the management of the process of pregnancy, labour and delivery. Control of this process was firmly located in the hands of professional groups of service providers, such as obstetricians and midwives. The reform process holds out the prospect of shifting the locus of this control from the service provider to the service user.

As the discussion in chapter 8 highlighted, the social characteristics and background of the panel's sample of women service users suggests that this group of respondents has many of the characteristics of a 'prototypical' sample.

That is to say, a group of people whose personal and social attributes are likely to particularly supportive of specific forms of social change. Despite this fact, panel members' experiences of antenatal care within the new NHS suggest that, across both the hospital and community sector, major problems still exist with the organisation and delivery of such care.

The main area of complaint concerns the *content* of such care, over which panel members feel that they little control. Panel members appear to be less concerned about the *context* within which care occurs, although the generally poorer quality of hospital-based care means that hospitals have to address problems or difficulties with both service content and service context. Overall, in both the hospital and community sectors of care, the analysis suggests that there is a deep-rooted mismatch between what service users want from maternity care services and what they get. In essence, women service users suffer from what might be termed, an information deficit. This is particularly relevant to any assessment of maternity care after the NHS reforms had been implemented, since the plethora of *pre-reform* research on maternity care shows that one of the over-riding needs of women users of modern maternity care is that of information.

In 1975, an ISSM study of 2,000 women found that there was "...clear evidence that many women were not given information they would have liked about various aspects of childbearing" (Cartwright 1979, p163). Furthermore, one fifth of first time mothers and one tenth of second time mothers felt that they needed to know more about labour and delivery during pregnancy (and this despite second time mothers having prior experience of the birthing process). In other words, a large number of women users of maternity services felt ill-prepared for both giving birth and motherhood itself. A number of further studies focusing of women's experiences of becoming a mother also identified information provision as a key area of dissatisfaction on the part of women service users. In a study of 66 first time mothers, Oakley (1979) highlighted that not being able to ask questions or having questions answered in an unsatisfactory manner was a *major* area of concern to mothers, and was one of the three major complaints about hospital based maternity services. Reid and McIlwaine (1980), in a study of hospital antenatal clinics also concluded that the provision of information to women failed to fulfil the needs of such clientele, since over a third (39%) reported that they were unable to find out all they wanted to know from the

doctor providing their hospital care. Such findings are not uncommon, Shapiro et al (1983, quoted in Reid 1994, p6) found that "...whilst 84% of women wanted to know about fetal deformities, only 21% of doctors identified the women's desire for such information". Furthermore, whilst women may have access to a wealth of information during pregnancy (from friends, specialist literature, women's magazines, NHS / NCT preparation classes) this does not necessarily meet their information requirements (Macintyre 1981). *Three fifths* of service users in Macintyre's study (n=50), for example, indicated that they would have liked more information about pregnancy and childbirth.

Community Health Council studies have also flagged up the problem of the perceived poor quality of information given to women by NHS staff. One CHC study (Newcastle 1979) found that 29% of respondents rated the information that they had been given at antenatal clinics as either "poor" or "very poor". This was also the case in a study by Hall et al which found that "49% of the women interviewed said that, whether or not they had asked questions of their attendants at some point in the pregnancy, they had questions which they planned to ask, or would have liked to ask, but did not" (1985, p92)

The provision of information to mothers on specific topics has also been the subject of a number of studies. Jacoby (1988), for example, found that women often felt that when monitoring / technical equipment was being used, technicians were often poor at communicating with women. In the case of ultrasound scanning for example, one woman commented that:-

> "...I was not spoken to. The scan was not explained and my questions were totally ignored. I felt I was a nuisance, and was sure something was wrong with the child as the comments written were placed in a large, firmly sealed envelope" (p107)

and Hall et al study also found that 49% said that they did not receive as much information as they would have liked on how their pregnancy was progressing and the results of examinations and tests (1985, p91). Such findings are not uncommon. Graham and McKee (1977) for example, found that 34% of women wanted to ask more questions, although "...some women found that there was a tendency [on the part of staff] not to take their questions seriously...questions about symptoms which although subjectively important were not seen as

clinically important tended to be dismissed" (p16).

Prima facie, therefore, this evaluation of panel members' experiences of antenatal care in the 'new' NHS suggests that the NHS reforms are not achieving one of their principal goal of empowering service users. Critics might argue that any such conclusion, however preliminary, is not especially convincing. It might be contended that the real test concerns panel members' experiences of intrapartum care, which is the centrepiece or core of modern maternity care, an area of enquiry to which we now turn in the following chapter.

# Chapter Ten

## Intrapartum care in the 'New' NHS - the Triumph of Obstetrics

### Introduction

The preceding analysis of panel members experiences of antenatal care in the 'new' NHS suggests that, at least at the antenatal stage of the maternity 'cycle', maternity care is failing to meet the needs or preferences of service users, as they themselves define them. The principal problem relates to panel members dissatisfaction with the 'content' of such care, namely the quality of information provision, choice in care and the degree of attention paid to respondents own opinions / concerns by service providers. This is especially surprising since the panel as a whole are generally interested in and responsive to health information.

Supporters of the 1991 NHS reforms might of course object that whilst the analysis of respondents experiences of antenatal care may suggest that the reform process is not achieving one of its key goals of 'empowering' service users, this does not necessarily constitute a critical 'test' of the reforms. It could be argued that the 'real' test of the reforms is whether the character of *intrapartum* care has changed or improved as a consequence of the reform process. As demonstrated in Section 1, the 'discourse of risk' led to development of a policy which resulted in the progressive transfer of the place of birth from the home to the hospital for almost all confinements. Consequently, it could be argued that it is in the area of *labour and delivery* where the most important or valid assessment of the effectiveness of the NHS reforms needs to be made. Certainly, as far as the 'discourse of risk' is concerned, intrapartum care constitutes the main focus of modern maternity care, due to the increasingly 'interventionist' character of intrapartum care.

The current chapter examines panel members experiences of intra-partum care, particularly in the light of the concerns expressed by panel members at the antenatal stage about the 'content' of maternity care. Although intrapartum care has been described, up until now, as the second stage of the maternity 'cycle' / 'career', with postnatal care completing the cycle, in practice, intrapartum care represents something of a 'mini-cycle' in itself. It includes the point of admission

of the service user to the hospital immediately prior to birth, labour and delivery (the intrapartum stage itself) and what is often referred to as the post-partum period immediately after delivery, prior to discharge. The study of women's experiences of intrapartum care is something which can only be attempted. of course, at the completion of this complex 'mini-cycle'. The second questionnaire, relating to intrapartum care, was sent out to panel members when notification of maternal hospital discharge was received by the respondent's GP. The present chapter begins by examining panel members experiences of intrapartum care up to the point of birth itself. This is followed by an examination of key aspects of their experiences during labour and delivery, which in turn is followed by an analysis of their experiences of the immediate, hospital-based, post-partum care.

**The Intrapartum Panel**

Of the original 282 respondents to the first antenatal stage of the panel, 237 women completed and returned the second questionnaire on intrapartum care. An examination of the social background and circumstances of those women who failed to return the second questionnaire did not however suggest that this process of attrition had occurred amongst a socially distinctive group amongst the original sample of respondents

**The Organisation of Labour and Delivery**

In broad terms, panel members received a form of care, at the point of labour and delivery, which was primarily obstetrics-led. 8 out of 10 respondents reported that both obstetricians and midwives were present during labour and delivery, whereas only 20% of the panel received a midwifery-led form of care during labour and delivery. Of those who experienced a midwifery-led system of care, only a very small number were cared for by their community midwife as well as hospital staff. Accordingly therefore, almost all women were delivered by hospital personnel, the majority of whom women were unlikely to have met beforehand (Winterton 1992). The potential significance of this largely obstetrics-led system of care will be considered in more detail presently.

## The Provision of Information To Mothers Regarding Labour and Delivery

Since panel members clearly attached great importance to the provision of information during the antenatal stage of their maternity 'careers', the development of the intrapartum questionnaire focused particular attention on this issue. The most striking result was that when asked to indicate their overall level of satisfaction with the quality of the general information provided to them during pregnancy about labour and delivery, the response of the panel as a whole was less than positive. Overall measures of patient satisfaction tend, of course, to produce positive rather than negative results. As the following table shows, less than 1 in 5 of the entire panel reported themselves to be "very satisfied" on this point, whilst over a fifth (21.9%) registered active dissatisfaction and a further 10% were neither satisfied nor dissatisfied. In other words, with hindsight a large proportion of the sample felt ill-prepared for labour and birth.

TABLE 10:1 Satisfaction levels within the panel regarding the information given to them about labour and delivery n=237

Level of Satisfaction

| Very Satisfied | Fairly Satisfied | Neither | Fairly Dissatisfied | Very Dissatisfied |
|---|---|---|---|---|
| 17.3 | 50.2 | 10.5 | 14.3 | 7.6 |

In addition to this general evaluation of the quality of information provision at the intrapartum stage, respondents were also asked a more detailed set of questions about information provision relating to key aspects of intrapartum care identified by earlier 'pre-reform' research. As Table 10:2 (overleaf) illustrates, at this more specific level, the levels of satisfaction continue to be relatively equivocal, with none of the specific areas identified attracting what might be described as a ringing endorsement from the panel .

The highest levels of satisfaction concerning the information provided about the birthing process were related to issues of pain control and maternal/infant bonding, although even in these two areas, the percentage of mothers who were prepared to describe themselves as "very satisfied" is still relatively low. Such results closely mirror findings from earlier research studies, which focus on women's dissatisfaction arising as a result of poor explanations of interventions

and events (Kirkham 1983) . For example, an OPCS survey (1989, p127) indicated that more than a third of the sample (36%) wished that they had, with hindsight, known more about labour and delivery, and such a need was not confined to first time mothers. Although, in retrospect, 50% of first time mothers would have liked more information about labour and delivery, one in five second time mothers (21%) also felt that they would have welcomed additional information, despite their greater experience.

TABLE 10:2 Maternal Satisfaction with Information Provided on specific topics concerned with Labour and Delivery

| Topic on Which Information Provided (during pregnancy) | Level Of Satisfaction (%) n=237 | | | | |
|---|---|---|---|---|---|
| | Very Satisfied | Fairly Satisfied | Neither | Fairly Dis - satisfied | Very Dis-satisfied |
| Induction of Labour | 14.8 | 29.5 | 33.3 | 13.5 | 8.9 |
| Having an Epidural | 22.8 | 36.3 | 25.4 | 7.6 | 8.0 |
| Being Attached to a Monitor | 24.5 | 39.2 | 19.8 | 9.7 | 6.8 |
| Moving Position During Labour | 19.8 | 32.1 | 24.5 | 13.5 | 10.1 |
| Methods of Pain Relief | 33.8 | 38.4 | 13.9 | 8.0 | 5.9 |
| When You Could Hold Your Baby | 30.0 | 32.1 | 20.7 | 8.9 | 8.4 |

As demonstrated in chapter 9, moreover, when one examines the *salience* or importance which respondents attach to these matters, then the poor quality of service delivery in this area is thrown into even sharper relief, as Table 10:3 demonstrates.

TABLE 10:3 The Extent to Which Panellists Regarded Areas of Information Provision to be Important n=237

| Topic on Which Information Provided | Importance of Information Provision (%) | | | | |
|---|---|---|---|---|---|
| | Very Important | Fairly Important | Neither | Fairly Un important | Very Un important |
| Induction | 45.6 | 29.1 | 12.7 | 5.9 | 6.8 |
| Epidural | 53.2 | 24.9 | 10.5 | 4.2 | 7.2 |
| Monitoring of Labour | 43.9 | 42.6 | 6.8 | 3.0 | 3.8 |
| Moving Position in Labour | 50.2 | 35.9 | 9.3 | 1.7 | 3.0 |
| Holding Baby | 67.5 | 24.9 | 4.2 | 0.8 | 2.5 |

Although over two thirds of mothers in the panel (67.5%) cited information about maternal / infant bonding as being of prime importance to them, only 3 out of 10 (30%) felt "very satisfied" with the information that they were given about this

topic. Similarly, whilst over half of the sample regarded information about epidurals of major importance, less than a quarter were "very satisfied" with the information they received.

**The Provision of Information and Role Organisation**

The provision of information to panel members about the intrapartum stage of maternity care was clearly therefore a major defect in the organisation and delivery of such care. The location of the responsibility for this failure is, derivatively, an issue of some significance in itself. It is evident, from the way in which panel members view their principal sources of information, that information provision is closely associated with the professional roles which different groups of service provider play in the delivery of intrapartum care, as the following table illustrates :-

Table 10:4 Principal Sources of Information About Labour and Delivery

| Topic of Information | % of Panel indicating that they obtained information from this source | | | | | |
|---|---|---|---|---|---|---|
| | GP | Community Midwife | Hospital Doctor | Hospital Midwife | Friend Relative | Antenatal Class |
| Induction | 5.1 | 16.5 | 16.9 | 14.3 | 13.1 | 38.9 |
| Epidurals | 5.5 | 24.9 | 11.4 | 18.6 | 14.8 | 45.6 |
| Monitoring | 1.3 | 19.0 | 8.9 | 36.3 | 7.2 | 36.7 |
| Labour positions | 1.3 | 17.7 | 2.1 | 22.8 | 7.6 | 44.3 |
| Pain Relief | 8.4 | 26.2 | 8.4 | 29.1 | 13.1 | 46.0 |
| Holding Baby | 1.3 | 16.9 | 2.5 | 30.4 | 9.3 | 35.4 |

The hospital midwife is seen by the panel as playing a key role in information provision, compared with other professional groups. Hospital midwives were identified as being the principal providers of information (on a one-to-one basis) about such issues as the monitoring process, methods of pain relief, positions during labour and infant/maternal bonding, and they also appeared to play an important ancillary role in providing information about epidurals and the induction of labour. Hospital doctors, by contrast, were regarded as providing little or no information about any aspect of labour and delivery, with the exception of induction and epidurals. Above all, however, it is clear that group *ante-natal classes* constituted the single most important source of information for women about labour and delivery. However, as has already been demonstrated, panel members' satisfaction with information provision is typically low, and not

all women attend such classes .

**Choice and Control over the Place of Birth**

Both the Winterton Report (1992), and Changing Childbirth (1993) advocate the involvement of women in choices relating to the care that they receive during pregnancy and birth. As a result, attention has focused, inter alia, on the Place of Birth debate, that is to say, home birth versus hospital birth, rekindling many of the criticisms of the maternity care services which were raised during the 1970's and 1980's by researchers such as Kitzinger (1979, 1980, 1996), Oakley (1979,1980), Cartwright (1979). The panel were asked about their views on this issue and about their own choice for the place of birth.

Whilst no panel members had ever experienced a home birth, 15.5% responded positively when asked whether they had *considered* home birth as an option. The panel cited friends and relatives as being the most encouraging influence when discussing home births, although 1 in 5 respondents (20.3%) said that their husband/partner actively *discouraged* them from pursuing such an option. By and large though, as the following table shows, the possible option of a home birth was hardly discussed at all, either in lay groups or between panel members and other health care professionals. In this sense, the 'discourse of risk' seems to exercise an almost hegemonic influence on the outlook of both practitioner and client, major national policy initiatives not withstanding.

Table 10:5 Discussion relating to Home Births (n=237)

| | Highly Encouraged | Neither Encouraged/ Discouraged | Discouraged | Home Birth Not Discussed At All |
|---|---|---|---|---|
| GP | | 8.9 | 9.3 | 81.9 |
| Partner | 1.3 | 19.4 | 20.3 | 59.0 |
| Community Midwife | 1.3 | 13.5 | 11.4 | 73.8 |
| Friend | 3.4 | 17.7 | 5.9 | 73.0 |
| Relative | 3.8 | 15.2 | 7.2 | 73.8 |
| Hospital Dr | | 7.6 | 8.0 | 84.4 |
| Hosp Midwife | | 6.8 | 6.8 | 86.5 |

Almost 1 in 10 (8.4%) panel members indicated they were not aware that there was any alternative to hospital births, whilst for 5.5% of respondents there was no practical alternative to hospital confinement since they had agreed to an elective caesarean during pregnancy for clinical reasons. Of the remainder, 1 in 10 (11.4%) said that they had been advised to go into hospital by their GP and 19% said that their previous experience of birth led them to follow a similar pattern.

The nature of the support provided for home and hospital births emerged as an issue to which respondents had given some thought. 1 in 20 (5.5%) of the panel reported that, whilst they had considered a home birth, they were anxious about the possibly lower level of clinical support associated with home births. Almost half of the panel (49.8%) were of the opinion that the support which they would receive in hospitals would be better than any other programme of care / place of birth, and indicated that this was their main reason for choosing a hospital birth. In the absence of alternative professional advice to the contrary, it is highly unlikely that women service users would be sufficiently confident to be able to exercise their right to make such a major choice in the type of care regime available to them. In Porter and Macintyre's study (1984), women were generally of the opinion that current service delivery represented the most appropriate organisational arrangements, on the basis that, in the words of Porter and Macintyre, "...What is must be best". Since the majority of panel members felt that there were areas in which they did not receive sufficient information on the *'conventional'* regime associated with labour and delivery, one can fairly safely assume the social/professional pressures against seeking an *alternative* to a hospital-based birth are likely to be considerable.

**The Panel's Experience of Labour and Delivery**

Before going into hospital to give birth, 85.2% of the panel anticipated that they would have a "normal delivery" (i.e.; not a caesarean), 5.5% of panel had been 'booked' for an elective caesarean and a further 9.3% thought that they might have to have a caesarean as a matter of necessity. In practice, 7 out of 10 mothers gave birth without the assistance of forceps or a vacuum extractor whilst 11.8% gave birth vaginally assisted by forceps or other aids. 5.5% of respondents had a planned caesarean, and the remainder (13.1%) had to have an emergency caesarean. A substantial minority (30%) of panel members either had their labour

augmented (accelerated) or were induced. Such data is reflective of the management of labour both before the 1991 reforms and following them, since a number of studies (Cartwright 1979; Ball 1989; Audit Commission 1997) report induction rates of between 24% and 35%. As we have seen in chapters 3 and 4, the increasing 'hospitalisation' of birth has been accompanied by the increased use of clinical intervention and medical technology (Francome et al 1993). Consequently, the panel's experience of labour and delivery is not unusual within late modern societies. The proportion of women undergoing caesarean sections in the UK, for example, has increased steadily throughout the past two decades, to a position whereby almost 1 in 5 women can expect to have a caesarean, whilst rates of assisted delivery (with both vacuum and forceps) have remained relatively constant at around 10% (Graham & McKee, 1980; Cartwright, 1979; Macintyre, 1981; Audit Commission, 1997)

When questioning panel members about their experiences of labour, it was decided not to ask about the specific drugs that women were given since, as Cartwright (1979) discovered, many women do not know the precise drug which they had been given. As an alternative, respondents were asked about their *perceptions* of the effectiveness of pain relief. Nearly 4 out of 10 of those panel members who had received pain relief thought that the methods used were "very effective" and a further 42% thought the pain relief received "fairly effective". Conversely, however, one fifth of all those respondents who had received various methods of pain relief' found that such measures did little to relieve their pain and 16% of the whole panel indicated that they did not receive any pain relief. The response of the panel towards the pain relief that they were given reflects the findings of an earlier study by Cartwright, (Cartwright, 1979) in which the majority of her sample (74%) were generally positive about the relative effectiveness of the pain relief they had received, 19% had either negative or had mixed feelings, whilst a further 19% did not receive any pain relief at all during labour. In general therefore, the relief of pain during the key intrapartum phase does not appear to be especially problematic as an aspect of the quality of service delivery.

One particular aspect of the organisation of intrapartum care which did seem to attract a great deal of criticism however was the degree of *physical control* exercised by service providers over service users during labour and delivery. 6 out

of 10 respondents (59.5%) reported that they wanted more freedom of physical movement during their labour, but only 20% were satisfied with the information they were given regarding the type and range of movement possible. Only 4 out of 10 respondents (41.4%) said that they were actually *encouraged* to move around and change position during labour itself, although almost 6 out of 10 (59.5%) indicated that they had wanted to do so. Women's relative ignorance about the range and types of physical movement which are clinically acceptable to the service providers during labour and delivery is an issue which arises repeatedly in pre-reform research as an important source of dissatisfaction amongst women service users (Cartwright 1979; Kirkham 1983). The physical position adopted by the large majority of the panel during delivery illustrates this point, with more than 4 out of 5 respondents giving birth in what might be described as a 'conventional' propped or prone position.

In contrast to women's high level of concern about the lack of physical control which they felt they had to endure during labour and delivery, there was a high level of satisfaction amongst panel members with the number of people who were present in the delivery room during birth. For 9 out of 10 (89%) respondents, this was evidently not an area of major concern - which may well have been due to the fact that more than 8 out of 10 mothers (84%) knew the reasons why people were present and 9 out of 10 (89.9%) felt that they were treated with respect whilst given birth. Within the labour ward or labour suite itself, the majority of women (91.5%) had their husband/partner present with them during the birth.

Respondents experiences of labour and delivery suggest, therefore, that a key area of dissatisfaction with hospital intrapartum care centres around the issue of control rather than, as the 'discourse of risk' seems to imply, the reduction of risk by, inter alia, the reduction of pain. When considering the transition to motherhood in late modern societies, the organisation of care may have a significant impact on women's experiences since, as Ball (1989, p163) notes, "...satisfaction with motherhood...was found to have been affected by factors related to the management of maternal care in hospital". Any future improvements in the quality of such care therefore involve changes in the management of intrapartum care, a point which is underlined by a consideration of the process of information provision *during* labour and delivery.

## The Provision of Information To Women During Birth and Delivery

Although the hospital may not necessarily be the principal source of information about labour and delivery for many respondents, during labour and delivery itself approximately twice as many women were "very satisfied" with the general information given to them about labour and delivery from hospital *midwives* compared to *obstetricians.* Almost half of the panel (48.9%) rated the quality of the information from hospital midwives very highly, whilst a further third (33.3%) were "fairly satisfied" with the information that was given to them during labour and delivery. The potential significance of this result becomes more apparent when one takes account of the division of labour between obstetricians and midwives during labour and delivery.

The large majority (80%) of panel members were delivered by an obstetrics-led system of intrapartum care. If one compares the perceived quality of information provision between obstetrics-led deliveries and midwifery-led deliveries, significant differences exist. Amongst those panel members who had received obstetrics-led care (i.e.; cared for in labour / delivery by both obstetric and midwifery staff), less than 1 in 4 (24%) described themselves as very satisfied with the quality of the information which had been provided by the obstetrician, whilst 1 in 2 (46%) were very satisfied with the information provided by midwives working under the direct control of the obstetrician. In the much smaller number of cases where women received midwifery-led care, 65% of respondents reported themselves 'very satisfied' with the information provided by their midwives. Consequently, although midwives in general appear to be more active providers of information than obstetricians, midwives seem to satisfy the information needs of women to a significantly greater extent under a midwifery-led than an obstetrics led system of labour and delivery $p=0.05$)

A similar situation applies when one examines the character of communication between different professional groups and service users under these two forms of care. Whilst almost 2 out of 3 (63%) respondents thought that the midwives working under the direct control of obstetricians took a lot of notice of their views and preferences during labour and delivery, only 1 in 3 (34%) respondents felt that the same could be said of obstetricians. Once again, however, it is the midwives providing a midwifery-led system of care, during labour and delivery,

who appear to be the most responsive group in this respect. Almost 8 out of 10 (78%) of women who received midwifery-led care felt that their midwives had taken a lot of notice of their views and preferences.

These results seem to confirm some of the central criticisms of modern maternity care advanced by the 'discourse of control', and also appear to provide additional support for the specific policy initiatives of Winterton (1992) and Changing Childbirth (1993). In developing a more women-centred system of maternity care, for example, the extension of midwifery-led care is strongly advocated as one means of achieving this goal, at least in the case of 'low-risk' confinements. However, it is important to note that while midwifery-led care seems to provide a more informative and responsive service, the quality of information is still rated as less satisfactory than the degree of notice taken of service users views. Information is crucial, since it is the key to providing women with choices. The ability to exercise choice in an informed manner in turn provides service users with the basis for exercising control over the process of maternity care. It is interesting to recall in this context that neither hospital nor community midwives constituted the *principal* source of personalised information about labour and delivery, *prior* to birth (although each run antenatal classes providing information of a general nature). It appears, in other words, that there is a general problem with information provision, irrespective of the question of how labour and delivery might be organised.

It is important to acknowledge however that midwifery-led intrapartum care certainly appears to improve both the quality of information provision and the responsiveness of the service to women's needs and preferences. Whether the extension of midwifery-led care proves to be one of the key means to achieve a more women-centred form of maternity care, as suggested by Winterton and Changing Childbirth, is arguably a more complex matter than either of these reports acknowledge, a point to which we shall return later in the thesis (Chapter 13). Certainly the definition and meaning of the term 'midwifery-led' care requires further clarification. For the present, at least as far as the large majority of panel members are concerned, at the stage of labour and delivery, an obstetrics-led form of care remains the norm and in this respect, the panel provides little evidence that the NHS reforms are achieving one of their key goals of empowering service users by providing them with more choice. This interim judgement is reinforced,

furthermore, by panel members' experience of the post-partum stage of intrapartum care.

**Hospital-based Postnatal Care**

According to the recent findings of an Audit Commission Report,

> "Women make more negative comments about hospital postnatal services than any other aspect of their maternity care" (Audit Commission 1997)

The principal postnatal priorities of panel members after the birth of their baby were reported as being, in decreasing order of importance, the health of their baby, their own health and infant development. The general or national relevance of these preferences has been re-enforced in a recent Audit Commission Report, which suggests that,

> " ... following birth, women need time to recover physically and emotionally, to establish feeding and, with their partners, to develop relationships with their babies. They need to be confident that any problems with their baby will be detected, and that appropriate care and treatment are available. " (Audit Commission 1997, page 51)

The transition to motherhood is a "rite de passage" and therefore often a period of stress and anxiety for women. The above report also claims this period of change is often hampered by the mother's own health problems. The provision of appropriate care during this time is said by the authors of the report to be crucial. In the case of panel members, these potential problems are in fact compounded by the failure of hospital staff to provide them with adequate information on a range of postnatal topics, as Table 10:6 illustrates .

On the question of infant health, for example, only 1 in 10 respondents (11.8%) felt that they did not need further help and advice about this particular issue. In the case of the majority of women who thought that they did need some additional support from hospital staff (89.2%), less than 1 in 5 (16%) felt that they received "a lot of help and advice". Likewise, on the question of the mother's own health, only 22.8% of the panel thought that the information they were given was adequate in relation to their own perceived needs. The third major priority area for panel members - that of infant development - reveals a similar story. A large

majority (67%) of the panel were either relatively or absolutely dissatisfied with the amount of help and advice that they had been given on this subject, and only one quarter of the panel (24.5%) felt confident about dealing with such matters.

