BIRTHING AND "BEING THERE": WOMEN'S SATISFACTION WITH CHILDBIRTH AND MATERNITY CARE

by

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ABSTRACT

This thesis examines birthing patients' views of maternity care in the Greater Victoria area. Although there is considerable sociological research on the work of medical practitioners and midwives, less data exist on patient satisfaction with their maternity care-givers. This gap in the literature is particularly significant given that maternity care is now under review by provincial governments across the country. Legislation to make midwifery an option for all birthing women has already been passed in Ontario, Alberta and British Columbia. In light of these changes, it is timely to examine patients' perspectives of formal care-givers from the prenatal through to the postpartum phase of the birthing process.

The primary objective of this research was to explore patient satisfaction with the quality of maternity care they received. I argue for the necessity of inductive research that grounds birthing knowledge in the lived experience of birthing women themselves. Data which are grounded in the lived experience necessitate the employment of a qualitative research method. Therefore, in-depth interviews were the chosen method for data collection, with the overall goal of giving voice to respondents.

Twelve maternity patients of various socio-economic backgrounds in the Greater Victoria area were interviewed in an attempt to understand their level of satisfaction with the maternity services they received. Six had received care from a physician and six from a midwife. The interviews focused on the experiences of each respondent and her family during the nine prenatal months, during labour and delivery, and in the postpartum period.

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A comparison of midwifery and physician services helped further understanding of: (1) the types of patient services offered by each maternity practitioner under study; (2) the appropriateness, from the patients' point of view, of the care provided by physicians and midwives; and (3) the overall satisfaction of birthing families with the types of maternity services rendered.

Emerging from my study is the finding that there are similarities and differences between the levels of satisfaction of two groups of women who used either physicians or midwives as their main care-givers. The two main differences between my groups of respondents were: (1) care-givers "being there" for their patients throughout the reproductive and birthing process. Respondents in the midwife group reported their midwives as "being there" to a much greater degree than did respondents in the physician group; (2) satisfaction with the care received in the postnatal phase, particularly when the women returned home and were alone with their new baby. The transition to motherhood was much more stressful for the women whose main care-givers were physicians. These women often felt unable to cope, lonely and unsure of their mothering abilities. The women who had the support of a privately hired midwife, by contrast, were much more comfortable with their new parenting role, not only because their midwife would come to the house to check their recovery and the newborn, but because they were also available by telephone at any time, day or night.

Overall, midwives' patients appeared to be more satisfied with the care they received. It is important to understand which services respondents found useful and the reasons why. This could help ensure that, in the future, the services rendered are as efficient, effective and supportive of birthing families as possible. Both midwives and physicians should be informed if their services are satisfactory or which part of their services could be improved. The findings from this research project contribute sociological insights on the factors that affect quality care for birthing families. Hopefully they will contribute to new provincial health care policies which will improve the maternity care available for birthing families.

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CHAPTER 1: INTRODUCTION

> Motherhood is a biological relationship in a social context, and a social relationship in a biological context (Rothman, 1982: 208).

Social science research on health and health care issues has tended to neglect the experiences of the recipients of care, focusing instead on either the care providers themselves, or the institutional structure in which they work. There is an abundance of sociological literature on the class, status, and power of physicians and the influence of the medical profession on the delivery of health care (Abbott, 1988; Arney, 1982; Becker, 1961; Derber, 1982; Fee, 1975; Illich, 1975; Johnson, 1972; McKinlay, 1982; Navarro, 1986). Other sociologists have focused their research on the medicalization of health care (Conrad and Schneider, 1980; Riessman, 1983). Researchers focusing on maternity provisions have tended to examine past and present roles of midwives and their occupational position compared to physicians (Benoit, 1991; Burtch, 1988; Donnison, 1977; Jordan, 1983; Riessman, 1983). While these works have provided important insights into the organization of maternity care and the roles of health providers, they are limited to the extent that patients[1], both women and their families, have not been given central attention.

This gap in the sociological literature has meant that only part of the practitioner-patient relationship has been studied. In short, patients have occupied a subordinate position in health research, which perhaps reflects the low status of patients. But such was not always the case. Before the 19th century, history tells us that the patient was at the centre of health care, and it seems that a more holistic approach was practiced by care-givers (Donnison, 1977). Advances in science and technology in the 19th and 20th centuries, however, led to the rise of a medical model of care (Norman, 1989). Medicine and technology became of utmost concern while patients' needs were rendered secondary (Graham and Oakley, 1981). As the 20th century draws to a close, however, many researchers are turning their attention to the recipients of care rather than merely to the

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[1]Maternity physicians prefer to use the term "patient" in reference to a particular birthing woman, whereas midwives generally prefer to use the term "client." Most of my respondents, however, referred to themselves as a "patient." The use of both of these terms in one document can be confusing. Given that I wanted to give women voice, birthing women are called patients throughout this thesis, as that is what they called themselves. I use this term guardedly, for lack of a better term, as there is no one term which adequately captures both groups.

working conditions and power of practitioners themselves, thus reflecting the re-newed status of patients.

Research on the public's view of maternity care services has been popular in this regard. Attention has focused particularly on the plight of birthing families in the turf wars between physicians and midwives (Arney, 1982; Benoit, 1991; Burtch, 1994a; Donnison, 1977; Devries, 1992; Ehrenreich and English, 1973; Weitz and Sullivan, 1985; Wertz and Wertz, 1977). Emerging from this qualitative research effort focusing on the perspective of recipients of maternity care are discernable models of care (Hodnett, 1983; McNally Hutton, 1985; Riessman, 1983; Rothman, 1982). It is to these I now turn.

1.1 Models of Patient Care

Models of maternity care, for conceptual purposes, are placed in this thesis along a health care continuum. These models are used to exemplify certain kinds of care; this thesis does not support one model over the other, nor does it promote one care-giver over the other. At one end of the continuum is the medical model of care; located at the other end is a holistic model of care. Nurses, physicians and obstetricians are characterized as providers of the medical model of care, while midwives are believed to provide maternity care based on the holistic, or midwifery model of care (Rothman, 1982). Located along the continuum are other care-givers, according to the degree of technological, pharmaceutical and psychological support they render patients (see figure 1.1). The nurse-midwifery model is typically placed by researchers at the centre of this continuum. Nurse-midwives are instructed under both the medical and midwifery models, although some scholars maintain they are heavily influenced by the medical model (Gamarnikow, 1978; Kitzinger, 1988). The nurse-midwifery model is not discussed at length in this thesis; it is included in figure 1.1 merely to demonstrate the complexity of the health care continuum. These models of care are ideal-type constructions not directly reflecting real life situations. Yet they are nevertheless useful to demonstrate the variation in caring philosophies available to patients. The central tenets of the medical model of care are examined below, followed by the midwifery model.

1.1.1 The Medical Model

The medical model of maternity care became popular in Anglo-America with the development of obstetric technology. Today, the care given to patients by most members

of the medical community is deeply rooted in this model of care, whereby medical and technological intervention are seen to begin before birth and end with the care of the aged and dying. Women patients, in particular, may experience a loss of individual autonomy compared to earlier times; they have become increasingly dependent on medical practitioners, medical technology and medical institutions (Clarke, 1990).

Figure 1.1 Models of Care

Medical Model	**Nurse-Midwifery Model**	**Midwifery Model**