Table 10:6 Reported Levels of Help and Advice Given by Hospital Staff Relating to A Number Of Key Areas (as highlighted by panellists themselves)

| SUBJECT | Level of advice (n=237) | | | |
|---|---|---|---|---|
| | Given a lot of help & advice | Given some help & advice | Given very little help & advice | Help & advice not needed |
| Feeding Methods | 30.4 | 35.4 | 16.0 | 18.1 |
| How to handle & look after your baby | 24.9 | 29.1 | 21.5 | 24.5 |
| Possible Health problems - baby | 16.0 | 30.0 | 42.2 | 11.8 |
| Your own health & recovery | 22.8 | 38.0 | 29.9 | 9.3 |

To summarise, it is clear that hospital personnel are consistently failing to meet the postnatal information needs as highlighted by the service users themselves (for whatever reason) in areas which are of prime significance to mothers. Recent research confirms this lack of progress within the NHS maternity care services. Despite the avowed intentions of national policy initiatives to develop a form of maternity care which is centred around the needs of the service user (e.g. Local Voices (1992) Winterton (1992) and Changing Childbirth (1993)) an Audit Commission Report (1997) found high levels of dissatisfaction amongst its respondents with the crucial intrapartum stage of maternity care in particular.

The need for information on a range of topics concerned with child care is a finding which is common of course to 'pre-reform' research on maternity care and relates to the relative inexperience of "modern" mothers in matters directly concerned with child care, for reasons discussed earlier in this thesis. Oakley's study of first time motherhood, for example, highlighted the fact that less than 1 in 4 of her respondents had changed a nappy or had bottle-fed a baby prior to becoming a mother (Oakley 1979) Similarly, only 40% of the mothers in Cartwright's study (1979) indicated that they "felt very confident" about caring for

their new-born baby. The role of health care professionals, especially in the period following birth, consequently assumes an increasing degree of significance in late modern societies, especially in relation to the support and advice that women service users feel they need.

In assessing the relative importance of midwives and doctors as sources of information for panel members, it is apparent that women service users perceive the role of hospital doctor and hospital midwife in very different ways. As the following table illustrates, respondents regarded the midwife as a source of information about a *range* of issues covering most aspects of maternal and infant health in the post partum period, but the role of hospital doctor was seen to be more specialised, and was primarily regarded as a source of information and advice about issues of a *clinical* or *medical* nature.

Table 10:7 The relative roles of (a) Hospital Midwives and (b) Hospital Doctors regarding the provision of information on a number of salient topics relating to postnatal care.

| Topic on which more information wanted | % indicating that they wanted to talk more | |
|---|---|---|
| | to **MIDWIVES** | to **DOCTORS** |
| Feeding - Methods & Success | 48.5 | 8.0 |
| How to handle & look after baby | 43.4 | 7.2 |
| Possible infant health problems | 65.8 | 55.7 |
| Own (maternal) health & recovery | 53.1 | 44.7 |
| Ward atmosphere / Routines | 31.2 | 9.3 |
| Amount of rest able/desirable to get | 51.5 | 20.7 |
| Infant development | 48.9 | 41.3 |

A large proportion of the panel would have welcomed the opportunity to discuss issues relating to infant feeding (48.5%), general baby care (43.4%), infant and maternal health (65.8% and 53.1% respectively), postnatal rest (51.5%), infant development (48.9%) with midwives. By contrast, and despite the apparent need for information on a range of topics, respondents highlighted only a few areas on which they would have welcomed more discussion with hospital doctors, and these can be seen to relate to those matters which may be thought of as clinically related, for example, infant health (55.7%), panel members own health (47.7%) and child development (41.3%).

Such findings raise a number of questions relating to the current proposals for fundamentally re-organising the provision of maternity care within the UK. A major thrust of the recommendations of Changing Childbirth (1993) centres around the idea that hospital midwives ought to play a more specialised role in labour and delivery. Since service users view the role of the hospital midwife as one which encompasses a wide range of areas relating to intra partum and postnatal care, the proposal for more specialised midwifery services, especially at the intrapartum stage, could present a number of difficulties, not least of which in the area of professional/maternal communication. The creation of a more specialised clinical role for hospital midwives may undermine the ability of midwives to advise pregnant women and respond to their needs on a wide range of issues concerned with birth and the post partum period. As things stand at the moment, women's need for information - especially information about alternative forms of care regime - is not being met, a point well illustrated by the issue of infant feeding.

**Methods of Infant Feeding**

The development of successful breastfeeding practices has come to be regarded as an important element in promoting the health of the newly born infant (Royal College of Midwives 1991, Breastfeeding Matters, 1989), and in an attempt to promote breastfeeding within the Hospital Trust in which this study took place a Breastfeeding Counsellor had been appointed to provide specialised support to women following the birth of their baby. This took the form of personal advice in hospital and via a Helpline/ home visits after discharge.

Whilst more than three quarters of the panel (78.5%) had decided during pregnancy that they wanted to breastfeed their baby, in practice slightly less than half (45.1%) managed to successfully establish and maintain breastfeeding (up to two months following birth), with a substantial number of women who started to breastfeed giving up within days. Slightly less than 1 in 5 (17.7%) of the panel decided to bottle feed their babies, although following the birth of their baby the number of panel members who indicated that they had bottle fed their babies had risen to 21.5%. A third of respondents (33.3%) said that they proposed to use more than one method of feeding if necessary, and a proportion of those who had decided that they would breastfeed attempted to do so but eventually resorted to

bottle feeding.

The only area of intrapartum care where variations in class background seem to have any significant influence on panel members attitudes and behaviour is in respect of breast feeding, where, for a significantly higher proportion of respondents from the registrar general's social classes I and II (as classified by their husband/.partners occupation) and who had some form of post 16 education, breast was regarded as best (p=0.00). Despite these class/educational-related differences in the tendency of women to breast feed or not, the average period of time which panel members spent breast feeding their babies was not particularly extensive. Of the 78.5% of respondents who started to breastfeed their baby, 1 in 5 indicated that they discontinued breastfeeding within less than a month (some after only a few days), whilst a further 12% stopped breastfeeding within a period of 8 weeks following the birth of their baby. Two thirds of the entire breastfeeding group ceased to use this method of infant feeding within 6 months, with only a third continuing beyond that point. In general therefore, it would appear that in this crucial area of health promotion, whilst three quarters of mothers indicated a desire to breastfeed, circumstances seem to mitigate against the successful adoption of this practice for a relatively high proportion of mothers, despite the seemingly high level of support for this practice within the NHS itself. A major factor which may influence the longevity of breastfeeding practices is whether women have to return to work - and therefore have to arrange child care. Since mothers who do return to work often do so at about 12 weeks after birth, the decision to cease breastfeeding may be a practical one, based on social and economic factors.

When one compares such findings with the results of earlier research, it is apparent that the relatively rapid fall off rate for breastfeeding within the panel is not untypical at a national level, although the proportion of mothers who attempted to breastfeed is higher than in many other studies. This may well reflect both the characteristics of the sample as a whole (which is "prototypical" and generally responsive to health information) and the increasing emphasis on the health benefits of breast feeding for the baby in public health education campaigns conducted during the 80's and 90's, in contrast to the 1970's when there was increasing support for bottle feeding amongst health care professionals. (Graham and McKee (1979) Volume 3, p2).

In many ways, the topic of infant feeding illustrates the general failure of modern maternity care services to cater for the needs and preferences of women. Although breast feeding may be beneficial for the healthy development of babies, the extent to which breast feeding is a practical option for many young women in the rapidly changing world of late modern society is an important issue, but one which appears to be largely ignored by health care professionals. In the UK, the past 50 years has witnessed considerable fluctuation in the proportion of women breastfeeding their babies. From a position in the early part of the century when the majority of babies were breastfed, such practices declined and during the 1960's less than 1 in 4 women chose to breastfeed their baby, preferring instead to use formula feed. Such variation has been linked to shifts in the location of birth, the development and marketing of infant formulas, and public opinion regarding the acceptability of breastfeeding in public. As Palmer comments, during the twentieth century, "... doctors were taking over the birth process and hospital deliveries increased ... Hospital practices destroyed breastfeeding, as they still do.... " (Palmer, 1988, pg. 201) The Royal College of Midwives also attributes the decline of breastfeeding to a rise in the proportion of hospital births, noting that "... the rules [about feeding] were firmly established in most hospitals and more women were exposed to them as hospital births increased." (RCM 1991, page xvi) According to Houston, the emergence of a modern hospital-based system of maternity care led to the following situation as far as infant feeding was concerned :

> "...Hospital practices were rigid, babies were taken out of the nursery to the mothers at 'feeding time', complementary feeds were routine and all babies were given formula feeds overnight so that their mothers could sleep undisturbed."
>
> (Houston, in Minchin, 1989, pg 335)

More recently, such practices have been largely abandoned and a wealth of literature has promoted the 'benefits' of breastfeeding. (for example, Garza et al, 1987; Riordan, 1983; Howie et al, 1990). "Breast is best" is now the message given to pregnant women and new mothers, with many hospitals actively supporting breastfeeding through specialised staff training, patient support and promotional literature. The rates of breastfeeding nation-wide have risen to a position whereby the majority of women (more than 6 out of 10 according to the

RCM) 'choose' to breastfeed their baby. The success of *maintaining* breastfeeding remains a key concern amongst health care professionals however, since a high proportion of women cease to breastfeed after only a short period of time. (Graham & McKee, 1980; RCM, 1991)

The possibility of and need for information on alternatives to breast feeding (given women's employment circumstances in particular) does not seem to have been given any serious consideration, since a relatively high proportion of respondents received positive encouragement to breastfeed, as the following table shows :

Table 10:8 Sources of encouragement for breastfeeding ( n=237)

| Person Consulted | Outcome of Discussion regarding breastfeeding (%) | | |
|---|---|---|---|
| | Encouraged | Discouraged | Not Discussed |
| GP | 40.9 | | 59.1 |
| Community Midwife | 75.9 | 1.3 | 22.8 |
| Husband/Partner | 69.6 | 3.8 | 26.6 |
| Relative/Friend | 48.5 | 4.6 | 46.8 |
| Hospital Doctor | 23.2 | 1.3 | 75.6 |
| Hospital Midwife | 59.9 | 2.1 | 37.9 |
| Antenatal Class | 63.7 | | 36.3 |

Panel members received support from a number of sources in order to encourage them to breastfeed. During the antenatal period, for example, when panel members discussed feeding methods with their GP, all of those GP's whose opinions were sought or who raised the issue themselves actively encouraged women to try to breastfeed, and the same is true of antenatal classes. The majority of mothers discussed feeding methods with, in order of statistical importance their community midwives (77.2%), their husbands/partners (73.4%), antenatal classes (63.7%) and hospital midwives (62%). In almost all of these cases, including, incidentally, women's' partners, women were rarely discouraged from breastfeeding.

Of those people who provided support and advice about feeding methods, respondents felt that a range of people had provided them with the most useful help and advice. Almost a third of respondents thought that their community

midwife played a central role in supporting breastfeeding, whilst 1 in 5 (20.3%) valued the advice and support given by hospital midwives as the most important. 15.6% of the sample regarded friends or relatives as providing the most help and advice and a further 11.4% regarded antenatal classes as supplying help and information which was of most use to them. Almost 1 in 5 panel members indicated that "other" individuals had, in their opinion, given the most help and advice, the most commonly cited being the respondent's health visitor whilst only a small minority of panel members reported that they had used hospital resources (viz the breastfeeding counsellor) as a source of advice, information and support. In other words, on an issue which service providers judge to be a prime health care 'need' of service users, there is widespread professional commitment - although this should not necessarily be taken to imply that the quality of information provision in this area is of a correspondingly high order. It is also worthy of note, given the high degree of emphasis placed on breastfeeding, that a number of women in the study wrote at length in the open ended section of the questionnaire about feelings of 'stress' and 'failure' when they were unable to successfully establish or maintain breastfeeding.

**Postpartum Maternal Health**

The relevance of this strong professional emphasis on breastfeeding has to be considered, inter alia, in relation to women's post partum state of health. Based on an assessment of panel members' own perceptions of their health at this stage of their maternity 'careers', a major problem faced by 6 out of 10 (61.6%) respondents was that of sheer physical exhaustion. Pain from stitches proved to be another major health problem with almost 6 out of 10 (58.5%) respondents affected in some way. In addition, up to 4 out of 10 respondents mentioned problems with cracked nipples (38.4%), other breast problems (38%) and backache (37.6%), and more than one quarter of respondents (27.6%) felt very depressed in the few days following the birth of their baby, commonly referred to as the "baby blues" (Kendall-Tackett 1993). The overall impact of the process of birth on the post partum health of panel members was therefore considerable.

As Table 10:9 shows, in seeking help and advice about such issues once respondents returned home, it is apparent that panel members sought advice on a selective basis :-

Table 10:9 Self-Reported Health Status in the 2 months following birth and advice sought (n=237)

| | % reporting not a problem / incidence of help-seeking behaviour | | | | | |
|---|---|---|---|---|---|---|
| | Not a problem | Health Visitor | GP | Midwife | Friend / Relative | Postnatal Class / Group |
| Pain from Stitches | 41.5 | 7.2 | 5.9 | 37.6 | 3.4 | 0.4 |
| Backache | 62.4 | 4.2 | 7.6 | 12.2 | 12.2 | 0.4 |
| Pain from Caesarean | 84.0 | 3.4 | 3.4 | 8.0 | 0.8 | |
| Urinary tract problems | 79.3 | 3.0 | 2.5 | 11.0 | 3.0 | 0.8 |
| Cracked nipples | 61.6 | 9.7 | 2.1 | 23.2 | 2.5 | |
| Feeling very depressed | 73.4 | 8.4 | 2.5 | 4.6 | 10.1 | 0.4 |
| Feeling very tired | 38.4 | 17.3 | 8.0 | 12.2 | 23.2 | 0.4 |
| Lack of sex drive | 77.6 | 1.3 | 1.7 | 0.4 | 17.3 | 0.4 |
| Problems "bonding" to baby | 95.8 | 1.3 | | 0.8 | 1.3 | |
| Sibling Rivalry | 78.1 | 11.4 | | 2.1 | 6.8 | 0.4 |
| Other breast problems | 62.0 | 8.0 | 5.1 | 21.5 | 2.5 | 0.4 |

Professional health agencies were used principally as a source of advice on matters of a specifically clinical or physical nature. In contrast, respondents relied more heavily on advice from friends and relatives about issues of mental health, stress or sexual matters. In other words, panel members appear to make a clear distinction between physical / clinical and 'personal' issues in their perception of the role of professional service providers, a judgement which in part, one could argue, reflects the way in which the service providers view the service users.

**The Response of First and Second+ Time Mothers to Intrapartum Care**

In attempting to assess the impact of maternity care on service users, it is important to consider the experiences of the 'first time' mother compared with the 'second time' mother who has previously experienced maternity care services. It might be assumed, for example, that the more 'experienced' are more knowledgeable about the whole process and therefore more relaxed than first time mothers. Derivatively, one might also presume that the priorities and preferences

of these two groups of service user would also differ significantly. As we have already seen at the antenatal stage however, the priorities and preferences of both groups were remarkably alike, and the problems encountered by both groups were also remarkably accordant, with the single exception that clinic waiting times proved to be more of an issue for the second time mothers, with their greater child care responsibilities.

Likewise, at the intrapartum stage, one discovers that the priorities and preferences of first and second-time mothers are strikingly similar - aside from a tendency for second time mothers to show an even greater sense of dissatisfaction with intrapartum care than first time mothers. It is evident, for example, from the comments that panel members made in a response to an open-ended question about their experience of intrapartum care, that 'second time' mothers felt that they had been 'short changed' by the system. Service providers were thought to treat second time mothers in a different way, due to the fact that such mothers had already successfully given birth on a previous occasion. One second time mother described herself as being treated as "someone who had done it all before" and who was not, therefore, expected to require the same level of support and advice.

Since first time mothers clearly feel that maternity care services suffer from what might be termed an 'information deficit', it may be unlikely that second time mothers will not be at any greater advantage in terms of their awareness and understanding of the care choices and options available to them during their subsequent pregnancies. There is little evidence, from either the antenatal or intrapartum stages of the panel study, that second time mothers are automatically more competent and confident as a result of their previous contact(s) with maternity care services - aside from their confidence about feeding and general baby care.

Second time mothers felt that they needed substantially less information and advice than first time mothers about infant feeding and general baby care (39.4% & 61.9% and 27.7% & 66% respectively) However, both groups of mothers needed more information about infant health (54% and 59% respectively) and maternal health (43.3% and 55.7% respectively). Interestingly, all women experienced remarkably similar health problems in the post-partum period. Such results emphasise the unique situation of women as they become mothers -

whether for the first, second or subsequent time - since each pregnancy and birth brings with it anxieties, physical trauma and social change.

**Summary and Conclusions**

The analysis in Chapter 9 of panel members experiences of antenatal care in the 'new' reformed NHS, strongly suggests that, at least within the area of maternity care services, the reforms have failed to achieve one of their key goals of empowering the service user by providing greater 'choice' of care. Antenatally, service users were dissatisfied with key areas of service provision, particularly the poor quality of information provision and communication. Since antenatal care constitutes only the first stage of the maternity care 'cycle', advocates of the reform of the NHS could reasonably argue that client dissatisfaction with antenatal care does not constitute a major 'test' of the impact of the impact of the NHS reforms. With the rise of modern maternity care and the 'hospitalisation' of birth, the intrapartum stage of the maternity care 'cycle' might be regarded as a more significant testing ground for an assessment of the reform process. It is important to note, therefore, that in the current chapter, panel members experiences of intrapartum closely parallel their experience of antenatal care.

At every level, from the general to the specific, panel members reported that their felt-needs (Bradshaw 1994) were not being met by the NHS's intrapartum services, particularly in the areas of information provision, communication and control over the birthing process (especially with regard to physical movement and monitoring). At the point of labour and delivery the majority of panel members wanted more information about issues concerned with the *control* and *management* of labour.

Consequently, the overall level of satisfaction with information was low and the level of respondents satisfaction with the quality of information provided about key aspects of intrapartum care was also low. This failure of service provision also varied to some degree with the differing professional roles of the service providers. During labour and delivery, obstetricians in particular appear to be characteristically poor communicators compared with midwives. This is especially significant since the principal form of care available to panel members during labour and delivery was obstetric-led. Although the highest level of

satisfaction with information provision and communication was registered by the minority of panel members who received *midwifery-led care*, both midwives and obstetricians failed to meet the needs of their clientele in several central areas of service provision.

The possible alternative to hospital birth, the home birth option, was rarely raised or discussed with service users and consequently proved to be no real 'alternative' at all. The image which emerges of intrapartum care from panel members responses has many of the 'classic' features of modern maternity care identified by the "discourse of control". The majority of women received an obstetrics-led (and therefore gendered) form of care at the stage of labour and delivery, characterised by generally poor information provision and communication, with a strong emphasis on interventions and the physical control of the movement of women service users.

During the immediate post partum period, panel members principal priorities centred around the need for more information and advice about infant feeding, infant health/development and maternal health - needs which they did not feel were met by the service providers. Significantly, women experienced a large number of physical health problems at the early post partum stage, a number of which were associated with the process of intervention at labour and delivery.

At what is generally regarded as one of the most important stages of the maternity care cycle therefore, the study of intrapartum care within the panel highlights that women users dissatisfaction with service provision corresponds closely to the elements of service deficiency identified by the discourse of control. Evidence that service provision has improved in the light of the very general or loose expectations of the discourse of choice, by contrast, are more difficult to discern.

Taken together, panel members experiences of both antenatal and intrapartum care within the new NHS constitutes formidable evidence in support of the claim that the 1991 reforms of the NHS have *not* in fact achieved one of their key goals of *empowering* service users by - in the case of maternity care services - providing a more 'woman-centred' form of care. Of course, it is important to acknowledge that the timing of the panel study may have some bearing on this issue, since it might be argued that the study did not allow sufficient time for the reforms of the NHS

to work. Certainly, this might be true of that part of the reform process aimed specifically at maternmity care - such as those changes in service provision directly associated with Changing Childbirth (although the recommendations of both Changing Childbirth and Winterton were reflected in the organisation and delivery of maternity care services in the locality before the end of the panel study). The general reforms of the NHS as a whole (Working for Patients 1989), on the other hand, were implemented and in operation throughout the duration of the panel study, in which case one might reasonably expect to see some evidence of a shift in service users attitudes and experiences compared with pre-reform studies.

Advocates of the reform process might of course retort that the lack of any widescale change in users experiences represents no more than an ideological or 'political' failure and the care itself may, nonetheless, be *clinically effective.* This raises a number of theoretical and methodological issues which can only be properly addressed, however, by examining panel members experiences of the third and final stage of the maternity care 'cycle', namely, postnatal care. It is to this issue which is discussed in the next chapter.

# Chapter Eleven

## Becoming a Mother in the 'New' NHS - The Postnatal Experience

### Introduction

The analysis in chapters 9 and 10 of panel members experiences of antenatal and intrapartum care within the 'new' NHS raises major questions about the impact of the reform process from the perspective of the service user. As far as the membership of the panel is concerned, key needs are reported by respondents as not being met. The principal problem concerns the 'content' of the service being provided, with the issues of information provision and the pattern of communication between service provider and service user constituting particular areas of concern. These results replicate many of the key criticisms levelled at maternity care in the UK *prior* to the implementation of the NHS 'reforms', criticisms which the reform process was designed to address. This is all the more surprising when one considers the social background of panel members. As indicated in chapter 8, the panel can be described as predominantly 'middle class' in origin, and the majority of panel members are responsive to health information. Since the reform process appears to have had little impact amongst a group of service user who are most likely to be able to capitalise on any new opportunities or choices available to them, it seems unlikely that the reforms will have had a more general impact amongst service users as a whole.

Research on the social science of health and medicine indicates that this political failure is also likely to have negative consequences for the *health* of service users as well (The Black Report 1980) a point which will be discussed in more detail in Chapter 12. For the moment, the principal concern of the current chapter is to examine panel members experiences of the postnatal phase of maternity care, focusing particularly on the health of the panel during this period.

Although service users may not be able to exercise a high degree of *choice* or *control* over service provision in the 'new' NHS, supporters of the reform process or those within the medical profession might argue that this does not necessarily imply that the NHS is thereby any less efficient or effective in a *clinical* sense. Chapters 11 and 12 of the thesis, which examine respondents experiences of the postnatal phase of the maternity care 'cycle', argue, on the contrary, that this is

not so. The thesis contends that the failure to empower service users is not simply a narrow political issue about the representation of users views, it is also a *health* issue as well. The theoretical assumptions which lie behind this claim and the evidence required to support it form the substance of the current chapter, using analysis derived entirely from the postnatal stage of the panel study. For a variety of reasons, which will be discussed presently, the postnatal period of the maternity care 'cycle' is central to the evaluation of the impact of modern maternity care on service users. Interestingly, however, this final stage of the cycle has, until recently, been largely neglected by medical and social science researchers alike.

**The Postnatal Period of the Maternity Care 'Cycle' - Problems and Issues**

Although both lay and professional groups have focused a great deal of public attention on the provision of maternity care in general during the past two decades, *postnatal* care has attracted little systematic attention compared with pregnancy and childbirth. The 1991 House of Commons Health Committee review of maternity services notes, for example, that:

> " ...the evidence we received from professionals had relatively *little* [our emphasis] to say about the post natal care of the mother compared to the other issues we have considered....despite its importance, post natal care does not have a sufficiently high priority."
>
> (Winterton 1992, page li)

This is underlined by a recent report by The Department of Obstetrics and Gynaecology and the Health Services Research Unit of the University of Aberdeen, the authors of which observe;

> " ... post natal care has been neglected for too long. Despite considerable resources, many women and their families experience post natal problems that are not addressed by the maternity services, which tend to take a narrow medical view of post natal care."
>
> ( HSRU 1991, para 38).

The need to give equal consideration to the long-term postnatal phase of women's maternity career has been further underlined by the Winterton reports

observations about the changing social context of motherhood and the potential implications of such changes for service delivery, viz. -

> " ... the birth of a baby is the birth of a new family. This sensitive time of adjustment and change is severely neglected in our culture; the postnatal period is a huge transition...and needs to be seen as a time of adjustment...and reflection... "
>
> (Winterton, 1992, page lxxix),

-and -

> " ... many women today have lives orientated towards work, and the post natal period can be a time of dislocation and loneliness. Others are under considerable economic pressure to return to work...Women with new born babies are not infrequently isolated...In many cultures special care and attention is given to new mothers but in this country as a whole, not simply in the NHS, there is little clarity or consistency in the approach taken to women at this important time."
>
> (Winterton, 1992, page liv)

Within the sphere of maternity care policy, the 'discourse of risk' played a major part in deflecting attention away from such issues by focusing clinical and public attention on the issue of mortality, particularly infant mortality. By focusing attention on *infant* as much as *maternal* health, and by 'measuring' health in terms of *mortality* rather than *morbidity*, the 'discourse of risk' also had an influence on the period over which the success or failure of modern maternity care might be assessed. Hence, the principal measure of success or failure of NHS maternity care services has typically centred around the incidence of infant mortality during and shortly after birth. Consequently, the influence of the discourse of risk over maternity care policy and practice has had the effect of ruling certain questions or issues 'out of court'- until relatively recently (Winterton 1992; Changing Childbirth 1993).

The development of a 'discourse of choice', embodied in both the general reforms of the NHS as a whole, and maternity care policy in particular, provides a new 'agenda' for research, especially when considered in relation to the largely feminist-inspired 'discourse of control'. The reforms not only require maternity care services to provide women service users with greater 'choice' of care but also place women's self-defined 'needs' at the centre of maternity care provision. Since both the 'discourse of control' and the antenatal and intrapartum stages of

the panel study highlight women service users' need for greater control over maternity care, any assessment of the possible impact of the NHS 'reforms' on maternity care provision cannot be confined solely to the intrapartum phase of such care.

So far, the thesis has indicated that the NHS reforms have failed in one of their central objectives of ceding more control from the service provider to the service user during the antenatal and intrapartum stages of the maternity care 'cycle'. This simply refers, however, to what might be called the *political* dimension of the failure of the reforms. In order to examine the question of whether the failure of the NHS reforms to 'empower' panel members is a *health* as well as a political issue, one has to begin by examining the health of women service users *after* the birth of their baby. As we have seen, however, the study of postnatal care is a relatively neglected area. What is more, the limited amount of research which has been conducted into postnatal care is often restricted to a relatively short period of time, sometimes concentrating simply on the antenatal experience and/or intrapartum care (Hall et al 1985). Studies of the post-natal period which extend beyond the post-partum care provided by the hospital after delivery often cover a relatively limited period, rarely extending beyond 16-20 weeks post-partum (Macintyre 1981, Graham and McKee 1979). These limitations of the existing research base were taken into account in the initial design of the panel study.

The examination of panel members experiences of the postnatal stage of the maternity care 'cycle' covers a much longer period of time than is conventional for research in this field. The postnatal questionnaire was distributed to panel members approximately 10-12 months post-partum in order to provide a more realistic timescale for the long term assessment of maternal and infant morbidity. Accordingly, the postnatal questionnaire focused on respondents health and their infants health during this period and the nature of their involvement with and experience of postnatal maternity services. At this third and final stage of the panel study, of the original 282 women who had responded to the antenatal questionnaire, 200 replied to the postnatal questionnaire. This further process of attrition from the intrapartum to the postnatal stage of the study did not, however, reflect the differential loss of respondents with socially distinctive demographic or behavioural characteristics.

## Maternal Post Natal Health

A concern with women's experiences of postnatal care is an important matter in its own right. Based on a review of the limited amount of research which has been conducted in this area, typically over a relatively short timescale, Winterton notes that,

> " ...the popular model of a healthy, fit woman able to care for her baby is the exception. Most are tired, in pain, physically unwell, depressed or unable to cope well."
>
> (Winterton, 1992, page lii ).

This confirmed by the postnatal stage of the panel study. The experience of birth and the process of becoming a mother had a major impact on the physical and mental health of a large proportion of the panel for some considerable period of time after delivery, thus replicating the findings of the limited research which has been undertaken in this area over much shorter timescales. (e.g., MacArthur et al 1991, Audit Commission 1997).

Following the birth of their baby, for example, less than half of the panel (47.5%) reported that they had "returned to their normal health" within a period of three months after the birth, whilst for three quarters of the panel, (76.6%) this took as long as six months from the point of delivery. Indeed, almost 1 in 10 (9.5%) panel members felt that it had taken up to 12 months to regain what they felt to be their normal health, whilst 4% reported that they had not yet regained their pre-pregnancy health status. Moreover, such outcomes do not appear to be especially unusual. Research undertaken by the University of Aberdeen (Glazener 1992) found that a substantial proportion of postnatal women (73%)

> " ...complained of relatively minor post natal health problems such as tiredness, backache or constipation [in hospital, and]...at home 87% of mothers experienced at least one health problem: major problems such as bleeding or high blood pressure occurred in 46 %; and 78% complained of minor problems" (Glazener 1992, p4)

Amongst panel members, it was clear that childbirth affected the health of mothers not only in a physical sense but also in a mental sense as well. as the following table illustrates:

Table 11:1 Panellists Self Assessment of their Health Status During Their Baby's First Year.

| % Response n=200 | | | | |
|---|---|---|---|---|
| | More Than Usual | Same As Usual | Less Than Usual | Not At All |
| Were you able to concentrate on what you were doing | 2.0 | 40.0 | 55.5 | 2.5 |
| Did you lose sleep because you were worrying | 27.0 | 29.5 | 4.5 | 39.0 |
| Did you feel mentally alert and wide awake | 5.0 | 27.5 | 57.0 | 10.5 |
| Did you feel energetic | 2.0 | 19.0 | 63.0 | 16.0 |
| Did you feel that you were managing well | 6.0 | 63.5 | 26.5 | 4.0 |
| Were you able to be affectionate towards others | 4.0 | 56.5 | 36.0 | 3.5 |
| Did you feel capable / confident about making decisions | 2.5 | 69.5 | 24.5 | 3.5 |
| Did you feel under strain | 50.5 | 30.5 | 6.5 | 12.5 |
| Were you able to enjoy your day to day activities | 5.5 | 43.5 | 46.0 | 5.0 |
| Did you find everything getting on top of you | 39.0 | 40.0 | 4.0 | 17.0 |
| Did you feel reasonably happy | 14.0 | 67.0 | 15.0 | 4.0 |
| Did you feel confident about yourself and your ability to handle situations | 10.0 | 60.0 | 27.0 | 3.0 |

When asked about their general state of health following the birth of their baby, panel members highlighted a number of areas which had had a significant impact on their ability to function as they would have liked. 63% of the panel reported that they felt less energetic than usual, with a further 16% saying that they had no energy at all. Similarly, 57% or women felt less mentally alert and wide awake that was usual, with 1 in 10 reporting that they did not feel mentally alert at all. Almost 6 out of 10 women (58%) noticed a decrease in their ability to concentrate on everyday/routine tasks and just over half of the panel, (50.5%) said that they felt under strain more than usual during the year following the birth of their baby and were not able to enjoy their day to day activities as they would have wished.

Furthermore, 3 out of 10 panel members reported that they did not think that they were managing well at home and that they did not feel confident about their ability to handle situations and were not as capable of making decisions as they had been. Since a substantial majority of the panel would have welcomed further information about the care and development of their baby at the immediate, hospital-based postpartum stage, this lack of confidence is not perhaps surprising. 40% of the panel felt that things were getting on top of them more than was usual and a similar proportion (39.5%) said that they were less able to be affectionate towards others than previously. These findings broadly reflect the results of a post natal study undertaken by the Health Research Unit which discovered that -

> "When the baby was two months old, 59% [of mothers] felt tired and 61% were unable to get as much rest as they needed. 49% felt that they were not coping well when they first went home and 44% still felt this way when their babies were 8 weeks old."
>
> (Glazener et al, 1992 Pg6 )

The image which emerges of the state of health of many panel members during the first 12 months after delivery is an image of considerable physical *and* mental stress. The process of becoming a mother, either for the first or second time, can hardly described as easy, with at least half of the panel feeling under mental 'strain'. Effective postnatal care and support, in order to deal with both the physical and mental stress of motherhood, is clearly central to the needs of many - if not most - of the women in the panel. As an examination of the pattern of postnatal service utilisation indicates however, these needs do not appear to have been met.

**Panel Members Pattern of Utilisation of Postnatal Services**

Despite the relatively high levels of both physical tiredness and mental fatigue reported by the panel, for example, not all those who experienced such problems sought professional medical advice. This suggests that the postnatal 'illness behaviour' of many women may well reflect what Wadsworth et al have described as a 'clinical iceberg'. (Wadsworth et al 1971). That is to say, the true incidence of ill-health, postnatally, is not revealed by the pattern of utilisation of professional healthcare services, irrespective of whether one considers either the

frequency with which women use such services or the type of complaints they report to the service providers. The most common postnatal problem which panel members referred to their GP was physical exhaustion, with just over a quarter (26.5%) of the panel visiting their GP for this reason. Of these, approximately half visited their GP on more than one occasion. The other most common causes of GP consultation were backache (21%) and depression (21%). Again, half of all the women who reported that they experienced health problems in these areas visited their GP on multiple occasions - which suggests that either the women concerned or their GP's thought that the condition warranted extended attention. Other reasons which panel members cited as causes for visiting their GP were, in order of descending importance, breast problems (16.5%), problems from episiotomy stitches (11.5%), lack of sex drive (9.5%), cracked nipples (7.0%) and problems holding urine (6.5%) - that is to say, problems directly associated with labour and delivery and its aftermath.

Just over one fifth of the sample (22.5%) said that they had visited their GP following the birth of their baby for reasons *other* than those associated specifically with labour and delivery (for example gallstones, chest pain, colds) and two thirds of these required repeated medical attention. Only a small percentage of the panel indicated that they had received postnatal medical attention (either as an in patient or as an out patient) from hospitals relating to any post birth complications (under 2%) and the most common cause of admittance to hospital (6%) was for factors *other* than those to do with labour and delivery.

In general therefore, not only could the maternal postnatal health of the panel be described as relatively poor, but the level of use of postnatal health care services was also comparatively low given the reported incidence of morbidity, and almost entirely confined to GP or community-based postnatal services. Furthermore, the data also suggests that women rarely seek help or support from professional health services for the considerable *mental* stress and social strain involved in the process of becoming a mother, beyond the stage of labour and delivery. Additional support for this assumption or inference is provided by the pattern of *practical* and *emotional* support provided to panel members by health care professionals.

## Social Support in Motherhood

In examining the sources of both practical help and emotional support provided to panel members postnatally, the panel study enquired into the levels of support provided by such professional groups as midwives, health visitors, and GPs, compared with husbands / partners, parents, in-laws, relatives and friends.

Post natal support, of both a practical and emotional nature, has been found to be of particular significance in assisting women in their transition to motherhood (Graham and McKee 1980; Crockenberg 1987, Kinard 1990, Ross and Mirowsky 1989, Oakley 1992). Since a large number of respondents indicated that they experienced relatively high levels of physical and mental strain in the period following birth, one might reasonably assume that practical and emotional support would be crucial in helping mothers to deal with the stresses and strains associated with this period of personal role adjustment, especially in the case of first time mothers. Indeed, as Kendal-Tackett et al highlight;

> " ... a woman's level of social support is perhaps the single most important variable to consider in the study of post partum depression. This variable examines her relationships with other people and the type of help she has available, especially in times of stress...when considering whether a woman is receiving adequate support it is easy to be fooled by appearances...people in a woman's social network might not offer to help. And even if they help, the woman must perceive it as support".
>
> (Kendal-Tackett et al 1993, p69)

Effective postnatal social support is associated with lower levels of post natal depression amongst new mothers and has also been seen to influence the extent to which women adjust to their new circumstances and their self-identity during this period (Cutrona 1984, O'Hara 1986). Barnett and Parker (1985) claim, for instance, that the provision of effective social support by health care professionals and non-professional women with experience of motherhood, reduced the level of maternal anxiety amongst their sample of highly anxious first time mothers to a significant extent. Furthermore, the degree of social support provided by postnatal carers potentially affects the relationship which mothers are able to form with their babies. Crockenberg and McClusky claim

that the level of social support given to mothers influences the extent to which mothers are sensitive to their child's needs. In their study, the greater the perceived levels of support provided to mothers, the more sensitivity mothers displayed towards their toddler. (Crockenberg & McCluskey, 1986)

**Support from Professional Carers**

The level of *practical support, help and information* provided to panel members by professional carers, specifically midwives and health visitors, was perceived to be relatively low (Table 11:2). Whilst 3 out of 10 panel members (31.5%) said that they received either "a lot" or "a fair amount" of such assistance from midwives, more than two thirds (67.5%) said that the level of help received for this professional group was either "not very much" or "none". A comparison with the role of the Health Visitor elicited a similar response. 35.5% of respondents indicated that they felt that they had been given relatively high levels of practical support (either "a lot" or a "fair amount") from their health visitor following the birth of their baby. 64% however reported that felt that they received little or no practical support / advice from their health visitor postnatally. This may of course impact on issues such as breastfeeding success and physical recovery.

A similar pattern of response also emerged when panellists were asked to evaluate the extent to which midwives and health visitors had been a source of *emotional* support in the year following the birth of their baby. Almost three quarters of the panel (74.5%) felt that they had not received substantial levels of emotional support (with only 3% responding that their midwives had given "a lot" of emotional support and 22% indicating that they had, in their opinion, received a "fair amount"). A similar picture emerges in relation to the perceived levels of support provided by health visitors, with less than one third of panellists (30%) indicating that they felt that they had received comparatively high levels of emotional support. The role of the HV may assume a greater degree of salience to women than that of the MW during the postnatal period, since midwives typically cease being involved in the care of women and their babies at approximately 8 weeks postpartum.

Interestingly, however, when asked as to whether they would have liked more practical help from their midwife, less than one fifth of the panel responded

positively (19.5%), with a similarly low proportion indicating that they wanted more practical help from their health visitor. The corresponding proportion of panel members who would have welcomed additional *emotional* support from midwives and health visitors was 14% and 22% respectively. In other words, not only were midwives and health visitors regarded as providing comparatively low levels of practical help and emotional support to the majority of panel members, but there appears to be a relatively little demand for *additional* support from either of these two professional sources during the postnatal period.

By contrast, respondents seem to regard midwives and health visitors as fulfilling a potentially central role in the *provision of information* about postnatal issues, a point which will be discussed at greater length later in this chapter. This does not imply that mothers do not value the support that they *are* given from such professional groups during the post natal period, or that support from such professional sources is irrelevant as far as the maintenance of women's postnatal health is concerned. As a recent study by Oakley (1992) has demonstrated, in a randomised control trial, the provision of *practical and emotional* support by midwives to women designated as "at risk" of having a low birthweight baby had significant positive health outcomes, both during pregnancy and birth.

However, the crucial difference between Oakley's study and the panel study is that the membership of the panel was drawn from a predominantly middle class area and respondents are therefore relatively advantaged, socially, economically and educationally, in comparison to Oakley's respondents. Since health and class position are closely related (Black Report 1980), one can reasonably assume that panel members (who are predominantly 'middle class') are likely to be generally healthier and less likely to be defined as 'at risk' by health care professionals during pregnancy and birth. Indeed, Oakley's respondents were selected precisely *because* they were "high risk", and such women may well benefit from increased *practical and emotional support* (from both midwives and health visitors), especially during the ante natal period. The same is not necessarily true, however, for women who do not fall into this category.

The nature of women's need for support during the postnatal period is of course a potentially complex issue. Such 'needs' may well reflect the impact of the individual's health status, as in the case of Oakley's "high risk" respondents who

appear to have different needs, compared with the majority of panel members who were not clinically defined as 'high risk' pregnancies. Equally, women's perceptions of their postnatal needs may also be shaped by their experiences of the kind of support or care provided for them by health care professionals. In which case, women may define all or some aspects of their postnatal 'needs' for care and support in a manner which in part reflects the *preferences* of service providers. The latter type of response from service users may of course take several forms for a variety of reasons. The service user may, for example, perceive the health care professional as being unwilling to provide the type of care or support that the user wishes, but this refusal may not be challenged, either because the user feels powerless or because the service providers 'preferences' may be accepted by the service user as constituting a legitimate restriction on the type of service on offer. In the latter case, exponents of the 'non-decision' making view of power and control (Backrach and Baratz, 1963) would of course stress the need to consider whether, under such circumstances, knowledge of possible alternatives have been fully disclosed to the service user by the service provider. In the case of the majority of the members of the panel, it appears that postnatal health care services do not satisfy their needs, both because such services are seen as *deficient* in certain ways - a point which will be discussed in more detail later - and also because panel members have needs which demand support from non-professional as well as professional sources.

**Sources of Non-Professional Help and Support**

As Table 11:2 illustrates, the respondent's husband or partner was the primary source of *practical* help to women during the post natal period :

Table 11:2 Sources of Practical Help to Mothers During The Post Natal Period.

| | % Response (n=200) | | | | | |
|---|---|---|---|---|---|---|
| | Too Much | A Lot | A Fair Amount | Not Very Much | None / Not Applicable | More Needed |
| Husband/Partner | | 42.0 | 35.0 | 16.0 | 7.0 | 32.5 |
| Your Parents | 2.0 | 24.0 | 35.0 | 16.0 | 23.0 | 27.0 |
| Partners Parents | | 5.5 | 19.5 | 28.5 | 46.5 | 27.0 |
| Relatives | | 8.5 | 16.5 | 16.5 | 58.5 | 18.0 |
| Close Friends | | 9.0 | 26.0 | 22.0 | 43.0 | 16.0 |
| Midwife | 1.0 | 7.5 | 24.0 | 44.0 | 23.5 | 19.5 |
| Health Visitor | 0.5 | 6.0 | 29.5 | 42.0 | 22.0 | 20.0 |
| Support Groups& | 0.5 | 1.5 | 10.5 | 17.0 | 70.5 | 6.5 |
| Other Sources $ | | 4.0 | 5.5 | | 90.5 | 2.0 $$ |

Key: & - support groups cited were those such as Mother and Toddler / Post Natal Groups etc; $ - other sources of practical help given by panellists such as their church (8%) and GP (1.5%); $$ - more practical help needed from GP (1.5%), Social Services (0.5%)

42% of the panel indicated that their husband or partner gave them "a lot" of practical help and support after their baby was born, whilst a further 35% felt that they received a "fair amount" of practical help from their husband or partner. However, almost 1 in 5 panel members reported that they felt that the level of help that they received from their husbands or partners was minimal and when asked whether they wanted a greater level of practical help and support from their partners, one third of the panel responded positively.

The second most important source of practical help were women's parents (almost certainly a woman's mother) although only 1 in 4 women felt that they had received 'a lot' of help from this source (reflective, in part, of the geographical dispersion of the family in late modern societies). The use of other relatives or close friends as sources of practical help and support was noticeable by its absence. In addition to the extra, non-professional practical help which many women wanted from their husbands, many women (27%) also wanted more practical help from their parents and parents-in-law.

As Table 11:3 illustrates, a broadly similar picture emerges when one examines the principal sources of emotional support for panel members during the postnatal period. Panel members husbands or partners were seen to be the major providers of emotional support to the newly delivered mothers, with over half (51%) of respondents indicated that their husband/partner gave them "a lot" of emotional support during the post natal period whilst a further 25% felt that had received "a fair amount". Almost 1 in 7 respondents indicated that they did not receive much support from their husband / partner, whilst 1 in 10 (8%) were devoid of what was perceived by the majority of panel members as a key source of support during the postnatal period. Almost 3 out of 10 respondents (27%) indicated that they would have liked more emotional support from their partner than they received.

TABLE 11:3 Source of Emotional Support to Mothers During Post Natal Period

| | % Response (n=200) | | | | | |
|---|---|---|---|---|---|---|
| | Too Much | A Lot | A Fair Amount | Not Very Much | None / Not Applicable | More Needed |
| Husband/Partner | 1.0 | 51.0 | 25.0 | 16.0 | 8.0 | 27.0 |
| Your Parents | 2.0 | 35.0 | 28.0 | 16.0 | 19.0 | 15.0 |
| Partners Parents | | 8.0 | 19.5 | 28.0 | 44.5 | 13.0 |
| Other Relatives | 0.5 | 13.0 | 17.0 | 20.0 | 49.5 | 7.5 |
| Close Friends | | 20.0 | 35.0 | 13.0 | 32.0 | 10.0 |
| Midwife | 0.5 | 3.0 | 22.0 | 37.0 | 37.5 | 14.0 |
| Health Visitor | | 3.5 | 26.5 | 38.5 | 31.5 | 22.0 |
| Support Groups* | | 1.0 | 12.5 | 14.0 | 72.5 | 4.5 |
| Other Sources $ | | | 5.5 | | 94.5 | 1.0 |

Such findings broadly parallel the results of an earlier study by Levitt, Weber and Clark (1986) in which the primary source of support for new mothers came from their husbands. The potential significance of the role played by women's husbands or partners postnatally is underlined by research which suggests that the level of support provided by the husbands or partners of women who were depressed, was of a lower order than that provided by those husbands or partners whose spouses did not develop symptoms of depression (Paykel 1980).

In general therefore, panel members relied principally on their partners or husbands for social support in motherhood. Respondents regarded their parents as an important source of support, in a practical and emotional sense, but such support was clearly of secondary importance compared with that provided by husbands/partners. Outside the confines of the immediate 'family' of a woman's husband or partner and her own parents, little support is provided to new mothers (either practically or emotionally) from other sources. Parents-in-law, for example, appeared to play little or no part in supporting respondents during the postnatal period, either practically (75%) or emotionally (72%) but only a small minority of the panel members wanted additional practical support of any kind from their "in-laws". Only close friends are thought by panel members to constitute a relatively important additional source of support, and even this is mainly limited to providing support of an emotional rather than a practical nature.

The central importance of the conjugal pair as the principal source of social support in the postnatal period is underlined by the panel's response to questions about the relative difficulties involved in obtaining *day-time* help from either family or friends. Only 16.5% of mothers in the sample said that they were able to get such help on a "very frequent" basis whilst a further 24% indicated that they could get assistance with child care on a "fairly frequent basis". For the majority (65%) of the panel obtaining assistance with child care during the day posed considerable difficulties. What is more, when asked about their *need* for more time to themselves, almost 6 out of 10 (57%) respondents indicated that they would have liked to have more time to themselves during the day - possibly for rest and recuperation given the high levels of morbidity within the panel.

On a related point, although postnatal support groups (for example, mother-and-toddler groups) are commonly perceived to play an important social function for mothers and their young children in satisfying such a need (Cutrona 1984), the level and frequency of use of such support groups amongst panel members was relatively low. Only one fifth of panellists (21%) indicated that they went to such post natal support groups on a "frequent" basis and a large proportion of the panel (42.5%) did not use them at all. Difficulty of access would not, prima facie, appear to be a reason for non-attendance since a high proportion (88%) of respondents (in the antenatal questionnaire) indicated that a car was available for them to use during the day. However, examining the potentially complex reasons for the low uptake of such groups (which may include factors such as perceived relevance, the postnatal employment characteristics of the panel etc) was beyond the scope of the current project.

Overall, therefore, the emotional and practical support which the majority of respondents received after they had been discharged from hospital was provided from non-professional sources, largely the husband or partner. In general, the contribution which professional carers (viz. midwives, health visitors and GP's) can make to the health and well-being of women is not seen to be particularly relevant to the long-term practical and emotional needs of newly delivered mothers. Rather, the professionals contribution appears to be defined more narrowly in terms of information provision. Since the pattern of postnatal maternal health within the panel is commonly characterised by a high incidence

of mental as well as physical stress, professional carers are clearly failing to relate to this key area of need. Moreover, as the remainder of the current chapter illustrates, even within the limited area of information provision, panel members commonly perceive postnatal health care workers as failing to deliver the kind of service they need.

**Panel Member's Expectations and Experiences of Becoming a Mother**

The extent of panel members previous experience of looking after young children (prior to their recent delivery) is likely to affect their reaction to postnatal care as well as their postnatal experiences in general. Whilst approximately half of the panel had had direct previous experience of motherhood itself, being second time mothers, one in five (19.5%) declared that they had *no* previous direct experience of looking after babies and young children prior to the birth of their own baby and almost 3 out of 10 felt that their experience was limited.

This in itself reflects a number of major social changes which have taken place in relating to the pattern of family, community and working life in modern industrial society as a whole, particularly during the twentieth century. Throughout the current century, for example, the size of the nuclear family has progressively declined as a result of a fall in the rate of conception (Banks 1954) At the same time, individuals employed in white collar/professional or 'middle class' occupations have become increasingly involved in a geographically mobile lifestyle, due to changes in the pattern of career development and the character of modern organisational life. Such "spiralists", as Watson (1964) has called them, are less able to call upon other family members (parents, siblings etc.) for regular practical help due to the dispersal of kinship networks - and indeed we have seen that within the panel, 4 out of 10 mothers received little or no practical support from their parents and an even larger proportion, 8 out of 10, received little or no help from other relatives. As Bott (1957) has argued, geographical mobility also has consequences for conjugal role relationships within the nuclear family, with partners increasingly come to rely on each other for mutual practical and emotional support, an argument supported by evidence from the current study - although critics of Bott point out that while geographical mobility may create the need for such mutual help, male partners do not necessarily respond in this manner. (Edgell, 1980)

The transmission of traditional "lay" knowledge about issues such as infant health and illness (especially in a practical "hands on" sense) is accordingly more difficult under such circumstances. This suggests that lay people will increasingly need more professional advice and information during key periods of change such as the process of becoming a mother. As the work of Oakley (1979) and Davis-Floyd (1992) amongst others highlights, the modern parent's comparative lack of experience and knowledge about parenting seems to be associated with a tendency to "romanticise" motherhood / parenthood. This in turn produces a substantial mismatch between adults prior expectations of parenthood and the reality itself (Oakley 1979)

Despite the comparatively low levels of experience amongst some sections of the panel, 1 in 4 mothers (39%) reported that they felt relatively confident about looking after their children and did not feel particularly anxious when caring for their baby. One third (32.5%) of the panel felt anxious "occasionally" and a further 23% indicated that they were anxious "some of the time". Only a small proportion reported almost constant levels of anxiety, with 3% feeling anxious "most of the time" and 2.5% "all of the time". Although, there is a tendency for rather more first-time than second time mothers to be anxious, this is not true to a statistically significant degree. Indeed it is the similarity of first and second time mothers postnatal needs, especially with respect to child development, which is so striking (see Appendix I). Whilst the levels of general maternal anxiety within the panel may be relatively low, when asked about their actual experiences of parenting compared to their prior expectations, 36% of panellists agreed strongly with the statement that "it is harder to be a parent than I imagined" and a further 46% agreed to some extent.

More than a quarter of panel members reported that they found the experience of becoming a mother "fairly difficult" and a further 4.5% said that had found the experience of motherhood and the accompanying role transition to be "very difficult". Less than half of the panel (42%) responded in a positive manner about the *process* of becoming a mother (viz physically, mentally and socially), even though more than half of the panel (54%) agreed strongly with the statement that "being a mother is the most important thing that I do." Although the majority of mothers (81.5%) felt that they coped reasonably well when looking after their baby, it is clear that the levels of maternal enjoyment with the role of "mother"

increased over time. Only 27.5% of the panel enjoying looking after their baby "all of the time" when they were under 6 months old, but this increased to 63%, after the child was more than six months old.

In addition to the mental as well as physical strain experienced by many panel members postnatally, the postnatal period was also a time when they had to adjust to new commitments and develop new competencies, typically in a situation of relative ignorance. Not surprisingly therefore, aside from their need for emotional and practical support as a means of overcoming the mental and physical strain of becoming a mother, either for the first or the enth time, the panel also elicited a clear need for information about a number of postnatal issues concerning infant health and infant development, as well as their own postnatal health.

**Maternal Information Needs During The Postnatal Period**

As chapters 9 and 10 have already highlighted, respondents attached a high degree of significance to the provision of information to them by health care professionals at the antenatal and intrapartum stages of maternity care - which is not in itself surprising, given many panel members lack of experience of pregnancy and birth and the individuality of each pregnancy experience. This key need for information was not however met by service providers during antenatal and intrapartum care. What is more, a similar problem occurs at the postnatal stage as well. During the post natal period, less than 1 in 5 respondents indicated that they were highly satisfied with the information that they were given following the birth of their baby. Panel members had quite specific views about who should provide the information that they needed, as table overleaf illustrates.

Respondents wanted more information on a wide range of topics from their Health Visitor (HV). In addition to their concerns about their own health, nearly 4 out of 10 mothers (39.5%) said that they wanted additional information about child sleeping habits, whilst 34% said that they would like further information about infant health and development as well as their own health. A further 29% required additional information on the transition to feeding their child solids. The latter is particularly pertinent in the light of research conducted by Martin and White (1988) which found that 22% of mothers had started their babies on some

solid food by two months, which was not in accordance with the national policy of avoiding solids until at least 4 months. Other areas of information needs included, in decreasing order of importance, breast feeding, child safety, how to handle and care for babies and bottle feeding.

Table 11:4 Topics on which panellists wanted further information from their Health Visitor and GP (% of panel indicating additional information required, (n=200)

| Subject Area | Health Visitor% | GP |
|---|---|---|
| Breast Feeding | 20.5 | 6.5 |
| Bottle Feeding | 13.0 | 3.0 |
| Feeding baby Solids | 29.0 | 8.0 |
| How to handle and look after your baby | 15.5 | 5.0 |
| Possible health problems - baby | 34.0 | 33.5 |
| Your own health and recovery | 34.0 | 40.5 |
| Development of your baby | 33.5 | 16.5 |
| Child Safety | 16.0 | 4.0 |
| Child Sleeping Habits | 39.5 | 18.0 |

In contrast to panel members perception of the role of the HV as a potential provider of information over a range of topics, GPs were seen as a source of information principally about maternal (40.5%) and child health (33.5%).

It is apparent therefore that the panel regarded differing health care professionals as playing quite distinctive roles in the provision of information about matters of child care and infant and maternal health, and deficiencies in the provision of information related to different professional roles in different ways. Hence midwives and health visitors are seen as the principal providers of information about such topics as child sleeping habits, feeding methods and general baby care, and are also perceived as being of at least equal if not more importance than GPs or Obstetricians in the provision of information about infant and maternal health. The roles of both GP and Obstetrician as information providers, by contrast, is seen to be more specialised or limited, as the following summary table indicates :

Table 11:5 A Comparison of the Demand for Information By Respondents From a Number of Key Personnel Involved in the Provision of Post Natal Maternity Care (% responding that wanted more information from key professional service providers)

| Subject Areas | Midwife* | Health Visitor # | GP # | Obstetrician * |
|---|---|---|---|---|
| Breast / Bottle Feeding | 48.0 | 33.5 | 9.5 | 7.6 |
| Feeding baby Solids | | 29.0 | 8.0 | |
| How to handle and look after your baby | 43.0 | 15.5 | 5.0 | 6.8 |
| Possible health problems - baby | 65.5 | 34.0 | 34.0 | 55.3 |
| Your own health and recovery | 52.7 | 34.0 | 40.5 | 47.3 |
| Development of your baby | 48.5 | 33.5 | 16.5 | 40.9 |
| Child Safety | | 16.0 | | |
| Child Sleeping Habits | | 39.5 | 18.0 | |

Key: (* n = 237 Second Stage of Panel Study)
(# n = 200 Third Stage of Panel Study)

In the case of GPs however, even though their role as information provider was conceived to be relatively narrow by panel members, the level of utilisation of GP services on matters of infant health, was relatively high. During their baby's first year, a high proportion of panel members (84%) indicated that they took their baby to their GP due to a perceived illness on at least one occasion. Nearly one quarter of the panel (23.5%) consulted their GP on two occasions in the year after birth, for reasons of child illness, whilst a further fifth of the panel (20%) reported using such services on three occasions. More than 1 in 10 visited their GP at least 5 times, specifically for childhood illness, in the year following birth.

Despite this comparatively frequent use of GP services, the relative severity of the illnesses involved would not appear to be very great, if measured by the subsequent level of admittance to hospital (confirmed during discussion with paediatricians and GP's). Although 84% of babies were seen by their GP for reasons of ill-health, the subsequent rate of hospital admission was less than 1 in 10 (8%). Whether this indicates an inappropriate use of such services is difficult to say, although such a pattern of service utilisation suggests that while midwives and HV's are seen as providing a potentially wider range of information than

GP's and Obstetricians, the more 'specialised' roles of the latter may carry greater *authority*. If true, this would merely add to the problems which panel members face in eliciting the type of information they need from service providers.

The uniformly high levels of childhood immunisation amongst the children of panel members, as illustrated in the following table, clearly show a high level of commitment amongst the panel to positive action as a means of maintaining a high standard of personal health.

TABLE 11:6 The Reported Rates of Immunisation Within the Panel

| Type of Immunisation | % uptake within the panel |
|---|---|
| 1st Diphtheria, Tetanus, Whooping Cough, Polio | 99.0 |
| 2nd Diphtheria, Tetanus, Whooping Cough, Polio | 98.5 |
| 3rd Diphtheria, Tetanus, Whooping Cough, Polio | 97.5 |
| Measles, Mumps, Rubella | 93.5 |

Equally, this also demonstrates a high level of awareness of and responsiveness to health information messages and campaign, reiterating a point made in earlier chapters about the positive and proactive attitude to health which characterises the panel in general. Any deficiencies in the provision of information from service providers to panel members cannot therefore easily be explained in terms of the lack of interest in or responsiveness to health information per se.

Despite the critical response by panel members to several aspects of the maternity care services which they received, the desire on the part of respondents for a *radical* alternative to the current system of maternity care seems relatively muted - if the attitude of panel members towards the question of the place of birth is anything to go by. At the antenatal stage, approximately 1 in 7 panel members considered having a home birth rather than a hospital birth. Shortly after labour and delivery, this proportion rose to 1 in 5, but twelve months later, the figure had fallen back to 1 in 6. In other words, a residual minority of panel members might have preferred to have a home birth, had this proved a realistic

alternative, a finding reiterated nationally by a recent Audit Commission Survey. (Audit Commission 1997).

## Conclusions

The image of a happy, newly-delivered mother and her bouncing health baby is something of a cultural icon in late modern societies. As both the present study and other research has demonstrated, this image is however a cultural *myth*. The process of becoming a mother clearly affected the health of respondents for some considerable time, even though respondents appeared to be relatively healthy prior to delivery, both on the basis of their own self assessment and the high proportion who were expected to have a normal vaginal delivery. Many panel members also found adjustment to motherhood far more difficult than they had previously imagined. Additionally, panel members experiences of postnatal health care services typically fell short of their expectations and requirements. Although many respondents experienced both mental as well as physical strain postnatally, the involvement of health care professionals in dealing with the former - compared with the latter - appears to be negligible. A key need for many panel members concerned information about infant health and development, as well as information about the nature of their own recovery from labour and delivery, but in both cases, a clear 'information deficit' exists.

The sense of a lack of choice and a loss of control in the period following birth emerges strongly from the postnatal stage of the panel study. The reality of modern motherhood is that many women are physically and mentally exhausted, and respondents reported that they were in need of additional help from, by preference, their husband / partner and close family, as opposed to service providers. The current chapter has highlighted that not only is women's health often poor post birth, but respondents also indicated that this may persist for a considerable period of time after delivery and discharge from hospital. Furthermore, postnatal health care services do not seem to match the needs of the panel in several different ways. What is particularly striking about panel members experience of postnatal care is the apparent lack of care available to women at this stage of the maternity care cycle. And this despite the fact that modern maternity care's approach to labour and delivery has been shown to have a negative impact on postnatal health for many women (Winterton 1992). The

image of modern maternity care which comes across strongly from the evidence of the panel study therefore is of a form of care which effectively begins and ends at the doors of the maternity unit.

Whether the poor postnatal health of the panel can be ascribed to the impact of the *organisation* of modern maternity care is however a separate issue, and one to which we now turn in the succeeding chapter of the thesis.

# Chapter Twelve

## The Health Implications of Modern Maternity Care : A Longitudinal Analysis

### Introduction

The preceding analysis of the postnatal stage of maternity care has highlighted the fact that, for the majority of the panel, this is a period marked by considerable physical and mental strain, typically for several months after discharge from hospital. The cause of such maternal ill-health during the postnatal period can be accounted for using several different explanatory frames of reference or approaches. As far as the issue of physical health is concerned, the high incidence of breast problems amongst the panel, such as 'cracked nipples' for instance, may be regarded as a 'natural' problem of motherhood, relating to the physical constitution or make-up of the individual. Similarly, in the case of mental strain, the so-called 'baby blues' or postnatal depression are commonly attributed, amongst health professionals and lay people alike, to hormonal changes associated with childbirth. (Enkin et al, 1996; Kendell et al 1984). However, several aspects of the postnatal health of women are clearly related to the nature of modern maternity care itself.

Amongst the panel, for instance, a high proportion of women reported postnatal pain and discomfort caused by stitches inserted after delivery, stitches which were necessary not simply to deal with natural 'tears' which occur during labour, but also as a means of sealing surgical incisions or episiotomies. These incisions were made during labour in order to 'assist' so-called 'normal' vaginal births and reflect the increasingly interventionist nature of modern maternity care (Cartwright 1979; Graham and McKee 1980; Ball 1989; Audit Commission 1997). Equally, the relatively high incidence of such problems as 'cracked nipples' may not be wholly ascribed to 'natural' causes either. Women's *knowledge* of or relative ignorance about breastfeeding, for instance, can lead to the onset of such physical problems and such a lack of knowledge may well be a product of both the kind of social changes in family life referred to earlier in chapter 11. Such social changes tend to undermine the transmission of knowledge across generations, and the relative quality of the

information provided by health care professionals may therefore assume a greater degree of significance. As has already been shown in chapters 10 and 11 however, many panel members regarded the quality of the information provided by health care professionals about breast feeding as inadequate.

On a similar note, both health care professionals and lay people alike commonly assume that postnatal/postpartum depression is a 'natural' phenomenon, which has its origins in biological / and or psychological change at the level of the individual, even though this belief bears little or no relationship to research evidence. (Enkin et al 1996) Rather, variations in the incidence of postnatal/postpartum depression have been found to relate to variations in the social circumstances and social background of individuals, thus highlighting the need for researchers to consider the influence of social structure or social organisation on postnatal mental health (Kendall-Tackett 1993). As Enkin et al emphasise, in their review of clinical research studies:

> ...no biochemical explanation of women's unhappiness after childbirth has been uncovered, and psychoanalytical explanations of postpartum depression cannot be validated empirically. Mothers of young children are often depressed and are no less likely to be so six months or a year after delivery than in the first few weeks or months following childbirth. Sociological and psychological studies have provided...evidence of a relationship between some social conditions and postpartum depression. (Enkin et al 1996, p346)

Derivatively, the current chapter of thesis argues that the social organisation of modern maternity care itself has a negative influence on the postnatal health of its users. The argument is initially developed by means of a review of the concept of the 'psychosomatic' dimension of health and illness and is then substantiated by a longitudinal analysis of the panel, focusing on the relationship between panel members experiences of pregnancy, labour and delivery on the one hand and their postnatal health on the other.

## Socio-Psychological Influences on Health

Social science research suggests that inequalities in health between individuals cannot be accounted for by the influence of genetic inheritance or psychological disposition alone. As both The Black Report and The Health Divide in the 70's and 80's (Townsend and Davidson 1982; Whitehead 1987) famously demonstrated, individual differences in health closely mirror socio-economic inequalities. Although Black and others have placed a great deal of emphasis on the influence of material inequality on health inequality, other aspects of social inequality have also been found to have important consequences for health. Research on health and social inequalities in the British Civil Service, for example, suggests that the degree to which an individual perceives themselves as being in 'control' of their life, in both work and leisure, has important consequences for the health of the individual (Rose & Marmot, 1981, Marmot et al, 1984). Those individuals who are able to exercise the greatest degree of control or freedom over their lives are likely to live longer and experience less ill-health than those with less freedom of action. Not surprisingly, in the highly structured or bureaucratic circumstances of the British Civil Service, the health of the individual is positively correlated with his or her organisational status - those with the highest status enjoying the best health. One of the general implications of this work is that the structure of modern organisational life is an important influence on health inequalities, quite apart from the influence of material inequality per se.

When one applies this idea to the study of maternity care, the issue of women's control over maternity care can viewed in a new light. Women's lack of control and choice over maternity care can be seen to be not only a *political* issue concerning women's *rights*, but also a *health* issue, since such a lack of control or choice may be literally *harmful* to one's *health*. The link between control and health can be explained, in this case, from a psychosomatic view of the relationship between the health of the individual and his or her social circumstances. A psychosomatic approach or perspective suggests that social circumstances can have implications for the mental state of the individual, especially when the individual perceives themselves to be in either a threatening (e.g. dangerous) or unrewarding (e.g. boring) situation, both of which invoke a sense of stress. The emergence of such a negative outlook can

in turn affect the physiological functions of the body itself. which may have harmful clinical consequences. Selye's development of his concept of the General Adaptation Syndrome in the 1950's provides a detailed illustration of the nature of the processes involved (Selye, 1956).

Stress is a key concept for the idea of psychosomatic illness and in its early usage by Selye, he defines 'stress' as simply an adaptive response in the human body to a 'stressor' or threatening stimulus. This adaptive response takes the form of a spontaneous secretion of adrenaline, a hormone produced by the pituitary gland, which then creates the conditions for what contemporary psychology calls 'fight or flight'. As the latter phrase implies, stress is not necessarily pathological. Such a response can be positive, enabling the body to call up more resources which improve physical performance and thereby enable the individual to either meet and overcome a threat or remove themselves from harm's way. If the initial adaptive response does not, however, enable the individual to deal with the threat - in whatever fashion- then the continuing presence of the stressor becomes clinically hazardous. Selye's concept of the General Adaptation Syndrome (G.A.S.) describes this latter more threatening scenario and involves a three stage process. To begin with, the continuing excessive secretion of hormones, due to the continuing presence of the stressor, leads to a build-up of corticosteriods in the blood stream. This process in turn reaches a point where an excessive level of corticosteriods in the blood begins to disturb the operation of the body's immune system, resulting in damage to bodily tissue as a consequence of the latters increasing inability to resist attack from infection and repair itself.

This early concern with the General Adaptation Syndrome focused particular attention on the threat from different types of *physical* stimuli, such as heat, cold, hunger etc. Later work in this field began to show that the G.A.S is initiated, not only by physical stressors but also by *psychological* stimuli alone (Brown and Harris 1978). This is a particularly important development, since it indicates that *thought processes* are central to our understanding of the nature of stress - it is thought and / or perception which 'determines' or decides whether an external stimuli should be regarded as a threat or not and if so of what magnitude. Once perceived as a threat, if the 'stressor' cannot be eliminated, then the different stages of the GAS begin to operate and

undermine the body's defence mechanisms. The recognition that subjective perceptions can play a significant role in initiating the adaptive response which Selye had originally defined as 'stress' implies that 'threats' or stressors needs to be related the social and cultural circumstances of the individual's way of life. Research began to be conducted into the impact of personal crises or what sociologists increasingly termed 'life events' on the health of the individual, using such psychosomatic concepts.

One example is Brown and Harris' study of the social origins of depression amongst women (Brown and Harris 1978) In this case, socio-psychological factors are seen as important influences on depression, particularly at a time of role-change. Brown and Harris found that their respondents capacity to cope with the change associated with a major life event or personal crisis (for example, bereavement, marriage, divorce, job promotion, job redundancy) varied according to the individual's social circumstances. Where such circumstances produced a feeling of low self-esteem, this left the individual with the feeling that they were unable to cope with the threat posed by the various changes which they had to face. This in turn led to the development of clinical depression in a similar manner to that suggested by Selye.

Interestingly, the factors which appeared to make women feel vulnerable in the face of major crises or major changes were associated with both the individual's contemporary social circumstances (for example, the presence or absence of a supportive social partner) and past events, such as the loss of a mother during a woman's teenage years. The latter in particular highlights the neglected role of *memory* in modern sociology and particularly the way in which memories can be recovered, reconstituted and re-interpreted in a contemporary context. At a broader level, Brown & Harris's study also implies that one needs to take account of not only the *past* and the *present* but also, potentially, the individual's perception or *imagination* of the *'future'*, especially when the 'future' is perceived to entail a major personal change or a rite de passage, as in the case of pregnancy and birth. Under these circumstances, one might assume that the individual's need to reduce the stress associated with a potential 'threat' or crisis in the 'future' would invoke a desire to exercise *control* over the prospect of such change by improving one's

understanding of the nature of this process - an understanding which therefore requires knowledge or information about this 'future' event.

Seen in this way, the process of becoming a mother, either for the first or second time - since both conditions involve a process of transition to a future situation which is 'new' in some sense or other - is likely to be perceived as *especially stressful* when a woman feels that she has little understanding or *prior knowledge* of how such a change may impact on her existing social relationships. Ensuring that women are well informed about the nature of such a change may well give them a sense of control over this process of transformation, in addition to endowing women with the capacity to make choices which they believe will help them to 'realise' their own particular preferred 'futures'.

Consequently, a failure to provide women users of maternity care services with the information they require on pregnancy, birth and motherhood (which in turn may also affect their ability to make *informed choices* about the direction which their maternity 'careers' will take) has potential implications for their personal health. This is in addition to 'political' implications for the distribution of power and control between service providers and service users. The well documented failure of modern maternity care to provide its users with the opportunity to make informed choices about their care seems, in several different ways, to be ineluctably bound up with the ideology and social organisation of maternity care. The discourse of risk, which, in the UK at least, has provided the ideological justification for the development of a modern obstetrics-driven system of maternity care, ignores or at least downplays, for example, postnatal maternal morbidity. Instead, the importance of infant mortality is stressed, during labour, delivery and the early post-partum phase in particular. This shifts attention away from women users and leads instead to an emphasis on the importance of the obstetrician, since it is the obstetrician who has to make the difficult technical 'judgements' in order to limit the risk of infant death.

Women service users have historically been viewed as passive objects or recipients of the obstetrician's knowledge and skills (Davis Floyd 1992). In its turn, this emphasis then creates a system of control of the service user by the

service provider which is markedly unequal in the latter's favour. Specifically, this relationship seems to be intrinsically characterised by a low level of communication of information between provider and user, especially over the more 'technical' aspects of the 'content' of maternity care.

Furthermore, the relationship between the two main service providers within hospitals, obstetrics and midwifery, has been characterised by a gendered form of 'competition' for the control of maternity care. Consequently, the gendered nature of maternity care is also likely to be implicated in this problem of the poor communication of information, as indeed the earlier discussion in chapter 10 of panel members experiences of intrapartum care indicates. 'Malestream' sociology's general lack of interest in the 'emotional' dimension of modern life may also have deflected attention away from the potential link between health inequalities and the social inequalities in the distribution of control, as seen from a more psychosomatic perspective. Certainly, the emergence of a largely feminist-inspired interest in the sociology of emotions in the 1990's reflects this important lacunae in contemporary sociological thought. (Jackson 1993, Duncombe and Marsden 1993, Craib 1995)

**The Health Implications of Modern Maternity Care - The Use of Longitudinal Analysis**

In order to assess whether the social organisation of modern maternity care constitutes an independent influence on the postnatal health of service users, a particular type of research design is required which would allow one to follow a single cohort of women through the three main stages of the maternity care cycle. One needs, in other words, to develop a longitudinal type of research design of the kind used by the thesis. In order to investigate the question, 'Is modern maternity care bad for women's health?', it is necessary, moreover, to go beyond the type of stage by stage analysis of the maternity care 'cycle' which has been used so far in the thesis and make longitudinal comparisons *between* different stages of the cycle.

Since modern maternity care is principally concerned with the first two stages of the maternity care cycle, *antenatal* and *intrapartum* care, the succeeding longitudinal analysis of the panel focuses particular attention on the

relationships between antenatal and intrapartum care on the one hand and the potential implications of each for the *postnatal* health, attitudes and behaviour of panel members.

At both the antenatal and intrapartum stages - as the discussion in chapters 9 and 10 has demonstrated - panel members principal concerns or priorities concentrate on the 'content' of the service they received, especially the quality of information provided to them by health care professionals. The information deficit which occurs at the intrapartum stage may not, however, have the same impact on the postnatal health of panel members compared with the impact of the information deficit which occurs at the antenatal stage of maternity care. As mentioned earlier, a psychosomatic approach to health and illness assumes that the impact on the health of a individual of a lack of control over a source of stress or anxiety is likely to be especially harmful when such stress occurs over a long period of time and cannot easily be dealt with or removed. In comparing the possible consequences for postnatal health of an information deficit which has occurred at *both* the antenatal and the intrapartum stages of maternity care, a central issue here is whether an information deficit which occurs over the relatively *lengthy* period of antenatal care is more harmful to health than an information deficit which occurs over the much *shorter* period of the intrapartum stage (which may last only hours or days).

It could be argued, of course, that an information deficit at the *postnatal* stage may also have important consequences for the *postnatal* health of the panel - but this is to raise a subtly different type of issue. If the postnatal health of panel members does suffer because of the poor quality of information provided to them at the postnatal stage about matters to do with *postnatal care,* such an issue is only tangentially related to the organisational character of modern maternity care. The quality or character of postnatal information may be *unrelated* to the way in which maternity care is organised at the antenatal and intrapartum stages. In other words, the quality of postnatal care, but specifically postnatal health information, can be effective or ineffective in both its content and method of delivery, irrespective of whether the type of antenatal or intrapartum stages of care which underpins it is based on a modern 'high tech' hospital-oriented system of delivery or on a more traditional, 'low-tech', home-oriented system of delivery. In either case, certain areas of postnatal

concern are likely to be common to women who experience both systems of delivery, such as infant development and infant health, although levels of infant morbidity are, according to Tew (op cit.) likely to be higher under a hospital-based than a home-based system of delivery and this is also likely to be true in the case of maternal morbidity.

## The Relationship Between Panel Members Experience of Antenatal Care and Intrapartum Care

In examining the impact that different stages of the maternity care 'cycle' have on maternal postnatal health, the most appropriate place to begin is antenatal care. One would assume, for example, that the character of panel members antenatal experiences are likely to have an important influence on their experience of intrapartum care. In practice, however, this does not appear to be the case. If one looks at the relationship between panel members evaluation of the 'content of antenatal care - either GP-based or hospital-based - and their experiences of intrapartum care, women's experiences during pregnancy seem to have very little impact on their evaluation and experiences of intrapartum care, even though the issue of service *content* figured prominently in panel members dissatisfaction with antenatal service provision.

Indeed, the impact of panel members satisfaction or dissatisfaction with GP and hospital-based antenatal care on members experience of intrapartum care seems to be restricted to a concern with the character of the relationship between service provider and service user during intrapartum care. When panel members are satisfied with the quality of information they received antenatally - from either of GP or Hospital based services - this is associated with a higher degree of satisfaction with the overall quality of intrapartum care provided by health care professionals (for GP-based antenatal care, $p=0.000$, for hospital-based antenatal care, $p=0.05$). In the specific case of hospital-based antenatal care, when panel members were satisfied with the amount of attention which was paid to their concerns and opinions by service providers, this was associated with lower level of demand for professional help during the early hospital based post-partum period ($p= 0.002$).

Apart from these two examples, therefore, the impact of antenatal care on members intrapartum experiences and attitudes is noticeable by its absence. One possible explanation might be that antenatal care focuses largely or entirely on antenatal matters (such as fetal growth, tests and women's health during pregnancy) and has no wider relevance outside of this stage of the maternity care cycle. It is only through attendance at additional antenatal classes that a large proportion of women learn about childbirth and as previous research has shown, women's ideas about labour and delivery often bear little relationship to their actual experiences (Oakley 1979).

Whilst antenatal care may indeed operate in such a narrow or blinkered manner, an examination of the relationship between the antenatal and postnatal stages of the 'cycle' suggests, on the contrary, that panel members experiences of antenatal care do have an important influence at later stages in the cycle - but primarily at the postnatal rather than the intrapartum stage of care.

**The Relationship Between Panel Members Experience of Antenatal Care And Their Postnatal Health, Behaviour and Social Relations**

In assessing panel members experiences of antenatal care in chapter 9, a key area of dissatisfaction was with the relatively poor quality of the 'content' of antenatal care, that is to say the quality of information provision, the degree of involvement in choices about care and the degree of attention given to the respondents own concerns and opinions. The potential long term consequences of these perceived problems with antenatal care for maternal postnatal health is therefore an important issue. From a psychosomatic point of view, one would assume that poor communication and the low quality of the information provided to panel members is likely to have serious consequences for the health of panel members. The failure of service providers to satisfy these key needs of the panel during pregnancy may, for example, create anxiety amongst service users about labour and delivery. Since the antenatal period is relatively long, such anxieties are also likely endure for a relatively long period of time, which, psychosomatically speaking, is harmful for an individual's health. At the same time, the emergence, at the antenatal stage, of anxieties about antenatal issues, may also *indirectly* increase women's general level of anxiety or state of apprehension about other phases of the maternity care 'cycle' as

well. Equally, since antenatal service providers not only provide antenatal care but also prepare women for labour, delivery (and give some limited information on such postnatal topics as feeding methods) poor communication and information provision at the antenatal stage may have a *direct* rather than an indirect effect on panel members anxieties about labour and delivery/intrapartum care. This may be demonstrated, inter alia, by a failure amongst service providers to provide information which enables women to create a meaningful, informed 'care plan' for labour and delivery.

The design of the panel study does not allow one to adjudicate on the comparative validity of these various hypotheses about the possible links between antenatal and intrapartum service delivery on the one hand and postnatal health on the other. However, longitudinal analysis of the panel data can provide a *statistical* analysis of the relationship between certain aspects of the social organisation of antenatal care and postnatal health. In so doing, this type of longitudinal analysis may also suggest areas where further research, using a different *qualitative* approach, designed to examine what C Wright Mills referred to the 'vocabularies of motives' of individuals, (Mills, 1959) might fruitfully be carried out.

Certainly, if one examines the relationship between panel members experiences of GP-based antenatal care and their postnatal health and behaviour, it is apparent that there are close empirical links between these two stages of the maternity care cycle, as Diagram 12:1 illustrates :

As Diagram 12:1 (overleaf) illustrates, when the quality of the information which panel members receive from GP-based service providers is high, the postnatal mental health of panel members is also high, in that women are more self-confident postnatally, less anxious and have a more positive attitude towards their changing role. Conversely, when panel members highlight a deficit with the quality of the information they receive from this source - which is more common, as has been demonstrated in chapter 9 - their postnatal mental state is worse. Similarly, when panel members are satisfied with the degree of choice they have over the range of care options available to them, this is not only linked to a more positive attitude towards their changing role, but also to a tendency to be more proactive. Women who feel they have more

choice also report that they feel better able to cope with change and adjust to motherhood more easily, than women who feel they have less choice. Finally, when women are satisfied with the degree of attention paid to their concerns and opinions by service providers, this is associated with greater confidence in their relationship with their baby and with a greater commitment to the existing pattern of service provision.

Diagram 12:1 GP-Based Antenatal Care and Panel Members' Postnatal Mental Health, Behaviour and Social Relationships
(level of significance (p=) and Pearson Chi squared value given [ ]

| **GP-Based Antenatal Care** | | **Panel Members Postnatal Health, Behaviour and Relationships** |
|---|---|---|
| ***Respondents who reported High Satisfaction With:*** | | ***Outcome*** |
| Information Provision | → | ★More Self-Confident following the birth of their baby (p =0.02 [19.1])<br>★Less Self Reported Postnatal Depression (p =0.009 [37.7])<br>★Were More likely to be positive about role changes associated with motherhood (p= 0.04 [17.5]) |
| Choice in Care | → | ★Found the Adjustment to motherhood easier (p=0.0001 [44.2])<br>★Were Less anxious about caring for their baby (p = 0.02 [28.5])<br>★Were More likely to be positive about role changes associated with motherhood (p=0.01 [31.0] ) |
| Attention Paid To Own Concerns / Opinions | → | ★Were more confident about caring for baby without professional help (p=0.04 [17.5]) |

| | |
|---|---|
| Attention Paid to Own Concerns / Opinions cont.. | ★Enjoyed caring for baby more than mothers who felt concerns were ignored (p=0.01 [19.7])<br>★Expressed a lower demand for future home birth (p =0.000 [17.8]) |

In other words, the quality of the content of GP-based antenatal care is strongly associated with the postnatal mental state of panel members, their ability to respond to change in a proactive, positive way and for their personal and professional relations. Not dissimilar results are produced when one compares the relationship between hospital-based antenatal care and the panel postnatal experiences, as the following diagram illustrates, although in this case, the postnatal links centre principally around aspects of panel members behaviour and their social relations, rather than with their mental state:

Diagram 12:2 Hospital-based Antenatal Care and Panel Members Postnatal Mental Health, Behaviour and Relationships

(level of significance given (p=) and Pearson Chi Squared value [ ])

| Hospital-based Antenatal Care | | Panel Members Reported Postnatal Health, Behaviour and Relationships |
|---|---|---|
| ***If respondents report High Satisfaction With*** | | ***Outcome*** |
| InformationProvision | ➔ | ★Felt that they Coped Better postnatally (p= 0.03 [22.2] )<br>★Adjusted Easier to Motherhood (p= 0.000 [41.3])<br>★Were Less interested in Home Births (p=0.002 [26.5]) |
| Choice in care | ➔ | ★More Self-confident post birth (p= 0.02 [23.2] )<br>★Adjusted Easier to Motherhood |

| | | |
|---|---|---|
| | | (p= 0.01 [30.6] )<br>★Had more energy following the birth of their baby than women who were less satisfied (p= 0.02 [23.6] )<br>★Were less interested in Home Births (p=0.009 [13.3])<br>★Reported higher levels of enjoyment of caring for baby than mothers who were less satisfied (0.00 [34.1]) |
| Attention Paid To Own Concerns / Opinions | ➔ | ★Greater Desire to Breast Feed (p=0.03 [16.6]) |

As far as hospital-based antenatal care is concerned, the link with panel members postnatal experiences and attitudes seem to focus more narrowly on issues of behavioural adaptation to the consequences of delivery, principally in relation to the quality of antenatal information provision and the degree of choice of care regime antenatally.

**The Relationship between Intrapartum Care and Panel Members Postnatal Experiences and Attitudes**

Interestingly, the 'direct' effect of the organisation and delivery of intrapartum care on panel members postnatal attitudes and behaviour was very limited, in a manner similar to the rather limited effect of antenatal care on intrapartum care. The principal links refer to issues to do with social relations, rather than the personal behaviour and mental state of panel members. Respondents degree of satisfaction with the attention paid by obstetricians and midwives to their concerns and opinions was, for example, linked to the degree of emotional support required from husbands / partners postnatally. When panel members felt that obstetricians and midwives had taken a lot of notice of their concerns, this was associated with less need for emotional support from partners postnatally (for midwives, p=0.000, for obstetricians, p=0.03). When

obstetricians were perceived by respondents to show an interest in panel members opinions and concerns during labour, this was associated with a lower level of patient demand for advice about maternal health postnatally.

When one examines the relationship between type of delivery (vaginal, assisted vaginal, planned caesarean and emergency caesarean) and postnatal health there was only one significant result. Amongst respondents who reported that they did not suffer sleep loss through anxiety, a greater proportion had an unassisted vaginal delivery ($p=0.01$). Whilst women do of course experience morbidity associated with interventions (stitches, pain etc from caesareans), the difference between type of delivery might not be as great as one might at first suppose. Women who have *unassisted* deliveries, for example, may also require stitches for natural tears or episiotomies. Furthermore, as Chapter 11 has emphasised, the majority of all respondents reported that they regained their pre-pregnancy physical health within 6 months of the birth, irrespective of type of delivery.

Whilst panel members experiences of maternity care technology per se does not appear to significantly influence their long term postnatal health (either psychologically or physically) it would seem that the degree of attention paid to women's own concerns and the quality of the information women receive makes the adjustment to motherhood less traumatic.

**The Relationship between Postnatal Care and Postnatal Consequences**

Having considered the relative importance the organisation of antenatal and intrapartum care as possible sources of influence on panel members postnatal health, it is important, briefly, to consider what influence if any does postnatal care itself have on postnatal health. As indicated earlier, this is, however, to examine a rather different kind of issue or problem from that which is concerned with the potential impact of modern maternity care on postnatal health. It might well be possible to reorganise postnatal care - in order to make it more responsive to service users needs - independently from the organisation of antenatal and intrapartum care, at least to some extent.

Certainly, those panel members who felt the need to talk more to their GP or Health Visitor (HV) about their *own* health, reported a significantly greater tendency to lose their ability to concentrate (GP, p= 0.01, HV, p= 0.006), lost sleep through anxiety (GP & HV, p= 0.000), felt constantly under strain ((GP p= 0.000, HV p= 0.003) and felt that they were not managing well. (GP & HV, p= 0.000). Hence the failure of postnatal services to provide a service which takes account of the needs of mothers for information about their own postnatal health, is likely to have negative consequences for the health of service users. Whether this issue can be addressed independently of any considerations about the need to re-organise antenatal and intrapartum care, is of course an important matter. Interestingly, at the postnatal stage, the professional outlook and attitudes of service providers seem to be remarkable similar to those of antenatal and intrapartum service providers. When one examines the postnatal experiences of panel members who had little or no previous experience of caring for babies or young children, for instance, such women typically felt that they had been given a lot of help and support on such matters as infant feeding (p= 0.000) and general baby care (p= 0.000) but a significant number also felt that they had *not* be given enough help on matters concerning their *own* postnatal health (p= 0.007) In other words, the disproportionate emphasis on the health and survival of *babies* ,which is apparent at both the antenatal and intrapartum stages of modern maternity and which typifies the concerns of the 'discourse of risk", is also evident at the postnatal stage as well.

**Conclusion**

Consequently, with the provisos highlighted in chapter 10, the thesis suggests that the failure of the NHS reforms in the area of maternity care provision is both a 'political' failure to enhance 'consumer choice' and also a health failure at the level of the individual user, due to the failure of the reforms to 'empower service users. It is also evident from the longitudinal analysis of data from the panel study that the impact of modern maternity care is not simply confined to the mental state of the service users. The organisation of modern maternity care appears to have implications both for women's postnatal mental state and also for their postnatal behaviour and their personal and professional relationships. Postnatally, service users are typically not only mentally stressed and anxious,

but are also typically less proactive and less confidant/more hesitant in their relations with others.

In assessing the reliability and validity of the results produced by this longitudinal process of analysis, it is essential to review the methodological strengths and weaknesses of the particular type of research design employed, as far as the central theoretical and explanatory claims of the thesis are concerned. One over-riding consideration is whether it is valid to suggest that the earlier stages of the maternity care cycle, specifically antenatal and intrapartum care, have a causal influence on the health of panel members at the final postnatal stage of this cycle. The 'logic' of this presumed link is that women service users typically lack control over the organisation and delivery of the 'content' of antenatal and intrapartum care, that this induces long term stress which manifests itself in poor maternal postnatal health, especially poor mental health. Critics might argue that confident service users are likely to impose their wills on service providers, gain a significant degree of 'control' over the organisation and delivery of the 'content' of maternity care services and thus emerge postnatally in a positive, proactive state of mind. The less confident user, by contrast, will be unable to wrest such control from the more confident/assertive service provider and the users poor state of postnatal mental health, may not be a product of their experiences of pregnancy, labour and delivery, but may in fact predate these experiences. In other words, the poor postnatal health of some panel members may not be a consequence or 'effect' of their experiences of the organisation of maternity care. However, this is likely to constitute a problem only if the panel sample is socially heterogeneous, since women from different social backgrounds may well respond differently to the challenge of ensuring that their needs are being met. But in practice this is not the case. Rather, the panel sample is fairly *homogenous*, in both attitudes and attributes. Furthermore, in chapter 8, the panel sample was described as broadly 'prototypical', consisting of women who are likely not only to assert themselves but also to grasp or capitalise on any new opportunities presented to them by the process of organisational 'reform'.

It is important however, to acknowledge the fact that the panel study cannot, by definition, claim to have eliminated all possible sources of variation on

women's attitudes to maternity care prior to their use of such services. It is theoretically possible, for example, that women who report a higher level of stress at the postnatal stage of the maternity care cycle may also have experienced a higher degree of stress prior to becoming pregnant. The links suggested by the panel data, on the other hand, are more strongly supportive of the opposite argument, although this is an issue which clearly demands further, more detailed investigation.

In general, therefore, although there are clear empirical links between the impact of modern maternity care on postnatal health, it is antenatal care rather than intrapartum care which seems to be the aspect of service provision which appears to be of the greatest significance for understanding how and why such a relationship exists - and within the area of antenatal care, it is GP-based rather than hospital-based care which seems to be of the greatest importance. Since it appears that it is community based antenatal services which seem to have a greater impact on women's transition to motherhood, one could argue that it is not necessarily the obstetric / medical profession who are failing women by providing a service which does not address their key requirements, but other groups of service providers. However, community based services are organised in a way which focuses on issues bound up with the "discourse of risk" (such as measuring fetal growth, undertaking antenatal tests and preparing women for hospital deliveries), and are provided by *both* GPs and midwives (respondents typically reported seeing both GPs and midwives on a number of occasions throughout their pregnancy).

What is more, the majority of births which midwives are required to attend in order to maintain their professional registration take place within an obstetrics-led environment (RCM 1997), and the failure of GP based antenatal service to adequately prepare women for birth was highlighted by the panel as a particular area of concern. With hindsight, a high proportion of respondents wished they had known more about key aspects of labour and delivery.

Whilst differences in professional ideology may therefore remain between midwifery and obstetrics - and there are also divisions within the professions themselves as to the orientation that modern maternity care should pursue (i.e.; ARM) - the organisation of *all* aspects of NHS maternity services typically

continues to reflect dominant medical perspective of pregnancy and birth, of which the discourse of "risk" constitutes its most explicit expression.

One solution which has been proposed in order to develop a more "woman centred" form of maternity care centres on the notion of creating a more midwifery-led, community-based service. It is argued that this would ameliorate some of the negative effects of modern obstetrics-led maternity care (Changing Childbirth 1993). Chapter 13 presents an evaluation and discussion of an innovative "team-midwifery" project, designed to address just such issues.

# Chapter Thirteen

## Re-Gendering Modern Maternity Care: A Case Study

### Introduction

The results from the panel study indicate that although the general reforms of the NHS aim to "empower" patients and create services which reflect local need, panel members experiences of maternity care *after* the general reforms of the NHS had been introduced, correspond closely to women's experiences of maternity care in Britain *prior* to the implementation of the reforms. That is to say, the concern that service users in the 70's and 80's expressed about their lack of control over the process of becoming a mother under a modern, hospital-based system of maternity care, is closely replicated amongst members of a 'post reform' panel of service users.

As the preceding chapter also suggested, the failure of the general reforms of the NHS to provide users of maternity care services with more choice and therefore greater control does not simply represent the *political* failure to 'empower' service users. The lack of control which women service users commonly experience under modern maternity care is also, the thesis suggests, harmful to women's health. One might argue therefore that the NHS reforms have failed not only by failing to provide service users with greater choice and control, but, in the case of maternity care services in particular, by failing to provide women with a service which delivers effective health care.

The reforms of the NHS were initiated, of course, as much out of a concern over the *cost* of health care than over the issue of choice (Paton, op cit.) Critics of the reform process have claimed, however, that the reforms may have failed to improve the cost efficiency of the NHS (Robinson and Le Grand 1994). If this is indeed the case, then as far as maternity care provision is concerned, the failure of the NHS reforms to improve the cost efficiency of the service appears to be combined with their failure to improve the effectiveness of the service as well - assuming that assessments of service effectiveness take account of the needs and priorities of service users rather just the clinical priorities determined by the service providers.

The apparent failure of the reforms to improve service effectiveness by transforming modern maternity care into a more 'woman-centred' form of service responsive to the needs of service users, obviously demands an explanation. A key issue which clearly needs to be addressed here concerns the gendered nature of 'modern' maternity care.

The need to 'recover' the role of the midwife was raised, of course, both by the 'discourse of control' and by the specific reforms of the NHS aimed at re-structuring the organisation and delivery of maternity care service provision in particular. Changing Childbirth (1993) for example, not only calls for the development of a more "woman centred" service but also questions the respective roles of key service providers in this field. In so doing, Changing Childbirth highlights the need for what is essentially a 're-gendering' of maternity care through, inter alia, the greater involvement of midwives in the development and delivery of such services. The organisation of midwifery care has been under scrutiny since the early 1980's, and the role of the midwife received particular attention from the DoH review of maternity care (Winterton 1992). Despite the strong emphasis on developing and enhancing the role of the midwife, particularly for low risk women, neither Winterton nor Changing Childbirth give specific guidance about the organisation of midwifery care. However, both reports stress the need for flexible care, which offers increased choice and continuity to women. The 'team' model was widely adopted as a system which promised to deliver improved continuity of care, and was set up partly in response to women's demands for fewer carers and wanting to know who would be attending them during delivery, but also to provide a system of care where midwives had greater autonomy and scope of practice (Turnbull et al 1996, Rosser 1997, Page 1997).

Changing Childbirth appears to make several assumptions about the nature of communication between mothers and health care practitioners and the comparative professional philosophies of midwifery and obstetrics, which constitute key elements of its strategy to produce a more woman-centred system of maternity care. Specifically, Changing Childbirth seems to assume, tacitly rather than explicitly, that communication between service provider and service user will be improved if the exclusively female clientele of maternity care receive such services from a predominantly female based profession (i.e.;

midwifery) rather than from a profession which is still dominated by men (obstetrics). This is presumably in the belief that women will communicate more easily with women - especially in such personal areas as pregnancy and childbirth (Reid 1994). The more holistic approach to maternity care favoured by some sections of the midwifery profession of also fits more closely with the aims of Changing Childbirth, in contrast to the approach adopted by modem obstetrics, which tends to view pregnancy and birth as a pathological abnormality (RCM 1993). The development of role of the midwife is therefore central to the debate on changing childbirth and the future of maternity care provision.

The current chapter is devoted to an evaluation of an innovative project concerned with the development of "team midwifery". This form of midwifery practice seeks to achieve many of the central aims and objectives of "Changing Childbirth", but specifically the aim of making maternity care more woman-centred by 're-gendering' the organisation and delivery of the service.

**Team Midwifery - Organisation and Rationale**

The concept, development and provision of team midwifery can be seen as a departure from the typical pattern of NHS maternity care. During the final stage of the panel study, an opportunity arose to undertake an evaluation of a team midwifery project which had been established in a different part of the county from where the panel study had taken place. The sample for the panel study had been drawn from the east of the county, whereas the team midwifery project was located at a GP practice in the west of the county.

This evaluation has been included in the thesis for a number of reasons. Firstly, the research design for this innovative team midwifery project evaluation allowed for a comparison of mothers who experienced the team midwifery pilot scheme and those who did not (i.e.; those who were users of conventional maternity care services). This is important for two reasons. Firstly, many of the evaluations of team midwifery do not allow for a comparison between women who experience this form of care and those who do not. One needs to be able to compare the experiences and attitudes of women who are not part of any innovation to a cohort who encounter new methods of working, since it is often

the case that "women who receive it, value it. Those who do not receive it are unconcerned - being unable to comment on something they have not experienced" (Sandall, 1996). Secondly, given that the evaluation of the team midwifery project included a sample of users of conventional maternity services, this provided an opportunity to compare the results from this particular sub-sample with the response from the earlier panel study (themselves randomly selected users of maternity care services in the east of the county). In developing a questionnaire schedule to use in the one-off survey evaluation of the team midwifery project, the original panel questionnaires were abridged and slightly modified in order to facilitate such comparisons.

The team midwifery project, (which was given the name Mothers and Midwives (MM), was developed as a potential solution to the lack of continuity of care and informed choice which characterises much current maternity care service provision. Although team midwifery can embody several different forms or models of professional practice (Page 1997), the basic concept or idea reflects a general concern to improve service provision by increasing the effectiveness of midwifery-based care throughout pregnancy, birth and the immediate post natal period. The fact that there are several 'models' of team midwifery may account for the high failure rate of team midwifery projects, as highlighted by Farquhar et al (1996). Although a number of innovations in midwifery practice have taken place, a large proportion of which are based on the concept of team midwifery, the high casualty rate-makes this an under researched area, despite the undoubted importance of this topic for the sociology of maternity care policy.

The specific purposes of the "Mothers and Midwives" project were:

- to give women more control over the type of care they receive
- to improve communication between women and their carers therefore enabling women to make informed choices
- for every woman to have a named midwife who will ensure continuity of care
- to ensure that at least 75% of women will know their carer during labour
- to promote excellence in midwifery practice by using all midwifery skills

and to develop these further

- to be sensitive to individual women's needs, values and beliefs and to facilitate their fulfilment by providing choice of care and carer

- to assess if this pattern of working is feasible and acceptable for midwives

Under this scheme, each midwife had a defined caseload of 35-40 women (i.e.; they book approximately 4 women per month) and midwives worked in partnerships or small teams. Women service users were given the opportunity to meet the midwives who operated this scheme during their pregnancy and a 24 hour "on call" midwifery service was provided to women participating in the project.

Diagram 13:a Conventional Care Compared to the Mothers and Midwives Scheme: Patterns of Working and Care Provided

| **Standard Pattern of Care** | **Mothers and Midwives Scheme** |
|---|---|
| **FOR MOTHERS**<br>• Named Midwife + GP and / or Consultant<br>• Antenatal clinics held at GP practice / Hospital | • Named Midwife + opportunity to get to know small team (usually 2 other midwives) + GP and / or consultant if "high risk"<br>• Antenatal clinics GP, Hospital or Home based |
| • Unknown carer during labour<br>• Usually into hospital at onset of labour<br>• Early assessment at home by MW not usual | • 75% to have "known" carer during delivery<br>• Choice of venue (home / hospital) for most of labour<br>• Early assessment of labour at home to prevent early admission to hospital |
| • Communication between Mothers and MW usually via third person at GP surgery<br>• Familiar midwife may cover postnatally | • Direct contact via mobile phone<br>• Any team midwife covers caseload |

| | |
|---|---|
| **FOR MIDWIVES**<br><br>• Live caseload for community MW (full-time) approx. 80 (may be higher<br><br>• Allocated to work in one area (of service provision) although some may be on rotation<br><br>• Working pattern = shift<br><br>• Regular working hours for community MW with, on average, 1 on call night per week | • Full-time on project approx. live caseload of 35<br><br>• Versatile / good use of all round skills<br><br>• Flexible working pattern with increased availability / on call time |

## Research Methodology

In order to carry out an evaluation of this innovative project, a questionnaire survey was conducted of a randomly selected sample of 450 women users of the maternity care services in the west of the county. The women who were selected to take part in this study had delivered their baby at the one local hospital in the area at least 6 months previously. The questionnaire (abridged from the panel study questionnaires) focused on key aspects of women's experiences of antenatal, intrapartum and postnatal service provision. Information was also collected about key aspects of the social background and social circumstances of the individuals involved. Copies of the same questionnaire were also sent to all the women who had participated in the "Mothers and Midwives" scheme and had delivered their babies at least 6 months previously (n=158). Of the 450 questionnaires sent out to the sample of 'conventional' maternity care service users in the west of the county, 310 were returned, representing a response rate of 69%. In the case of the "Mothers and Midwives" (MM) sample, of the 158 questionnaires sent out, 95 were returned, representing a response rate of approximately 60%.

## The Socio-Demographic Characteristics of the Panel Study (East) Sample Compared to the West Sample (n=405)

The mean average age of respondents in the east of the county was 29 and in the west 31. In both the east and west samples, a large minority of respondents were

first time mothers (44% and 46% respectively) whilst the majority of the respondents in each area were either married or cohabiting. A high proportion of the husbands or partners of the respondents in both the east and the west were in full time employment (more than 9 out of 10), reflecting the fact that the county as a whole is an area where the overall level of unemployment is low compared to the national average. Not surprisingly therefore, in both the east and west of the county, a high proportion of respondents either owned or had access to a car, 88% in the east and 86% in the west) and either owned or were in the process; of buying their home (77% in the east, 86% in the west). The proportion of respondents in each sample who had received some form of full-time education beyond the minimum school leaving age of 16 was also similar. Both samples (the panel study and the cohort from the west of the county) included respondents from ethnic communities, as well as single and/or young mothers. Although the proportion of women in each of these groups was representative of the wider population as a whole, the actual numbers involved were small, which meant that it was difficult to carry out analysis on these sub-groups within the sample.

In several significant respects therefore, respondents from both the east and west of the county can be described as relatively affluent. As the more detailed analysis undertaken of the panel sample has already shown, such generally affluent, mobile and well-educated respondents also tend to have "positive" or proactive attitude to the maintenance of their own health and for that reason tend to be interested in and responsive to health education and health information

**A Comparison of Service Users Views of the Quality of Maternity Care Provision in the East and West of the County.**

The panel study in the east of the county indicated that the kind of service which women *received* from their local maternity care services was not necessarily what they *wanted*. Overall, the quality of the 'content' of such services did not satisfy the expectations and priorities of the service user, a deficiency which was particularly apparent in the area of information provision This was evident, moreover, at all three key stages of service provision, antenatal, intrapartum and postnatal, although slight variations occurred between the different groups or sectors of service provider, with hospital-based care attracting marginally more

criticism than GP-based care.

Notwithstanding some minor differences, service users made virtually the same criticisms of the quality of maternity care service provision in the west of the county as those made by panel members (in the east). That is to say, the major areas of concern for maternity care service users, irrespective of location, focused on the 'content' of such services and especially the issue of information provision, which was the top priority of virtually all respondents This is particularly significant since at the time that the second study of team midwifery was being carried out, the east and west areas of the county were operationally separate (each with a local DHA and separate Hospital Trusts).

Since the large majority of respondents in both the east and west samples are generally affluent, articulate and responsive to health education information, one cannot easily account for service users dissatisfaction with the quality of maternity care in terms of some supposed deficiency on the part of the service users themselves - for example, their presumed inability to articulate their concerns or their lack of interest in health issues.

When viewed against the background of women's experiences of 'conventional' maternity care, the "Mothers and Midwives" project takes on special significance. This initiative was explicitly designed to take account of several of the recommendations of Changing Childbirth (1993) which seek to remedy the kind of deficiencies in the quality of service provision outlined above.

**Innovation in Practice at the Antenatal Stage: Team Midwifery (Mothers and Midwives) compared with Conventional Maternity Care Provision**

Irrespective of whether women were receiving their antenatal care check-ups under a 'team midwifery system of care or not, the large majority of such check-ups took place at GP based clinics. 8 out of 10 (82.1 %) women in the Mothers and Midwives (MM) team midwifery project and 9 out of 10 (91.9%) of the sample of non-MM service users in the west of the county received most of their check-ups from this source. In the case of the non-MM group, the remainder (8.1%) attended hospital for the majority of their antenatal care. Of the MM group, 11.6% of women received most of their antenatal care in their own home,

while 5.3% had their check-ups at hospital antenatal clinics. The members of both groups (MM and non-MM) saw a midwife more often than a GP, but the MM group saw their GP least - suggesting that GP's are not as involved in midwifery-led forms of antenatal care as distinctive from the more 'conventional' form of maternity care provision.

MM mothers saw a significantly higher number of midwives on average than nonMM mothers (p=0.00) which may be attributable to the operation of team midwifery. One of the stated benefits of the MM project is that mothers will know a small team of midwives - one of whom will be her named midwife and one whom will assess the woman during labour and accompany her into hospital to deliver. However, the fact that MM women saw a larger number of midwives raises questions about the extent to which this facilitates or impedes continuity of care and the giving of information. As far as women's experiences of GP-based antenatal care as a whole was concerned, significant differences emerged between the MM and non-MM groups. Whilst the overall priorities of the two sub groups within the study are similar, the experiences of non-MM mothers would appear to be less satisfactory than their MM counterparts as the following table illustrates;.

Table 13:1 The Experiences of Mothers According to System of GP based Antenatal Care Provided

| | % Very Satisfied Mothers and Midwives (n=95) | % Very Satisfied Non-Mothers and Midwives (n=310) |
|---|---|---|
| Waiting Times (to see GP) | 38.9 | 35.8 |
| Waiting Times (to see MW) | 40.0 | 44.3 |
| Surroundings | 73.7 | 65.6 |
| Degree of Privacy | 84.2 | 72.1 |
| Information Provision | 64.2 | 56.8 |
| Clinic Times | 56.8 | 49.8 |
| Attention Given to Own Concerns | 71.6 | **54.4** |
| Involvement in Care Choices | 70.5 | **47.6** |

In evaluating the development of a team midwifery scheme, an important objective of the study was to examine the extent to which the MM project met mothers felt-needs compared to the conventional form of antenatal maternity care provided to non-MM mothers. In attempting to assess the overall quality of

the provision of maternity care services provided to MM and non-MM groups, the "gap" between levels of maternal satisfaction and the degree of importance respondents attached to particular features of care was examined in order to see if the MM scheme provided a higher degree of 'control' (Tannenbaum op cit.) to service users, along the lines discussed in Chapter 9.

Table 13:2 The Comparative Attitudes and Experiences of GP based antenatal care expressed as a % difference

| | % gap between "Very Important" and "Very Satisfied" Mothers and Midwives n=95) | % gap between "Very Important" and "Very Satisfied" Non-Mothers and Midwives(n=310) |
|---|---|---|
| Waiting Times (to see GP) | -14.7 | -8.1 |
| Waiting Times (to see MW) | -9.5 | -16.7 |
| Surroundings | -54.8 | -42.9 |
| Degree of Privacy | -17.9 | -4.0 |
| Information Provision | +26.3 | +30.9 |
| Clinic Times | -43.1 | -30.6 |
| Attention Given to Own Concerns | +18.9 | **+33.3** |
| Involvement in Care Choices | +22.1 | **+35.5** |

In the table above, a positive figure indicates an unmet need amongst the sample (in that a higher proportion of mothers said that they regarded a particular feature of service provision as "very important" compared to the proportion who were "very satisfied" with the same aspect of care). Consequently, two features are of particular significance for any evaluation of the quality of the community based antenatal care provided to the MM and non-MM group:

- *The Mothers and Midwives Scheme met women's needs to a greater extent than the standard pattern of GP based antenatal care provision*

This is evident from the higher unmet need (represented by a positive figure) amongst non-MM respondents in areas that were rated as being of particular importance - viz. information provision, choice in care and attention given to women's own concerns. However, and notwithstanding the above

- *there remained an unmet need in relation to all aspects of service*

*content amongst all service users, irrespective of the pattern of care that they received* (illustrated by the gap between satisfaction and salience in key areas of service provision throughout the sample).

**Women's Experiences of and Attitudes Towards the Provision of Hospital-based Antenatal care**

The large majority of women in both the MM and non-MM groups said that they went to their local hospital at least once during their pregnancy, with the most common pattern of hospital antenatal visits being between 1 and 4 times. Only a relatively small proportion from each group (approximately 1 in 7) attended more frequently - typically between 5 and 8 times. The overall level of maternal satisfaction with hospital antenatal care was of a lower order than that relating to GP based antenatal services, with only 29.1% of the whole sample (MM and Non-MM combined n=405) indicating that they were "very satisfied" with the hospital antenatal care that they had received. Additionally, almost 1 in 10 users of such services were actively dissatisfied with the antenatal care that they had received from their local hospital. No significant differences occurred between the MM and non-MM groups in the overall level of satisfaction recorded, but non-MM woman rated some key feature of hospital antenatal care more highly than MM women, as the following table indicates;

Table13: 3 Respondents Evaluation of the Hospital Antenatal Care

| | % Very Satisfied Mothers and Midwives (n=95) | % Very Satisfied Non-Mothers and Midwives (n=310) |
|---|---|---|
| Waiting Times | 16.8 | 15.1 |
| Surroundings | 10.5 | 19.0 |
| Degree of Privacy | 22.1 | 29.3 |
| Information Provision | 27.4 | **38.4** |
| Clinic Times | 20.0 | 23.7 |
| Attention Given to Own Concerns | 24.2 | **34.6** |
| Involvement in Care Choices | 27.4 | **33.9** |

It might be the case that staff within hospital units knew that some mothers were taking part in the MM scheme, and were therefore likely to be delivered by a member of the MM scheme and their attitudes towards such mothers differed as

a result of this (as respondents own comments seem to suggest). On the other hand, mothers in the MM scheme may have had increased expectations as a result of being part of an innovative project and were therefore less satisfied than "typical" service users. However, this latter explanation is less likely since the 'halo' or 'hawthorn' effect of becoming the object of a researchers interest tends to induce a positive rather than a negative reaction on the part of the person who is the research subject.

When one examines specific areas of information provision, the picture becomes even more complex. Almost all respondents in the second study (from both the MM and non-MM groups - 99.5%) had at least one ultrasound scan during their pregnancy, although only slightly more than half of these (55.1%) were "very satisfied" with the information about this. In respect of ante natal tests, less than half of respondents (44.2% of MM and 43.7% of non-MM mothers) were "very satisfied" with the information they received about both the tests themselves and the results. MM respondents however reported higher levels of satisfaction with the provision of information relating to particular topics than their non-MM counterparts, specifically information relating to labour and delivery.

The women who took part in the "Mothers and Midwives" project, for example, were more satisfied with the information that they had been given on all matters concerned with labour and delivery compared with their non-"Mothers and Midwives" counterparts. This may be due to the fact that a midwife from the "Mothers and Midwives" project was scheduled to deliver MM women, and matters concerned with labour and delivery might therefore have been accorded particular significance at ante natal visits. However, whilst women participating in the MM scheme reported higher levels of satisfaction than non-MM mothers (46.3% of MM were "very satisfied compared to 27.8% of non-MM), there remained a substantial proportion of respondents in both groups who felt that their information needs had not been met by service providers).

This is particularly significant in light of the arguments which have been put forward by the discourse of control and Changing Childbirth (1993) about the need to "regender" / re-organise maternity services by developing a service which is predominately midwifery led. The assumption being, presumably, that such changes will improve communication and facilitate informed choice on the

part of the service user. Although the experience of MM mothers suggests that some degree of improvement has occurred through such innovations as team midwifery, the data also suggests that the scheme does not meet the information needs of mothers as fully as might have been expected. This might be accounted for by the fact that although the MM project is designed to provide care within a very structured framework of personnel, women may still see a number of midwives and the problems of continuity of care and of information "confusions" may prevail. Equally, in informal discussions held between the project researcher and midwives in both the community and in the hospital about the Mothers and Midwives project, intra-professional rivalry amongst midwives was apparent over the issue of the management control and location of birth. This was an unexpected effect of the MM project, but may be an important consideration if the project were to be developed further.

**The Provision of Intra Partum Care: Team Midwifery Vs Conventional Care**

Since the current case study of a team midwifery project involves a comparison between two groups of women who experienced quite differing patterns of maternity care (viz. MM and Non-MM mothers), especially at the stage of intrapartum care, it is not necessarily surprising to find significant differences in the intra partum experiences of the two groups. This was particularly noticeable when one examines such issues as assessment in labour and the range of professional personnel involved in intra partum care.

Once in hospital, MM mothers were more likely to be seen by a smaller number of professional personnel than non-MM mothers. The majority of non-MM mothers saw 3 or more staff whereas the majority of MM respondents indicated that they were cared for by 1 or 2 hospital staff during labour and, as one would expect, both subgroups indicated that the majority of professional carers were midwives.

Amongst non-MM mothers almost 8 out of 10 (78.4%) said that they had "never met" the person who was most involved in their care during labour and delivery before. Significantly, the majority of mothers in the "Mothers and Midwives" scheme (72.3%), whilst not necessarily being delivered by their named midwife,

did report that their main carer was known to them beforehand (even if they did not know them very well). Interestingly, having been part of the "Mothers and Midwives" project, the majority of these mothers (n=95) expressed a strong desire in the future to know the person who might care for them in labour "very well", with 55.8% indicating that this would be their preference. By contrast, the majority of non-MM mothers said that they would prefer either "a familiar face" (42.4%) or said they had "no preference" (31.4%) regarding this aspect of their care at all. Such findings re-enforce the view that mother's expectations are often shaped by the patterns of care that they experience, as opposed to actively choosing an alternative system of care of which they have no direct experience. That is to say, they assume, in the words of Porter and Macintyre (1984) that "what is, must be best".

Although mothers' experiences of professional carers differed between the two sub-groups, there were no significant variations in respect of their attitudes towards pain relief and the type of delivery that they had. Overall (n=405), more than 6 out of 10 of all respondents said that they found the pain relief that they had either "very" or "fairly" effective, although 1 in 7 found their experience of pain relief unsatisfactory. The large majority of all mothers (70%) reported that they gave birth without the aid of either forceps or ventouse, with a further 6.4% of the sample indicating that they had a planned caesarean and 7.2% reporting that an emergency caesarean was required.

In general, there was little difference between the MM and non-MM groups in the degree to which obstetricians became involved in *delivery* (with 20% of MM and 28.2% of non-MM being delivered by an obstetrician). The crucial difference is, of course, that the MM group had much greater knowledge of the midwifery staff involved in managing their care during labour and delivery than the non-MM group. The majority of MM mothers, for example, said that they were delivered by their project midwife (50.5%) with a further 23% reporting being delivered by a midwife whom they had met previously. Comparatively, only 16 % of the non-MM respondents had previously met the person who delivered their baby.

Of course, such patterns of care are likely to have an impact on mother's attitudes and responses during this period. A higher proportion of MM

respondents, for example, said that they were "very satisfied" with the level of support that they were given during their labour and delivery than non-MM mothers - 76.8% compared to 54.9%, which may be accounted for by the fact that MM mothers were, perhaps, more able to establish a good relationship with their midwife prior to labour and delivery. Similarly, and possibly for the same reason, MM mothers felt that the information that was given to them during the delivery of their baby met their needs to a significantly greater extent than the information provided to non-MM mothers, in that 74% of the MM sub-group were "very satisfied" with information provided during the intra partum period compared to 55% of non-MM women. (p=0.00). This may be accounted for, in part, by the fact that more than 8 out of 10 (85.3%) MM mothers felt that midwives "took a lot of notice" of what the mothers themselves were saying during labour compared to less than 7 out of 10 (68.9%) non-MM respondents (p=0.00). The experiences of the non-MM user-group tend to highlight the fact that for a large number of women within the district, their experiences of the maternity services are often less than satisfactory.

As a series of open-ended comments highlighted, women who experienced the MM scheme typically felt that they had established a feeling of trust with their midwife, which in turn engendered feelings of confidence and relaxation, particularly during the intra partum phase of their maternity care 'career'.

**The Provision of Post Natal Services: Team Midwifery Vs Conventional Care**

As the panel study has shown, women who felt that their need for information, and therefore their ability to exercise "informed choice" about the options available to them, had been met during pregnancy enjoyed better postnatal health than those who experienced an 'information deficit'. In other words, the failure to provide service users with the information that they require in order to make choices about care and to allay their concerns almost certainly represents a health cost to the individual - and potentially therefore to the health authority as well. Accordingly, a crucial issue which needs to be addressed by the attempt to re-organise maternity care services through the introduction of such innovations as "team midwifery" is whether the latter will deliver significant improvements in the quality of the information provided to service users - since this is

associated with, inter alia, improvements in the levels of post natal health.

Importantly, although most of the mothers participating in the study had prior experience of motherhood only a relatively small proportion (approximately 1 in 5) said that they did not need *any* help, assistance and advice from hospital staff on basic aspects of health and caring for their baby - a finding which mirrors almost exactly the results of the panel study.

In addition to a need for information on a range of post natal topics, as the following diagram illustrates, women from both the "Mothers and Midwives" cohort and Non"Mothers and Midwives" women also reported a relatively high need for practical assistance. However, a large proportion of new mothers (from both MM and non-MM groups) felt that their needs were not adequately met during this period. In such areas as infant feeding, general baby care and infant and maternal health for example, there is a consistent gap between the perceived (relatively low) level of assistance and advice provided to mothers and the (comparatively high) demand for such advice and assistance.

As the panel cohort demonstrated, women may regarded midwifery staff as playing a different role in the provision of information compared to clinical staff. This finding was also apparent within the second study, in which doctors were regarded as a source of information primarily on matters concerning infant and maternal health whereas the midwife was seen as being able to provide information on a much wider range of issues. This is illustrated by the main topics which mothers wanted to discuss further with midwives, which included:

* general baby care
* child sleeping habits & establishing a routine
* rest following the birth
* feeding methods
* maternal health and recovery

and the major areas on which further information would have been welcome from hospital doctors, which were:

* maternal health and recovery
* infant health

Some differences were evident - although none were statistically significant - between the MM and non-MM sub-groups, in that MM mothers expressed both a slightly lower demand for further discussions with midwives and a lower demand for more information from doctors regarding their own health and that of their baby. This latter result may have occurred as a result of the nature of the "Mothers and Midwives" project itself which aimed to maximise the contact between 'Mothers and Midwives". Hospital medical staff may therefore be seen in a different light by MM mothers.

Whilst more than three quarters of all mothers (75.1%, n=410) indicated that they had decided to try to breastfeed their baby (a choice made during pregnancy) in practice only three quarters of those who attempted to do so said that they managed to establish breast feeding successfully. Just under half of all mothers (45%) ceased to breastfeed within four months, with 1 in 10 mothers giving up within a month. Moreover, the rate for successfully establishing breast feeding was broadly similar between both the MM and non-MM samples. Amongst all women, the success of maintaining breast feeding was closely associated with the social class and educational characteristics of respondents, in that those women in social classes I and II (categorised according to the occupational status of their husband / partner) and mothers educated beyond the age of 16 were more likely to try to breastfeed - a findings which corresponds with the panel study and to previous research in this field (Minchin 1989).

Although midwives may have responded differently to their clients according to whether the midwives themselves were part of the MM group or not, during the immediate postpartum phase, as far as the provision of information about such a crucial issue as breastfeeding is concerned, there is no discernible difference in the reported quality of the information provided by the midwives in one group compared with the other group. In other words, postnatally midwives operating under either system of care appear to work in a very similar fashion which suggests that the dominant tendency of modern maternity care to focus on labour and delivery continues even when innovations in practice are introduced.

The majority of mothers in this later "one-off" study (41.7%) cited their midwife as the most useful source of information and advice on matters concerned with

breast feeding, with hospital midwifery staff being regarded as the second principal source of effective assistance on this matter. Surprisingly, very few mothers from either of the groups regarded their Health Visitor as their major provider of help and assistance regarding breast feeding. Since a mother's contact with her midwife typically ceases at the end of the midwife's statutory period of post natal care, with responsibility passing into the hands of the Health Visitor, this may be an area where the Health Visitors role needs to be examined so that further assistance can be provided to those mothers who require support in this area during the longer post natal period. Indeed, as a consideration of women's postnatal health indicates, maternal postnatal health needs are extensive and long term.

As Chapter 11 indicates, a large number of women in the panel study reported experiencing a number of physical and mental health problems following the birth of their baby, although not all women sought professional help for such symptoms, which suggests that a "clinical iceberg" of illness exists within this local population (Wadsworth 1971). The same was also true amongst women in the west of the county, the majority of whom found the postnatal period one of tiredness, stress, and physical discomfort for a not inconsiderable period of time.

* a third of mothers said that their concentration was severely affected well into the year following the birth of their baby
* 20% of women said that felt under substantial strain after the birth of their baby
* 4 out of 10 reported that they experienced a substantial, long term decrease in energy, with almost 1 in 10 indicating that they had no energy at all
* 40% of respondents said that they were less mentally alert than usual
* 1 in 5 mothers felt less able to be affectionate
* more than 1 in 10 reported regularly losing sleep due to worry
* 1 in 5 felt less able to enjoy their day to day activities

Intriguingly, there were no significant differences between MM mothers and non-MM mothers regarding their self-reported health status during the post natal period.

As was the case with women respondents to the panel study, it is clear that mothers wanted more *information* from their midwives and health visitors rather

than practical or emotional support. Respondents cited lay contacts as their preferred source of additional practical help and emotional support, principally from within the conjugal unit. The nature of the "emotional" support / reassurance required from health visitors focused on specific post natal issues, with a large number of respondents wanting more information on a range of child care matters. Despite the fact that the majority of mothers said that they were satisfied with the general level of information provided by health visitors and midwives (with 7 out of 10 mothers indicating satisfaction with information from midwives and 6 out of 10 for health visitors) respondents identified a number of specific areas on which more information was needed, viz.

* child sleeping habits
* feeding solids / weaning
* infant development / infant health

Non-"Mothers and Midwives" mothers expressed a higher need for information from Health Visitors specifically regarding child sleeping habits (32.6% compared to 23.2%) and a higher proportion of non-MM respondents also wanted more information on infant and maternal health from their GP compared to "Mothers and Midwives" mothers.

Despite the fact that the majority of mothers participating in the study were second time mothers (53.8% n=405), only a slight majority of the sample (55.7%) indicated that their experiences of adjustment to motherhood was either "very easy" or "fairly easy". A quarter of all mothers (27.2%) indicated that they had found such a transition "fairly difficult" and almost 1 in 10 reported that they found the experience "very difficult". As pointed out previously, the difficulties women experience in their transition to motherhood is reflective of a number of major social changes which have occurred in the pattern of family, community and working life in modern industrial societies during the twentieth century - the effects of which are compounded by the particularly geographically mobile character of the residents in the locality from which the sample was drawn. Consequently, there is a clear need in such localities for increasing levels of professional advice and information about such significant, but relatively rare, personal life events as the birth of a child and childhood illnesses, a need which is generally not met.

## The Development of Woman Centred Care: Conclusions

The findings from this case study broadly confirm the results of the panel study which was designed to examines women's experiences of NHS maternity care provided at all stages of women's maternity career. It is apparent, that women have similar experiences and share common views about the nature and quality of the maternity care services that they received in the 'new' NHS, irrespective of the location or of the timing of such services. The common experience of women users, is that a major gap exists between:

(a) the kind of maternity care services they receive,
and
(b) the kind of maternity services they want

Service providers may, of course, believe that such a problem arises from the personal inadequacies of the service user, who may be perceived as being inarticulate, and therefore unable to highlight their concerns adequately, and / or uninterested in health matters. The analysis and evidence demonstrates that this is unlikely to be the case, however, since the respondents in both the panel study and in the later "one-off' survey had received an average or above average level of education and were responsive to health education messages. Furthermore, respondents in both studies specifically rated information provision as their highest priority regarding the delivery of local maternity care services. Such evidence suggests that the problem of "information deficit" has therefore to be seen as a problem with service provision either in respect of the format and content of information provided, the time at which information is provided, the behaviour and attitudes of service providers or in the organisation of care systems all of which may impede effective communication.

## The "Mothers and Midwives" Project

Respondents own comments about their experiences of the mothers and midwives project highlight the benefits which such a scheme created amongst service users.

Amongst First Time Mothers:

> Case 139: I not only had the opportunity of getting to know my midwife, but also for her to get to know me. This meant that by the time I went into labour she was aware of my birth plan and in particular my preferences for pain relief. As a first time mother it gave me great confidence knowing that someone I had grown to trust would be there throughout my labour...
>
> Case 17: As it was my first baby I was frightened of giving birth, but as I was familiar with my midwife I was therefore very relaxed and had an easy birth, and enjoyed doing so !

and amongst second time mothers:

> Case 77: I feel this birth went so well due to the presence of the [project] midwife. It was completely different to my first birth experience which was dreadful
>
> Case 95: This was my third baby, [my first] under the new "community midwife scheme", where you are assigned one midwife who comes into hospital with you and discharges you. I found this scheme much better than my first two pregnancies, especially for the labour....

For the women who participated in the "Mothers and Midwives" scheme, significant differences also emerged in their attitudes and experiences compared to women who received the more 'conventional' type of care", particularly in relation to labour and delivery MM women:

* saw more midwives during pregnancy than Non-MM women ($p=0.00$) due to the design of the team midwifery project which aims to ensure that women know a small number of midwives reasonably well, one of whom will deliver the woman

* were more satisfied with the information that they had been given during pregnancy on matters concerned with labour and delivery than Non-MM women ($p=0.006$)

* typically knew their principal professional carer in labour either "very well" or "fairly well", compared to Non-MM women, the majority of whom had never met their delivery midwife beforehand ($p=0.00$)

* felt that their own views and concerns were accorded a higher degree

of importance by those caring for them during labour than Non-MM women (p=0.00)

Such results broadly confirm the findings of other studies which have examined women's experiences of team midwifery. For example, Melia et al (1991) discovered that the majority of women who had met their delivering midwife before reported that they felt more at ease during labour. However, as the current study has illustrated, there remain several areas of maternity care provision which, even when operating within the context of 'team midwifery', fail to deliver maternity care services in a format which meets mothers' self-defined needs. This was particularly apparent in respect of information provision.

Whilst the "Mothers and Midwives" Project clearly achieved some measure of success in improving the quality of maternity care provision, it is equally apparent that the scheme also has certain crucial weaknesses. Arguably the most critical weakness is that, whilst MM mothers reported improved confidence and trust in service providers (principally their midwife) and there are some indications that this was associated with improvements in the perceived continuity of care delivered, there is little evidence to suggest that the "Mothers and Midwives" scheme had a significant impact on reducing the "information deficit" associated with maternity care, particularly during pregnancy. Furthermore, MM women and non-MM women experienced similar levels of postnatal morbidity, an outcome which has important implications for the re-gendering and re-organisation of maternity care services.

On a national basis, a Policy Studies Institute Report into three examples of team midwifery (Allen et al 1997) concluded that team midwifery offers the prospect of considerable continuity of care and carer, and there were many reports of close and supportive relationships between midwives and women. However, the report also notes that many women did not regard continuity of care as important as quality of care. Tensions were also apparent between hospital midwives and the midwifery group practices, which affected the care given to women. The report makes specific reference to the problems of perceived disputes between different professionals (hospital and community midwives, for example), illustrated by one woman's comment that "I get the feeling that there is competition for being in charge and in control" - thereby

echoing respondents comments in the present study. The costs of the different models of care assessed were difficult to identify in the absence of robust financial information, but were accepted to be higher than more traditional models. Additional problems of team size, on-call rotas, poor continuity (especially in covering for sickness / absenteeism) are also commonly reported in evaluations of team midwifery (Lewis 1995). Notwithstanding such problems, team midwifery does offer the prospect of improved care for some groups of service users. A randomised controlled trial of the efficacy of midwifery managed care concluded that "midwife managed care, for healthy women, integrated within existing services, is clinically effective and enhances women's satisfaction with maternity care" (Turnbull et al 1996). However, many team midwifery projects, including both the one evaluated in this chapter and the nationally acclaimed "One-to One" midwifery service at Queen Charlottes Hospital, London (Page 1997) are being discontinued as HAs are overspent and as the maternity services are "dropped from the political agenda" (Rosser 1997, p141).

Most importantly, when looking at the wider issue of developing a more midwifery-led maternity care services, there are still many issues which need to be addressed. As both the Mother's and Midwives project and the panel study have demonstrated, further research into the areas of women's experiences of maternity care should take account of the perceived *salience* of any new innovations in practice from the *service-users* point of view.

## Chapter Fourteen

## Becoming A Mother In the New NHS - Conclusion

### Markets, Medical Hierarchies and Gender

In the late 1980's and early 1990's, quasi-market mechanisms were introduced into the NHS as a means of reforming the organisation and delivery of services. These 'reforms' were championed by a right-wing libertarian government on explicitly ideological grounds and were heralded as a means of making public sector organisations such as the NHS more responsive to the needs of its clientele or 'consumers'. A set of general reforms which affected the overall management structure of the NHS were introduced first, dividing the service into 'purchasers' and 'providers'. Theoretically, the latter were in competition with each other for 'contracts' issued by the former. These 'contracts' allocated financial support to health care provider units in accordance with the activity levels and standards set by the contract. At the outset, all DHAs became purchasers and hospitals were able to become self-governing "trusts". GP-based services had the choice of opting into the new structure as 'fundholders' responsible for managing a fixed 'budget', with which they purchased some services on behalf of their patients from other 'providers'. Those GPs who chose to remain outside of the new system continued to be funded as previously, under the umbrella of the FHSA. To begin with, although all hospital-based forms of maternity care were affected by these general reforms, the budget allocated to GP "Fundholders" was not intended to support GP or community-based maternity care.

In the early 1990's, the organisation and delivery of maternity care services became the subject of a dedicated national policy review of its own area of operations, with the publication of the Winterton Report (1992) and shortly afterwards, Changing Childbirth (1993). In keeping with one of the key emphases of the general reforms, both reports stressed the need for maternity care to become more client-centred and sensitive to the 'needs' of women service users. Changing Childbirth in particular provided a list of key targets or objectives which maternity care services needed to achieve within the context of the newly reformed NHS. The way in which NHS services are organised and delivered post the 1991 reforms represents

therefore a central 'test of the effectiveness of the reform process. Have the reforms 'empowered' women users of maternity care services by providing them with more *choice* and *control* over service provision? - and if not, why not?

Prior to the introduction of the NHS reforms, critics argued that women's experience of becoming a mother within a modern hospital-based system of labour and delivery was 'alienating' and therefore stressful. Modern maternity care is seen by such critics as a system within which women service users typically have little say or control. Specifically, this 'discourse of control', as the thesis has described it, claims that women are given very little information about the nature of such care and the choices or options available to them are limited. Women users also commonly reported that little notice was taken of their concerns or opinions by service providers. At its worst, the image of modern maternity care which emerges from this critique is of a regimented 'meat market' dealing in 'bodies' rather people. The system is seen to operate in an inflexible and insensitive manner, according neither privacy nor dignity to women, as they 'become' mothers. The 'discourse of control' attributes the cause of this state of affairs to the rise of the male-dominated clinical specialism of obstetrics, the practitioners of which have sought to justify the development of an almost wholly hospital-based system of labour and delivery, through what the thesis describes as a 'discourse of risk'.

Rather surprisingly perhaps, several key elements of the largely feminist-inspired discourse of control are reflected in the national review of maternity care policy, which is closely associated with central government attempts to 'reform' the NHS as a whole. Both the feminist-inspired 'discourse of control' and the libertarian-inspired 'discourse of choice' emphasise the need for maternity care to become more 'woman-centred'. This requires service providers to be more responsive to the needs of the service user and at the same time, both discourses also emphasise the need to 'regender' the organisation of maternity care, by redressing the relative balance of professional control between obstetrics and midwifery in favour of the latter.

Consequently, the relationship between the reform process and the organisation and delivery of maternity care raises several major

sociological issues. At the most general level, it is important to assess the impact of the reform process on maternity care, especially as this relates to women's experiences of becoming a mother in the 'new' NHS.

## Becoming A Mother In the New NHS

At each of the three major stages of the panel study, it is apparent that panel member's experience of maternity care within the new, market orientated NHS shows a remarkable degree of *similarity* with women's experiences of modern *unreformed* maternity care provision, both in the UK and elsewhere. This is particularly so as far as the *content* of maternity care service provision is concerned. At the antenatal stage of the maternity care 'cycle', for instance, while panel members regarded the quality of information provision, the degree to which they were involved in choices about their care and the degree of attention paid to their concerns/opinions by service providers as priority issues, these key 'needs' were not met for a high proportion of respondents. In general, antenatal care was also characterised by an apparent lack of concern on the part of service providers about the wider implications of motherhood for their clientele, especially the postnatal dimension.

Although panel members perceived some differences between the quality of care provided by different sectors of the antenatal services, such differences were relatively marginal. GP-based antenatal care elicited a higher overall level of satisfaction than hospital-based antenatal care, for example. In both cases, however, the quality of the 'content' of the service failed to satisfy the needs of panel members. 'Pre-reform' studies of women's experiences of modern maternity care, both in the UK and elsewhere, demonstrate very similar types of concern on the part of the service user (Cartwright 1979; Oakley 1979,1980; Reid and McIlwaine 1980; Graham & McKee 1980; Macintyre 1981; Hall et al 1985; OPCS 1989).

On the other hand, it would not be correct to say that panel members experiences of antenatal care in the 'new' NHS reflect women's experiences of modern maternity care in the pre-reform era in every sense. While 'pre-reform' research in the field of antenatal care highlights women's dissatisfaction with the regimented and impersonal nature of much of the care they received - especially in a hospital environment - this does not necessarily resonate with the experiences of panel members. The

panel as a whole were generally more satisfied with the 'context' within which their care was delivered than its 'content'. This included the degree of privacy accorded the service user, the relative convenience of clinic opening times and waiting times and the quality of the physical surroundings. This is not necessarily all that surprising however, when one considers that in its attempt to reform the NHS, central government paid a great deal of attention to the 'context' within which services are provided. In its creation of the so-called "Patient's Charter' for example, central government emphasised the importance of such matters as reducing waiting times.

It is possible, therefore, that the reforms may well have had a positive effect in improving the quality of the 'context' within which antenatal care is delivered, if not the actual 'content' of antenatal care. However, even if this is the case, the results from the panel study also indicate that any such improvement has not occurred uniformly across each of the two main 'sectors' of antenatal care. Panel members were considerably more critical of the 'context' within which hospital-based antenatal care was delivered, compared with GP-based care, and this was especially true for second time mothers, who were highly critical of waiting times in hospital antenatal clinics. Lengthy waiting periods are likely to be particularly inconvenient, of course, for pregnant women who also have other child care responsibilities.

Overall, therefore, the results from the panel study strongly suggests that the reform process has brought about only limited improvements in the quality of the antenatal maternity care services provided for women, the above provisos not withstanding. This naturally raises the question, "Why?". As the thesis has argued, one cannot easily 'explain' panel member's views and comments in terms of the personal characteristics of the members themselves. It is unlikely, for instance, that panel members dissatisfaction with either the poor quality of the information about antenatal care or the lack of attention given by service providers to their own concerns or opinions is a product of the panel's lack of interest in health matters or an inability to express their views and opinions. As the thesis has demonstrated, the majority of the panel were both interested in and responsive to health education information, and a large minority had stayed on at school beyond the statutory leaving age and were therefore presumably capable of articulating their views and opinions to health care

professionals. Similarly, since panel members level of use of antenatal service seems to be relatively high, one cannot account for the fact that service providers failed to provide their clientele with adequate information by assuming that the service users did not attend antenatal clinics on a regular basis.

Perhaps the clearest indication that the responsibility for such service failure lies principally at the door of the service providers is the fact that panel members report similar problems with poor information provision and unresponsive staff at each of the other two main stages of the maternity care 'cycle', intrapartum care and postnatal care. At the intrapartum stage, for example, panel members report a common need for a range of information about the control and management of labour and delivery, while at the postnatal stage information and advice was needed - but not adequately provided - on such major topics as infant health and development and maternal health. Interestingly, in the case of childhood immunisations, an issue which health care professionals themselves deem to be important and where great stress is laid on the importance of getting the message or health information across to client groups, panel members clearly responded in a positive and vigorous manner since the level of uptake was very high.

Furthermore, this apparent failure of the reform process to make maternity care services more responsive to the needs of their service users does not simply represent a '*political*' failure. As the longitudinal analysis of the panel data indicates, the failure of the NHS reforms to 'empower' women may also have *health* implications for the service user as well. Panel members experience of the postnatal period of their maternity care 'career' was typically characterised by a relatively high level of morbidity - both physical and mental - over a considerable period of time. Systematic comparisons between the panel's antenatal and intrapartum experiences on the one hand and their postnatal experiences on the other - which a panel study design facilitates - shows several empirical links between the quality of service provision and women's postnatal health, although this is an area which requires further study.

The postnatal period of the maternity care 'cycle' has been largely neglected by both clinical and non-clinical researchers alike, probably due

to the ideological influence of the discourse of risk. Modern maternity care, with it emphasis on the importance of institutional confinement during labour and delivery, focuses clinical and non-clinical attention on intrapartum care, due to its almost obsessive concern with reducing the risk of infant mortality. The idea that modern maternity care may actually be harmful has never been systematically considered, although this possibility was raised by Tew (1990) amongst others, in her critical statistical evaluation of the validity of the argument that hospital confinement reduces the risk of infant mortality. In Tew's case, her principal concern was with the effect of increasing levels of clinical 'intervention on maternal *physical* morbidity. In this sense, Tew's analysis can be described as an extension of Illich's notion of iatrogenic processes, in her case extending Illich's original concern with cross-infection to include the unanticipated consequences of clinical intervention itself. (Illich, op cit.) The longitudinal analysis presented by the thesis suggests that Illich's notion may be extended even further still, to include the effects of the *social organisation* of health care on the health of the service user - in the case of maternity care services, on the *postnatal mental* morbidity of the service user - what might be termed '*social iatrogensis*'.

Since the panel study suggests that the reforms of the NHS are likely to have failed in one of their key aims of producing a form of maternity care provision which is responsive to the needs of women, the reasons *why* maternity care service providers have failed to respond in this way are clearly a matter of central importance for the sociology of maternity care.

One potentially very important reason why the type of maternity care service received by the panel did not meet their needs is because the large majority received a form of care which can be variously described as obstetrics-led or obstetrics dominated. According to the opinions of the panel itself, obstetricians were commonly viewed as the custodians of knowledge about the central 'technical' nature of modern maternity. However, panel members clearly had difficulties eliciting information about such matters from obstetricians and also reported difficulties in trying to get service providers to take their own concerns and opinions seriously. Such findings echo the results of research focusing on professional / client interaction which highlights that the transmission of knowledge between

professionals and patients is often a source of tension and conflict (Cartwright and Anderson 1981).

Both the Winterton Report and Changing Childbirth imply that a move towards a greater use of midwifery-led care is likely to contribute towards the development of a more responsive 'woman-centred' form of service, in contrast to the more inflexible approach of the male-dominated profession of modern obstetrics. Accordingly, the thesis sought to apply the general evaluative approach to service assessment developed by the panel study to a one-off case study of just such an attempt to 're-gender' maternity provision, called 'team-midwifery'. However, at least as far as the case study is concerned, whilst this midwifery-led form of maternity care appears to have created a personally more *responsive* form of care, the midwives who participated in this 'experiment' were not necessarily more *informative* from the point of view of the service user, since an information deficit was still apparent amongst respondents who took part in the innovative scheme.

This is broadly confirmed by a comparison of panel members experiences of 'conventional' forms of midwifery-led care compared with obstetrics-led care. In those minority of confinements where panel members received 'conventional' forms of *midwifery-led* care, the midwives concerned were reported as more responsive to the need to pay attention to the concerns and opinions of their 'clients' than obstetricians, but again, like their colleagues who participated in the 'team-midwifery experiment', there remained a problem with the provision of information since a large proportion of the panel had information needs on a number of topics which remained unmet.

How and why obstetrics appears to have the effect that it does have on the organisation and delivery of maternity care is obviously an important additional issue in itself. On the one hand, women service users dissatisfaction with modern maternity care seems to revolve around the problem of being under the 'control' of the service provider. The service user's demand for more information about the nature of modern maternity care practice and for a greater say over the process of professional decision-making necessarily draws the user into the technical/technological aspects of such care, which, in the words of Arney, makes them dependent on what he refers to as technology's 'web of power' (Arney, 1982). Crucially, in the

case of health care, this technological web of power is also male-dominated, as several contemporary feminist critics point out and this has implications not only for the service user but also for the prospects of creating a more woman-centred form of maternity care.

In one of the earliest sociological reviews of the nature of medical power and authority Freidson claimed that possession of scientific knowledge was the key to understanding the nature of the professional power and authority of doctors or clinicians (Freidson 1970). Johnson's later and theoretically more wide-ranging account of the nature of professional power argues, however, that while professional power and authority might well rest on the possession of a complex knowledge base, such knowledge is typically used in a self-interested way (Johnson, 1972). Professions, according to Johnson, are primarily forms of occupational monopoly. The more contemporary feminist critique of professional power and authority developed by Witz (Witz op cit.) suggests that not only are professions essentially self-interested as opposed to altruistic forms of organisation, but they are also quintessentially patriarchal in character. In the specific case of medicine, Davies develops Witz's analysis further and points out that the division of labour between doctors and nurses is based not simply on technical considerations but on considerations of gender. Thus doctors define themselves as being responsible of the 'technical' or clinical aspects of health care, but define nurses as being responsible for the 'caring' aspect of medicine.

In the case of maternity care, attempts to 're-gender' service provision by encouraging the development of midwifery-led care may well have failed to grasp the point that any attempt to create a more women-centred service has implications for women as service providers as well as for women as service users. The intra-professional tensions based on the gendered nature of the role of doctor and nurse/obstetrician and midwife may not only manifest itself in conflicts between two gendered professionals groups however. The prospect of change can also create tensions and conflicts within what otherwise appears to be a group of service providers who seem to share a common identity, by virtue of both their common gender and their relatively uniform professional role. In the case of the team midwifery project, for instance, opposition to this innovation came not only from obstetricians but also from hospital midwives who were not party to the

project and who perceived this innovation to be a threat to their own 'conventional' working practices. Similarly, not all midwives may wish to see widescale change to their existing practices.

**Towards A Sociology of Informed Choice**

Several national initiatives have been launched following the publication of Winterton and Changing Childbirth designed to address the paucity of information available to maternity care users, of which the Informed Choice campaign has attracted much attention. Through the use of new 'information packs' this initiative aims to provide women service users with the information which will allow them to make an *informed choice* about maternity care. This approach tends to see the 'problem' of women's dissatisfaction with modern maternity care (pre or post the NHS reforms) as a largely 'technical' problem of information deficiency, detached from the social framework of organisational relations within which such a deficiency occurs. It also regards the notion of information itself as a 'technical' issue, unrelated to the social transformatory nature of the process of 'becoming' a mother, which applies under either the 'new' or the 'old' NHS.

The true prospects for changing childbirth and therefore for changing women's experience of the process of becoming a mother in the 'new' NHS, seem at the present time to be limited. Changing Childbirth was clearly influenced by the largely feminist inspired discourse of control. Its aim to transform modern maternity care into a more 'woman centred' service is one which would undoubtedly be endorsed by a majority of the women who took part in the panel study. On the basis of panel members experiences of maternity care in the post 1991 NHS however, the current research seems to suggest that the achievements of this aim may be a long term prospect. Certainly the notion that the general reforms of the NHS as a whole will lead to greater choice for service users does not appear to be supported by the results of the panel study (and later research supports the view that user choice is often very limited (Paton et al 1997). On the issue of whether or not the specific or focused attempts to reform maternity care directly are likely to be any more successful in achieving their aims, there is no clear support for this particular belief - but one does have to acknowledge the fact that the implementation of the recommendations of Changing Childbirth were still at a relatively early stage when the panel study was

implemented. Later research on team midwifery (Turnbull et al 1996) suggests that some improvements in service delivery may be achieved through revised working patterns, although such forms of care are generally not seen as wholescale replacements to the more conventional forms of service provision. It is important to underline the point that the contribution made by feminism to such policy developments is complex, reflecting the diversity of feminist thought itself. Equally, feminist opinions about the future of maternity care are similarly diverse.

With the election of a Labour government in 1997, the NHS is once again subject to widescale review and reform. Issues of quality, equity and access are high on the agenda, as is the desire to "abolish" the internal market. Under such circumstances, the position of maternity care services on the political agenda remains to be determined. However, irrespective of the organisation within which care is delivered, what is apparent is that without a more sociologically informed approach to both the development and implementation of maternity care policy, and specifically the *role* that information plays during women's maternity careers, it seems highly likely that the problems which the discourse of control identified will continue to characterise women's experiences of contemporary maternity care.

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# APPENDIX I

## Illustrative analysis of the experiences and attitudes of First Time Mothers (FTM's) compared to women with previous experience of motherhood (Second (+) Time Mothers (STM's))

**Antenatal Care (123 = FTM's, 159=STM's)**

I:i The response of FTM's to GP antenatal care and the rank order of such responses

| | % very satisfied (rank) | % very important (rank) |
|---|---|---|
| Waiting Times | 23.6 (5) | 26.8 (5) |
| Surroundings | 26.8 (4) | 12.2 (6) |
| Privacy | 35.0 (1) | 50.4 (4) |
| Information provision | 27.6 (3) | 77.2 (1) |
| Choice / Involvement in care | 22.8 (6) | 61.8 (2) |
| Attention given to own concerns/ anxieties | 31.7 (2) | 60.2 (3) |
| Clinic Times | 20.3 (7) | 8.9 (7) |

I:ii The response of STM's to GP antenatal care and the rank order of such responses

| | % very satisfied (rank) | % very important (rank) |
|---|---|---|
| Waiting Times | 17.0 (7) | 40.3 (5) |
| Surroundings | 31.4 (2) | 18.2 (6) |
| Privacy | 34.6 (1) | 49.7 (4) |
| Information provision | 22.6 (4) | 74.8 (1) |
| Choice / Involvement in care | 22.0 (5) | 69.2 (2) |
| Attention given to own concerns/ anxieties | 24.5 (3) | 67.9 (3) |
| Clinic Times | 17.6 (6) | 17.6 (7) |

I:iii The response of FTM's to Hospital antenatal care and the rank order of such responses

| | % very satisfied (rank) | % very important (rank) |
|---|---|---|
| Waiting Times | 4.9 (6=) | 28.5 (5) |
| Surroundings | 4.9 (6=) | 10.6 (6) |
| Privacy | 11.4 (4) | 40.7 (4) |
| Information provision | 17.1 (2) | 62.6 (1) |
| Choice / Involvement in care | 18.7 (1) | 55.3 (2) |
| Attention given to own concerns/ anxieties | 13.8 (3) | 52.8 (3) |
| Clinic Times | 5.7 (5) | 5.7 (7) |

I:iv The response of STM's to Hospital antenatal care and the rank order of such responses

| | % very satisfied (rank) | % very important (rank) |
|---|---|---|
| Waiting Times | 2.5 (7) | 43.4 (4) |
| Surroundings | 5.7 (6) | 14.5 (6) |
| Privacy | 8.8 (4) | 40.3 (5) |
| Information provision | 15.7 (3) | 67.9 (1=) |
| Choice / Involvement in care | 20.1 (1) | 67.9 (1=) |
| Attention given to own concerns/ anxieties | 17.6 (2) | 67.9 (1=) |
| Clinic Times | 6.9 (5) | 12.6 (7) |

I:v The Most Salient Aspects of GP based antenatal care (% gap between attitudes and experiences)

| | FTM's | | | STM's | | |
|---|---|---|---|---|---|---|
| | % very important | % very satisfied | **% gap** | % very important | % very satisfied | **% gap** |
| Information Provision | 77.2 | 27.6 | **49.6** | 74.8 | 17.0 | **57.8** |
| Involvement in care | 61.8 | 22.8 | **39.0** | 69.2 | 22.0 | **47.2** |
| Attention given to own views | 60.2 | 31.7 | **28.5** | 67.9 | 24.5 | **43.4** |

I:vi The Most Salient Aspects of Hospital based antenatal care (% gap between attitudes and experiences)

| | FTM's | | | STM's | | |
|---|---|---|---|---|---|---|
| | % very important | % very satisfied | **% gap** | % very important | % very satisfied | **% gap** |
| Information Provision | 62.6 | 17.1 | **45.5** | 67.9 | 15.7 | **52.2** |
| Involvement in care | 55.3 | 18.7 | **36.6** | 67.9 | 20.1 | **47.8** |
| Attention given to own views | 52.8 | 13.8 | **39.0** | 67.9 | 17.6 | **50.3** |

I:vii Attitudes towards the importance of information on matters concerned with labour and delivery

| Topic | % response | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | % very important | | % fairly important | | neither | | % fairly unimportant | | % very unimportan | |
| | ftm | stm | ftm | stm | ftm | stm | ftm | stm | ftm | stm |
| Induction | 47.4 | 46.3 | 34.7 | 26.5 | 10.5 | 11.0 | 4.2 | 6.6 | 3.2 | 9.6 |
| Epidurals | 55.7 | 52.2 | 29.9 | 22.1 | 6.2 | 11.8 | 3.1 | 5.1 | 3.2 | 8.8 |
| Monitoring | 49.0 | 41.6 | 43.8 | 43.1 | 4.2 | 6.6 | 2.1 | 2.9 | 1.0 | 5.8 |
| Movement | 56.3 | 47.8 | 36.5 | 36.8 | 5.2 | 9.6 | 1.0 | 1.5 | 1.0 | 4.4 |
| Holding baby | 69.1 | 67.2 | 27.0 | 22.6 | 2.1 | 5.1 | 1.0 | 1.5 | | 3.6 |

I:viii Key providers of information to women

| | GP | | Community Midwife | | Hospital Dr | | Hospital Midwife | | Friend / Relative | | Antena Clas | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | ftm | stm | ftm | stm | ftm | stm | ftm | stm | ftm | stm | ftm | s |
| Induction | 6.1 | 4.4 | 22.4 | 12.7 | 13.3 | 20.1 | 10.2 | 17.2 | 13.3 | 13.4 | 50.0 | 2 |
| Epidurals | 4.1 | 5.9 | 33.7 | 18.7 | 9.2 | 12.7 | 13.3 | 21.6 | 16.3 | 14.2 | 62.2 | 3 |
| Monitoring | 1.0 | 1.5 | 24.5 | 15.7 | 8.2 | 9.7 | 28.6 | 42.5 | 8.2 | 6.7 | 50.0 | 2 |
| Movement | 1.0 | 1.5 | 27.6 | 11.2 | 3.1 | 1.5 | 13.3 | 29.9 | 6.1 | 9.0 | 56.1 | 3 |
| Holding baby | | 2.2 | 25.5 | 11.2 | 4.1 | 1.5 | 20.4 | 38.1 | 11.2 | 8.2 | 45.9 | 2 |
| Pain Relief | 6.1 | 9.7 | 34.7 | 20.1 | 7.1 | 9.0 | 17.3 | 37.3 | 15.3 | 11.9 | 60.2 | 3 |

I:ix Maternal Satisfaction with information on labour and delivery issues

| | % very satisfied | | % fairly satisfied | | % neither | | % fairly dissatisfied | | % very dissatisfied | |
|---|---|---|---|---|---|---|---|---|---|---|
| | ftm | stm | ftm | stm | ftm | stm | ftm | stm | ftm | stm |
| Induction | 19.4 | 12.0 | 31.6 | 29.3 | 25.5 | 36.1 | 11.2 | 15.8 | 12.2 | 6.8 |
| Epidurals | 29.6 | 17.9 | 37.8 | 36.6 | 17.3 | 29.1 | 7.1 | 8.2 | 8.2 | 8.2 |
| Monitoring | 30.6 | 20.6 | 40.8 | 38.2 | 13.3 | 23.5 | 8.2 | 11.0 | 7.1 | 6.6 |
| Movement | 25.5 | 16.4 | 34.7 | 30.6 | 20.4 | 25.4 | 7.1 | 18.7 | 12.2 | 9.0 |
| Holding baby | 35.7 | 26.5 | 31.6 | 32.4 | 15.3 | 23.5 | 7.1 | 10.3 | 10.2 | 7.4 |
| Pain Relief | 42.9 | 27.4 | 35.7 | 40.7 | 11.2 | 14.8 | 5.1 | 10.4 | 5.1 | 6.7 |

I:x The information deficit expressed as a % gap between those who were very satisfied and those who rated a topic very important

| | First Time Mothers | | | Second Time Mothers | | |
|---|---|---|---|---|---|---|
| | % Very important | % Very satisfied | **% Gap** | % Very Important | % Very satisfied | **% gap** |
| Induction | 47.4 | 19.4 | **28.0** | 46.3 | 12.0 | **34.3** |
| Epidurals | 55.7 | 29.6 | **26.1** | 52.2 | 17.9 | **34.3** |
| Monitoring | 49.0 | 30.6 | **18.4** | 41.6 | 20.6 | **21.0** |
| Movement | 53.6 | 25.5 | **28.1** | 47.8 | 16.4 | **31.4** |
| Holding baby | 69.1 | 35.7 | **33.4** | 67.2 | 26.5 | **40.7** |

**Care during the Intrapartum Phase of Women's maternity Career (up until discharge from hospital) (FTM's, n=98, S(+)TM's n=139)**

I:xi Women's birth experience

| | FTM's (%) | STM's (%) |
|---|---|---|
| Unassisted vaginal delivery | 59.2 | 76.6 |
| Assisted Vaginal Delivery (*) | 20.4 | 5.8 |
| Planned Caesarean | 4.1 | 6.6 |
| Emergency Caesarean | 16.3 | 10.9 |

(Key: * = either ventouse or forceps)

I:xii Maternal satisfaction with key aspects of professional care during delivery

| | % Very satisfied | | % Fairly satisfied | | % Actively dissatisfied | |
|---|---|---|---|---|---|---|
| | ftm | stm | ftm | stm | ftm | stm |
| Level of support | 53.1 | 45.3 | 32.7 | 32.1 | 11.2 | 18.3 |
| Information given by midwives | 54.6 | 45.9 | 32.0 | 34.8 | 7.2 | 13.4 |
| Information given by Drs | 33.3 | 25.0 | 39.3 | 35.8 | 14.3 | 18.8 |

I:xiii Postnatal information needs immediately following birth & level of help and support provided by hospital staff

| | A lot of help & advice given | | Some help & advice given | | Very little help & advice given | | Help & advice not needed | |
|---|---|---|---|---|---|---|---|---|
| | ftm | stm | ftm | stm | ftm | stm | ftm | stm |
| Feeding (methods and practice) | 40.8 | 23.4 | 38.8 | 32.1 | 19.4 | 13.9 | 1.0 | 30.7 |
| General baby care | 34.7 | 18.2 | 34.7 | 24.8 | 28.6 | 16.8 | 2.0 | 40.1 |
| Infant health | 15.3 | 16.8 | 30.6 | 29.2 | 50.0 | 36.5 | 4.1 | 17.5 |
| Maternal health | 21.4 | 24.1 | 38.8 | 37.2 | 37.8 | 24.1 | 2.0 | 14.6 |

I:xiv Areas where respondent indicated they wanted greater discussion with Midwives and hospital Obstetric staff

| | More discussion wanted with hospital midwives | | More discussion wanted with hospital doctors | |
|---|---|---|---|---|
| | FTM | STM | FTM | STM |
| Feeding | 61.9 | 39.4 | 8.2 | 7.3 |
| General baby care | 66.0 | 27.7 | 6.2 | 7.3 |
| Infant health | 74.2 | 59.9 | 58.8 | 54.0 |
| Maternal health | 59.8 | 48.9 | 55.7 | 42.3 |
| Ward Atmosphere | 24.7 | 35.0 | 2.1 | 13.9 |
| Amount of Rest | 48.5 | 53.3 | 17.5 | 22.6 |
| Infant Development | 55.7 | 44.5 | 41.2 | 41.6 |

I:xv Discussion and Maternal perceptions of Professional encouragement for breastfeeding

| | % Encouraged | | % Discouraged | | % Not discussed | |
|---|---|---|---|---|---|---|
| | FTM | STM | FTM | STM | FTM | STM |
| GP | 40.8 | 41.6 | | | 59.2 | 58.4 |
| Community midwives | 81.4 | 73.0 | 2.1 | 0.7 | 16.5 | 26.3 |
| Husband / Partner | 82.4 | 65.9 | 5.5 | 3.0 | 12.1 | 31.1 |
| Relative / Friend | 57.3 | 44.4 | 5.2 | 4.4 | 37.5 | 51.1 |
| Hospital Doctor | 27.1 | 21.3 | 1.0 | 1.5 | 71.9 | 77.2 |
| Hospital Midwives | 70.8 | 54.0 | 3.1 | 1.5 | 26.0 | 44.5 |
| Antenatal Class | 84.2 | 56.9 | | . | 15.8 | 43.1 |

**Postnatal Health and Postnatal Care -**

(First Time Mothers n=87, Second (+) Time Mothers n=113)

I:xvi Self-reported incidence of health problems / issues post birth

| | % Responding "Not a Problem" | |
|---|---|---|
| | First Time Mothers | Second (+) Time Mothers |
| Pain from stitches | 38.1 | 50.4 |
| Backache | 62.9 | 62.0 |
| Pain from caesarean | 81.4 | 86.1 |
| Problems holding urine | 81.4 | 78.1 |
| Cracked nipples | 59.8 | 62.8 |
| Other breast problems | 62.9 | 62.0 |
| Feeling very depressed | 70.1 | 75.9 |
| Feeling exhausted | 33.0 | 42.3 |
| Lack of sex drive | 72.6 | 82.5 |
| Problems with bonding | 95.8 | 97.1 |
| Sibling Rivalry | n/a | 65.7 |

I: xvii The rate at which Respondents regained their "normal" (pre-pregnancy) health

| Time elapsed since birth (months) | FTM cumulative % | STM cumulative % |
|---|---|---|
| 1 | 6.9 | 7.1 |
| 2 | 21.8 | 31.0 |
| 3 | 39.1 | 54.0 |
| 4 | 50.6 | 61.9 |
| 5 | 57.5 | 65.5 |
| 6 | 74.7 | 77.0 |
| 7-12 | 90.8 | 90.3 |

I: xviii Respondents perceptions regarding the difficulties of parenting

| | "It's Harder to Be a Parent than I Imagined" | | | | |
|---|---|---|---|---|---|
| | Strongly Agree | Agree to Some Extent | Neither agree / disagree | Disagree to some extent | Strongly Disagree |
| FTM | 28.7 | 47.1 | 16.1 | 6.9 | 1.1 |
| STM | 39.8 | 46.0 | 9.7 | 2.7 | 1.8 |

I: xix Respondents Experience of the Personal Adjustment to Motherhood (%)

| | Very Easy | Fairly Easy | Neither | Fairly Difficult | Very Difficult |
|---|---|---|---|---|---|
| FTM | 6.9 | 32.2 | 26.4 | 28.7 | 5.7 |
| STM | 14.2 | 30.1 | 26.5 | 25.7 | 3.5 |

I: xx Respondents perceived needs regarding practical help and emotional support

| | More practical help needed | | More emotional support needed | |
|---|---|---|---|---|
| | FTM | STM | FTM | STM |
| Husband / partner | 26.4 | 37.2 | 28.7 | 25.7 |
| Parents | 24.1 | 28.3 | 12.6 | 16.8 |
| Parents-in-law | 27.6 | 26.5 | 12.6 | 13.3 |
| Other Relatives | 17.2 | 17.7 | 6.9 | 8.0 |
| Close Friends | 12.6 | 17.7 | 6.9 | 12.4 |
| Community Midwife | 24.1 | 15.9 | 16.1 | 12.4 |
| Health Visitor | 24.1 | 16.8 | 23.0 | 21.2 |

I: xxi Demand for Information on Postnatal issues (% responding that they wanted more information).

| | **From HV** | | **From GP** | |
|---|---|---|---|---|
| | FTM | STM | FTM | STM |
| Breastfeeding | 29.9 | 13.3 | 8.0 | 5.3 |
| Bottle feeding | 19.5 | 8.0 | 2.3 | 3.5 |
| Feeding solids | 37.9 | 22.1 | 9.2 | 7.1 |
| General baby care/handling | 19.5 | 12.4 | 6.9 | 3.5 |
| Child health | 41.4 | 27.4 | 49.4 | 42.6 |
| Own health & recovery | 39.1 | 29.2 | 18.4 | 33.6 |
| Child development | 42.5 | 25.7 | 2.3 | 15.0 |
| Child safety | 19.5 | 13.3 | 18.4 | 5.3 |
| Child sleeping patterns | 49.4 | 31.0 | 24.1 | 17.7 |

# Appendix II

## The impact of respondents education on their experiences of and attitudes towards modern maternity care services - illustrative data

The panel was split into those who left school / full time education (i) below the age of 16, (ii) at the age of 16, (iii) 17 or 18 (i.e.; received some form of further education and (iv) 19+ (higher education). No significant differences were found relating to educational characteristics alone, although respondents educational characteristics combined with husband / partner's class appeared to influence women's attitudes towards feeding methods (as discussed in Chapter 11). Two derived variables were then produced in relation to the educational characteristics of the sample: one of which combined (i) and (ii) - i.e.; those who left at or below the age of 16 - and the second which combined (iii) and (iv) - i.e.; those who received some form of education beyond the statutory school leaving age. 159 respondents left school at or below 16 whilst 121 received some form of education beyond this.

As the following tables illustrates, very few significant differences were evident amongst panel members regarding GP based antenatal care - and none in those areas of practitioner / client interaction, where one might have expected differences to emerge given the research literature on this subject (Morgan et al 1985, McCraine, Horowitz and Martin 1978, Stimson and Webb 1975). This re-emphasises the point made by Winterton that "even the most articulate and assertive woman may have difficulty in achieving maximum choice in their contact with the maternity services" (Winterton, 1992, page xv).

### II i Levels of satisfaction with GP based antenatal care (%)

| | post 16 education | left at / under 16 |
|---|---|---|
| **Overall GP based care** | | |
| Very satisfied | 30.6 | 38.4 |
| Fairly Satisfied | 54.5 | 49.1 |
| Neither | 10.7 | 8.8 |
| Fairly Dissatisfied | 1.7 | 3.1 |
| Very Dissatisfied | 2.5 | 0.6 |
| | | |
| **Length of Waiting Times* (p=0.01)** | | |
| Very satisfied | 25.0 | 16.5 |
| Fairly Satisfied | 41.7 | 53.8 |
| Neither | 20.8 | 12.7 |
| Fairly Dissatisfied | 11.7 | 11.4 |
| Very Dissatisfied | 0.8 | 5.7 |

| | post 16 education | left at / below 16 |
|---|---|---|
| **Clinic environment / facilities** | | |
| Very satisfied | 33.9 | 26.4 |
| Fairly Satisfied | 43.8 | 57.2 |
| Neither | 16.5 | 12.6 |
| Fairly Dissatisfied | 5.8 | 3.8 |
| Very Dissatisfied | -- | -- |
| | | |
| **Privacy** | | |
| Very satisfied | 37.2 | 33.3 |
| Fairly Satisfied | 57.0 | 56.0 |
| Neither | 3.3 | 8.8 |
| Fairly Dissatisfied | 2.5 | 1.9 |
| Very Dissatisfied | -- | -- |
| | | |
| **Information provision** | | |
| Very satisfied | 22.5 | 27.0 |
| Fairly Satisfied | 52.5 | 44.7 |
| Neither | 15.0 | 20.1 |
| Fairly Dissatisfied | 8.3 | 7.5 |
| Very Dissatisfied | 1.7 | 0.6 |
| | | |
| **Opening times** | | |
| Very satisfied | 19.8 | 18.2 |
| Fairly Satisfied | 55.4 | 62.3 |
| Neither | 17.4 | 14.5 |
| Fairly Dissatisfied | 7.4 | 3.8 |
| Very Dissatisfied | -- | 1.3 |
| | | |
| **Attention given to own concerns** | | |
| Very satisfied | 24.4 | 31.0 |
| Fairly Satisfied | 46.2 | 47.5 |
| Neither | 19.3 | 16.5 |
| Fairly Dissatisfied | 9.2 | 4.4 |
| Very Dissatisfied | 0.8 | 0.6 |
| | | |
| **Involvement in care choices** | | |
| Very satisfied | 23.5 | 22.0 |
| Fairly Satisfied | 39.5 | 50.3 |
| Neither | 25.2 | 18.9 |
| Fairly Dissatisfied | 9.2 | 6.3 |
| Very Dissatisfied | 2.5 | 2.5 |

## II ii The Salience of Key Features of GP Based Antenatal Care

| | post 16 education | left at / below 16 |
|---|---|---|
| | | |
| **Waiting Times** | | |
| Very Important | 33.1 | 35.8 |
| Fairly Important | 49.6 | 49.7 |
| Neither | 14.9 | 13.8 |
| Fairly Unimportant | 2.5 | 0.6 |
| Very Unimportant | -- | -- |
| | | |
| **Clinic environment / facilities * (p=0.02)** | | |
| Very Important | 8.3 | 21.4 |
| Fairly Important | 57.5 | 53.5 |
| Neither | 31.7 | 22.0 |
| Fairly Unimportant | 2.5 | 2.5 |
| Very Unimportant | -- | 0.6 |
| | | |
| **Privacy** | | |
| Very Important | 46.7 | 53.5 |
| Fairly Important | 45.0 | 39.6 |
| Neither | 8.3 | 6.3 |
| Fairly Unimportant | -- | -- |
| Very Unimportant | -- | 0.6 |
| | | |
| **Information provision** | | |
| Very Important | 76.0 | 76.7 |
| Fairly Important | 24.0 | 20.1 |
| Neither | -- | 3.1 |
| Fairly Unimportant | -- | -- |
| Very Unimportant | -- | -- |
| | | |
| **Opening times** | | |
| Very Important | 11.6 | 15.7 |
| Fairly Important | 57.9 | 49.1 |
| Neither | 28.9 | 30.8 |
| Fairly Unimportant | 1.7 | 4.4 |
| Very Unimportant | -- | -- |
| | | |

| | | |
|---|---|---|
| **Attention given to own concerns** | | |
| Very Important | 68.6 | 62.3 |
| Fairly Important | 30.6 | 33.3 |
| Neither | 0.8 | 4.4 |
| Fairly Unimportant | -- | -- |
| Very Unimportant | -- | -- |
| | | |
| **Involvement in care choices** | | |
| Very Important | 69.4 | 64.2 |
| Fairly Important | 26.4 | 30.8 |
| Neither | 4.1 | 5.0 |
| Fairly Unimportant | -- | -- |
| Very Unimportant | -- | -- |

The panel were therefore remarkably homogeneous in their attitudes and experiences, and in the two cases where significant differences were found they both relate to areas of "context" rather than content. Given that one significant difference occurred in the area of GP waiting times one might wish, through further research, to examine the issue of whether this occurred due to the characteristics of the panel or whether it might, in some way, be related to differences in the organisation of GP clinics and/or their patient population. A similar argument could be forwarded about the importance of the surroundings at GP clinics, although again one would have to research panellists views in greater depth, using qualitative methods, in order to determine the relationship between women's attitudes towards contextual issues and specific (practice based) providers of antenatal care. The scope of this more focused analysis however was beyond the limits of the current project.

Further analysis was conducted regarding hospital based care, and again the experiences of the panel are remarkably similar (i.e.; in the key area of information provision, only 16.9% of those who received post 16 education and 17.6% of those who left full time education at / below 16 reported that they "very satisfied" with this feature of care).

# APPENDIX III

## QUESTIONNAIRE USED IN EVALUATION OF MOTHERS AND MIDWIVES TEAM MIDWIFERY PROJECT

# MATERNITY CARE SURVEY

YOUR CONFIDENTIALITY IS ASSURED

1. How old are you ? (please write in) 32 years

2. Could you tell us your marital status ? Are You

(please tick 1 box)

| | |
|---|---|
| Single (never married) | |
| Married (first marriage) | ✓ |
| Re-married | |
| Divorced / Separated | |
| Widowed | |

3. Do you and your children currently live with -

(please tick 1 box)

| | |
|---|---|
| Your husband | ✓ |
| A partner to whom you are not married | |
| Alone (with no other adults) | |
| With relatives | |

4. Which of the following ethnic groups do you consider that you belong to ?

(please tick 1 box)

| | | | |
|---|---|---|---|
| White | ✓ | Black Caribbean | |
| Indian | | Black African | |
| Pakistani | | Chinese | |
| Bangladeshi | | Other (please write in) | |

5. What is your first language ? (please write in) English

6. If English is not your first language, how fluent are you in English ?

(please tick box)

| | |
|---|---|
| I am fluent in English | |
| I understand English, but do not speak it very well | |

7. Was this your first baby ?

(please tick 1 box)

| | |
|---|---|
| Yes | ✓ |
| No | |

8. How old were you when you left school ? (please write in) 16

9. Are you in paid work at the moment ? (please tick one box)

| | |
|---|---|
| Yes | ✓ |
| No | |
| On paid maternity leave | |

If you are not in work, please go to Question 11

10. What is your job? (please write in) Housewife

11. Does your husband / partner have a paid job ? (please tick 1 box)

| | |
|---|---|
| Yes | ✓ |
| No | |

12. What is your Husband / Partners job ? (please write in) Carpenter

13. Do you ....
(please tick 1 box)

| | |
|---|---|
| Own your own house (or buying on a mortgage) | ✓ |
| Rent from a Private Landlord | |
| Rent from the Council / Housing Association | |

14. Is there a car that you can use during the day ? (please tick 1 box)

| | |
|---|---|
| Yes, always | ✓ |
| Yes, when necessary | |
| No | |

## YOUR ANTE NATAL CARE

The questions in the following section are about the ante natal care that you received. If you wish to expand on any of the answers, please do not hesitate to do so on the blank pages at the end of this questionnaire.

15. Which system of ante natal care were you booked under ?
(please tick one box)

| | |
|---|---|
| GP / Midwife | ✓ |
| Consultant | |
| Can't remember | |

16. Did this change while you were pregnant ?
(please tick 1 box)

| | |
|---|---|
| Yes | |
| No | |

17. Where did you have most of your check ups ?
(please tick 1 box)

| | |
|---|---|
| At a Surgery | |
| At a Hospital | |
| In my own Home | |

18. If you could choose, where would you like to have your check ups ?
(please tick 1 box)

| | |
|---|---|
| At a Surgery | |
| At Hospital | |
| In my own Home | |

19. Approximately how many times were you seen by your midwife and your GP during your pregnancy ? (please tick 1 box for each )

GP

| | |
|---|---|
| 0 - 4 times | |
| 5 - 8 times | |
| 9 - 12 times | |
| 13 - 16 times | |
| 17 + times | |

MIDWIFE

| | |
|---|---|
| 0 - 4 times | |
| 5 - 8 times | |
| 9 - 12 times | |
| 13 - 16 times | |
| 17+ times | |

20. Did you know the name of your midwife ?
(please tick 1 box)

| | |
|---|---|
| Yes | |
| No | |

21. During your ante natal care, how many midwives did you see ? (please tick 1 box)

| One | Two | Three | More than three |
|---|---|---|---|
| | | | |

22. Did you attend any midwife ante natal classes ? (please tick one box for each)

At your Surgery

| | |
|---|---|
| Yes | |
| No | |

At Hospital

| | |
|---|---|
| Yes | |
| No | |

If you answered "No", why did you decide not to attend these classes ? (please write in below)

23 Overall, how satisfied were you with the ante natal care provided within your GP SURGERY ? (please tick 1 box)

| Very Satisfied | Fairly Satisfied | Neither | Fairly Dissatisfied | Very Dissatisfied |
|---|---|---|---|---|
| ✓ | | | | |

24. I general, how satisfied were you with each of the following at your GP SURGERY ? (please tick one box for each)

| | Very Satisfied | Fairly Satisfied | Neither | Fairly Dissatisfied | Very Dissatisfied |
|---|---|---|---|---|---|
| Length of Time you had to wait to see GP | ✓ | | | | |
| Length of time you had to wait to see MIDWIFE | ✓ | | | | |
| Surroundings (facilities.toilets etc) | ✓ | | | | |
| Degree of privacy | ✓ | | | | |
| The Medical Information You Were Given | ✓ | | | | |
| The Clinic Opening Times | ✓ | | | | |
| The Attention that was Given to What You Had to Say | ✓ | | | | |
| The Extent to Which You Were Involved in Choices About your Care | ✓ | | | | |

25. In general **HOW IMPORTANT** did you consider each of these features to be during your pregnancy ? (please tick 1 box for each)

| | Very Important | Fairly Important | Neither | Fairly Unimportant | Very Unimportant |
|---|---|---|---|---|---|
| Length of Time you had to wait to see GP | | ✓ | | | |
| Length of time you had to wait to see MIDWIFE | | ✓ | | | |
| Surroundings (facilities,toilets etc) | ✓ | | | | |
| Degree of privacy | ✓ | | | | |
| The Medical Information You Were Given | ✓ | | | | |
| The Clinic Opening Times | | ✓ | | | |
| The Attention that was Given to What You Had to Say | ✓ | | | | |
| The Extent to Which You Were Involved in Choices About your Care | ✓ | | | | |

26. Approximately how many times during your pregnancy were you seen in a Hospital (including scans and tests). Please tick 1 box.

| None At All | 1 - 4 times | 5 - 8 times | 9 - 12 times | 13 - 16 times | 17+ times |
|---|---|---|---|---|---|
| | ✓ | | | | |

27. Overall, how satisfied were you with the ante natal care provided in HOSPITAL ? (please tick)

| Very Satisfied | Fairly Satisfied | Neither | Fairly Dissatisfied | Very Dissatisfied |
|---|---|---|---|---|
| | ✓ | | | |

28. In general, how SATISFIED were you with each of the following aspects of HOSPITAL ante natal care ? (please tick one box for each)

| | Very Satisfied | Fairly Satisfied | Neither | Fairly Dissatisfied | Very Dissatisfied |
|---|---|---|---|---|---|
| Length of Time you had to wait to see Doctor / Midwife | | ✓ | | | |
| Surroundings (facilities,toilets etc) | | ✓ | | | |
| Degree of privacy | | ✓ | | | |
| The Medical Information You Were Given | | ✓ | | | |
| The Clinic Opening Times | ✓ | | | | |
| The Attention that was Given to What You Had to Say | | ✓ | | | |
| The Extent to Which You Were Involved in Choices About your Care | | ✓ | | | |

29. In general, how IMPORTANT were each of these features of HOSPITAL ante natal care to you during your pregnancy ? (please tick one box for each).

| | Very ~~Satisfied~~ | Fairly ~~Satisfied~~ | Neither | Fairly ~~Dissatisfied~~ | Very ~~Dissatisfied~~ |
|---|---|---|---|---|---|
| Length of Time you had to wait to see Doctor / Midwife | | ✓ | | | |
| Surroundings (facilities,toilets etc) | ✓ | | | | |
| Degree of privacy | ✓ | | | | |
| The Medical Information You Were Given | ✓ | | | | |
| The Clinic Opening Times | | ✓ | | | |
| The Attention that was Given to What You Had to Say | ✓ | | | | |
| The Extent to Which You Were Involved in Choices About your Care | ✓ | | | | |

30. During your pregnancy, did you have an ultrasound scan ?

| | |
|---|---|
| Yes | ✓ |
| No | |

31. If you did have an ultrasound scan, how satisfied were you with the information that you were given about the scan?

(please tick 1 box)

| | |
|---|---|
| Very Satisfied | ✓ |
| Fairly Satisfied | |
| Neither | |
| Fairly Dissatisfied | |
| Very Dissatisfied | |

32. Overall, how satisfied were you with the information that you were given about ALL of the tests that were carried out during your pregnancy ?

| | |
|---|---|
| Very Satisfied | ✓ |
| Fairly Satisfied | |
| Neither | |
| Fairly Dissatisfied | |
| Very Dissatisfied | |

33. Before you went into Hospital to have your baby, how satisfied **were** you with the information that you had been given about the following issues ? (please tick one box for each)

| | Very Satisfied | Fairly Satisfied | Neither | Fairly Dissatisfied | Very Dissatisfied |
|---|---|---|---|---|---|
| Induction | ✓ | | | | |
| Epidurals | ✓ | | | | |
| Monitoring of Labour | ✓ | | | | |
| Moving Position During Labour | ✓ | | | | |
| Methods of Pain Relief | ✓ | | | | |
| When you could hold your baby | ✓ | | | | |

34. Who discussed these topics with you ? (please tick any boxes which apply)

| | GP | Community Midwife | Hospital Doctor | Hospital Midwife | Friend / Relative | Ante Natal Class |
|---|---|---|---|---|---|---|
| Induction | | ✓ | | | | ✓ |
| Epidurals | | ✓ | | | | ✓ |
| Monitoring of Labour | | ✓ | | | | ✓ |
| Moving position during labour | | ✓ | | | | ✓ |
| Methods of pain Relief | | ✓ | | | | ✓ |
| When you could hold your baby | | ✓ | | | | ✓ |

35. Looking back now, how satisfied were you with the information you were given about what might happen during labour and delivery ?

| Very Satisfied | Fairly Satisfied | Neither | Fairly Dissatisfied | Very Dissatisfied |
|---|---|---|---|---|
| ✓ | | | | |

36. How IMPORTANT was it for you to know about the following topics ? (please tick 1 box for each)

| | Very Important | Fairly Important | Neither | Fairly Unimportant | Very Unimportant |
|---|---|---|---|---|---|
| Induction | ✓ | | | | |
| Epidurals | ✓ | | | | |
| Monitoring of Labour | ✓ | | | | |
| Moving Position During Labour | ✓ | | | | |
| Methods of Pain Relief | ✓ | | | | |
| When you could hold your baby | ✓ | | | | |

## SECTION 3. LABOUR AND DELIVERY

37. When you went into labour, how long was it before you went into Hospital ?

| Less than 1 hour | 1 - 4 hours | 5 - 10 hours |
|---|---|---|
| | | ✓ |

38. How many people were involved in your care whilst you were in labour ? (please tick 1 box)

| One | Two | Three | Four | More than 4 |
|---|---|---|---|---|
| | | | | ✓ |

39. How many of these were midwives ? (please write in) 1

40. How well did you know the person who was most involved in your care during labour ?

| I knew the person very well | I knew the person fairly well | I did not know the person very well | I had never met this person before I went into labour |
|---|---|---|---|
| | | | ✓ |

41. In your opinion, how effective were the methods of pain relief that you received during labour ?

| Very Effective | Fairly Effective | Neither | Fairly Ineffective | Very Ineffective | Did Not Receive Any Pain Relief |
|---|---|---|---|---|---|
| ✓ | | | | | |

42. What type of delivery did you have ? (please tick 1 box)

| Normal | Forceps or Ventouse | Planned Caesarean | Emergency Caesarean |
|---|---|---|---|
| | ✓ | | |

43. Who delivered your baby ? (please tick 1 box)

| | |
|---|---|
| Midwife | |
| Student Midwife | |
| Doctor | ✓ |
| Balmore Park Project Midwife | |
| Other (please write in) | |

44. Had you met this person before ? (please tick 1 box)

| | |
|---|---|
| Yes | |
| No | ✓ |

45. Were you satisfied with the level of support that you were given during your labour and delivery ?

| Very Satisfied | Fairly Satisfied | Neither | Fairly Dissatisfied | Very Dissatisfied |
|---|---|---|---|---|
| ✓ | | | | |

46. Did you feel that you were treated with respect by the Hospital Staff during your labour and delivery ? (please tick 1 box)

| | |
|---|---|
| Yes | ✓ |
| No | |

47. Were you SATISFIED with the information that you were given by the Doctors and Midwives during your labour and delivery ? (please tick 1 box for each person)

| | Very Satisfied | Fairly Satisfied | Neither | Fairly Dissatisfied | Very Dissatisfied | NOT PRESENT |
|---|---|---|---|---|---|---|
| Doctors | ✓ | | | | | |
| Midwives | ✓ | | | | | |

48. Did you think that the Doctors and Midwives took enough notice of what you were saying during labour and delivery ? (please tick 1 box for each person)

DOCTORS

| | |
|---|---|
| Took a Lot of Notice | ✓ |
| Sometimes Listened | |
| Didn't' listen At All | |
| Not Present | |

MIDWIVES

| | |
|---|---|
| Took a lot of Notice | ✓ |
| Sometimes Listened | |
| Didn't listen At All | |
| Not Present | |

49. Were you able to hold your baby as soon as you wanted to after the birth? (please tick 1 box)

| | |
|---|---|
| Yes | ✓ |
| No | |

50. Is there anything else which you would like to say about your experiences of labour and delivery which we have not covered in this section?

## SECTION 4 POST NATAL CARE

51. How long did you stay in Hospital after the birth of your baby ? (please tick 1 box)

| | |
|---|---|
| Under 6 hours | |
| 7 - 24 hours | ✓ |
| 25 - 48 hours | |
| more than 48 hours | |

52. Before your baby was born, had you decided on how you wanted to feed your baby ? (please tick 1 box)

| | |
|---|---|
| I wanted to try to breastfeed | ✓ |
| I had decided to bottle-feed | |
| I was going to se both methods | |
| I was unsure about which method I would use | |

53. After your baby was born, which method of feeding did you use ? (please tick one box)

| Breast feeding Only | Bottle-feeding Only | I used both feeding methods |
|---|---|---|
| ✓ | | ✓ |

54. If you started breast feeding your baby, how long did you continue ? 4 months

55. In your opinion, who gave you the most useful help and advice about feeding your baby ? (please tick 1 box)

| | | | |
|---|---|---|---|
| GP | | Midwife | |
| Hospital Doctor | | Hospital Midwife | |
| Friend / Relative | ✓ | Ante Natal Class | |
| Post Natal Class | | Health Visitor | |
| Other (write in) | | | |

56. When you were in Hospital following the birth of your baby, were you given enough help and advice about the following topics ? (please tick 1 box for each)

| | I was Given A Lot of Help & Advice | I was Given Some Help & Advice | I was Given Very Little Help & Advice | I Did Not Need Any Help & Advice |
|---|---|---|---|---|
| Feeding Methods | | ✓ | | |
| General Baby Care | | ✓ | | |
| Infant Health | | ✓ | | |
| Your Own Health & Recovery | | | ✓ | |

57. Whilst you were in Hospital, would you have liked to discuss any of the following topics in more detail with either Midwives or Doctors ? (please tick any boxes which apply)

| | Would have liked to Discuss more with MIDWIVES | Would have liked to Discuss more with DOCTORS |
|---|---|---|
| Feeding Methods | ✓ | |
| General Baby Care | | |
| Infant health | ✓ | |
| Your Own Health & Recovery | ✓ | |
| Ward Atmosphere | | |
| Amount of rest you were able to get | | |
| Infant Development | | |
| Child Sleeping Habits | | |

58. If you had another baby, which of the following would you prefer ? (please tick 1 box)

| | |
|---|---|
| To know the person who cared for you in labour very well | |
| To have a "familiar face" to look after you during labour | ✓ |
| Prefer to have someone you don't know particularly well | |
| No preference | |
| Other (please write in) | |

59. After you went home, how many midwives visited you? (please write in) 2

60. Of these, how many had you met before ? (please write in) 1

61. Looking back now, how satisfied were you with the information that you received from Midwives and health Visitors after you went home with your baby ? (please tick 1 box for each)

| | Very Satisfied | Fairly Satisfied | Neither | Fairly Dissatisfied | Very Dissatisfied |
|---|---|---|---|---|---|
| From Midwives | ✓ | | | | |
| From Health Visitors | | ✓ | | | |

62. After your baby was born, how long did it take for you to feel that you had returned to your "normal" state of health " (please write in) 10 months

63. Following the birth of your baby, would you have liked more PRACTICAL HELP or EMOTIONAL SUPPORT from any of the following people ? (please tick any boxes which apply)

| | More PRACTICAL HELP Needed | More EMOTIONAL SUPPORT needed |
|---|---|---|
| Husband / Partner | ✓ | ✓ |
| Your Parents | ✓ | |
| Partner's parents | | |
| Other Relatives | | |
| Close Friends | ✓ | ✓ |
| Midwife | | |
| Health Visitor | | |
| Mother & baby Group | | |
| Other (write in) | | |

64. Who do you feel gave you the most practical help following the birth of your baby ? (please write in) _____

65. Who gave you the most emotional support after your baby was born ? Mum

66. How old is your baby now ? (please write in) 13 months

67. Since the birth of your baby, how has your general state of health been ? (please tick 1 box for each)

| | Better Than Usual | Same As Usual | Less Than Usual | Not At All |
|---|---|---|---|---|
| Are you able to concentrate on what you are doing ? | | ✓ | | |
| Do you lose sleep because you are worrying ? | | ✓ | | |
| Do you feel mentally alert and wide awake ? | | ✓ | | |
| Do you feel energetic ? | | ✓ | | |
| Do you feel that you are managing well ? | | ✓ | | |
| Are you able to be affectionate towards others ? | | ✓ | | |
| Do you feel capable of making decisions ? | | ✓ | | |
| Do you feel under strain ? | | ✓ | | |
| Are you able to enjoy your day to day activities ? | | ✓ | | |
| Do you find things getting on top of you ? | | ✓ | | |
| Do you fell reasonable happy, all things considered ? | | ✓ | | |
| Do you feel confident about your ability to handle situations ? | | ✓ | | |

68. Would you consider giving birth at home if you became pregnant again

| | |
|---|---|
| Yes | |
| No | ✓ |

69. Since your baby was born, have you had to see your GP about health problems resulting from the birth of your baby (such as pain from stitches, breast problems etc.). Please write in below

| | | Problem | Number of Times Seen GP |
|---|---|---|---|
| Yes | | | |
| | | | |
| | | | |
| No | ✓ | | |

70. Since the birth of your baby, have you had to see your GP for an illness or problems NOT connected with the birth of your baby ? (please tick box and write in number of times)

Yes
No ✓

Seen GP_____ times

70. Before the birth of your baby, how much experience had you had of looking after babies and young children ? (please tick 1 box)

| A Lot of Experience | Some Experience | Hardly Any Experience | None at All |
|---|---|---|---|
| | ✓ | | |

71. Would you say that becoming a mother has been an easy experience for you, or a difficult one ? (please tick 1 box)

| Very Easy | Fairly Easy | Neither | Fairly Difficult | Very Difficult |
|---|---|---|---|---|
| | ✓ | | | |

72. Ho far would do you agree with the following statement ?

**" It's Harder To Be A Parent Than I Imagined "**

| Strongly Agree | Agree to Some Extent | Neither Agree nor Disagree | Disagree to Some Extent | Strongly Disagree |
|---|---|---|---|---|
| | ✓ | | | |

73. Could you tell us whether you baby was

| | |
|---|---|
| A Boy | |
| A Girl | ✓ |
| Twins | |
| Triplets | |

## CHILD HEALTH

This section looks at the general health of your baby following their birth.

74. During your baby's first year, has your GP had to treat your child for any illnesses ?

| No | Once | Twice | Three Times | Four Times | Five Times | 6+ times |
|---|---|---|---|---|---|---|
| | | | ✓ | | | |

75. Has your baby been admitted to Hospital because of illness ? (please tick box)

| No | Once | Twice | Three Times | Four Times | Five times | 6+ times |
|---|---|---|---|---|---|---|
| ✓ | | | | | | |

76. Have you had to take your baby to Hospital because of an accident

| | No | Once | Twice | Three Times | 4- times |
|---|---|---|---|---|---|
| To Accident and Emergency Department | ✓ | | | | |
| As an in patient (admitted to children's ward) | ✓ | | | | |

77. Has your child had the following immunisations ? (please tick box for each)

| | Yes | No |
|---|---|---|
| Ist Diphtheria, Tetanus, Whooping Cough, Polio | ✓ | |
| 2nd Diphtheria, Whooping Cough, Tetanus, Polio | ✓ | |
| 3rd Diphtheria, Tetanus, Whooping Cough Polio | ✓ | |
| Measles, Mumps, Rubella | | |

78. In your opinion, was your Health Visitor generally satisfied with your baby's development ? (please tick 1 box)

| All of the Time | Most of the time | Some of the Time | Hardly ever |
|---|---|---|---|
| ✓ | | | |

79. Would you have liked to talk more to your Health Visitor or GP about any of the following topics? (please tick any boxes which apply)

| Topic | Would have liked to talk more to HEALTH VISITOR | Would have liked to talk more to GP |
|---|---|---|
| Breast feeding | ✓ | |
| Bottle Feeding | ✓ | |
| Feeding your Baby Solids | ✓ | |
| General Baby Care | | |
| Possible Health Problems (baby) | | |
| Your Own Health & Recovery | | |
| Infant Development | | |
| Child Safety | | |
| Child Sleeping Habits | ✓ | |

80. Overall, how satisfied are you with the care that you received from your GP surgery following the birth of your baby ? (please tick 1 box)

| Very Satisfied | Fairly Satisfied | Neither | Fairly Dissatisfied | Very Dissatisfied |
|---|---|---|---|---|
| ✓ | | | | |

81. Following the birth of your baby, how SATISFIED are you with each of the following aspects of GP based care ? (please tick 1 box for each)

| | Very Satisfied | Fairly Satisfied | Neither | Fairly Dissatisfied | Very Dissatisfied |
|---|---|---|---|---|---|
| Length of Time you had to wait | ✓ | | | | |
| Surroundings (facilities,toilets etc) | ✓ | | | | |
| Degree of privacy | ✓ | | | | |
| The Medical Information You Were Given | ✓ | | | | |
| The Clinic Opening Times | ✓ | | | | |
| The Attention that was Given to What You Had to Say | ✓ | | | | |
| The Extent to Which You Were Involved in Choices About your Care | ✓ | | | | |

82. How IMPORTANT are each of these features of GP care to you following the birth of your baby ? (please tick 1 box for each)

| | Very Important | Fairly Important | Neither | Fairly Unimportant | Very Unimportant |
|---|---|---|---|---|---|
| Length of Time you had to wait | | ✓ | | | |
| Surroundings (facilities,toilets etc) | ✓ | | | | |
| Degree of privacy | | ✓ | | | |
| The Medical Information You Were Given | ✓ | | | | |
| The Clinic Opening Times | | ✓ | | | |
| The Attention that was Given to What You Had to Say | | ✓ | | | |
| The Extent to Which You Were Involved in Choices About your Care | | ✓ | | | |

83. Overall, how SATISFIED were you with the post natal care (for both yourself and your baby) that you received after your baby was born ? (please tick one box )

| Very Satisfied | Fairly Satisfied | Neither | Fairly Dissatisfied | Very Dissatisfied |
|---|---|---|---|---|
| ✓ | | | | |

84. How satisfied are you with the following features of HOSPITAL post natal care (please tick box for each)

| | Very Satisfied | Fairly Satisfied | Neither | Fairly Dissatisfied | Very Dissatisfied |
|---|---|---|---|---|---|
| Length of Time you had to wait | | | | | |
| Surroundings (facilities,toilets etc) | | | | | |
| Degree of privacy | | | | | |
| The Medical Information You Were Given | | | | | |
| The Clinic Opening Times | | | | | |
| The Attention that was Given to What You Had to Say | | | | | |
| The Extent to Which You Were Involved in Choices About your Care | | | | | |

85. How important are the following features of Hospital post natal care ? (please tick 1 box for each)

| | Very Important | Fairly Important | Neither | Fairly Unimportant | Very Unimportant |
|---|---|---|---|---|---|
| Length of Time you had to wait | | | | | |
| Surroundings (facilities,toilets etc) | | | | | |
| Degree of privacy | | | | | |
| The Medical Information You Were Given | | | | | |
| The Clinic Opening Times | | | | | |
| The Attention that was Given to What You Had to Say | | | | | |
| The Extent to Which You Were Involved in Choices About your Care | | | | | |

86. Do you have any further comments about the care that you received (during pregnancy, birth and post natally) which you would like to mention but which has not been covered in this questionnaire ? Please write in below (and on the back of this page) if you wish to do so.

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE. PLEASE RETURN IT IN THE STAMPED ADDRESSED ENVELOPE PROVIDED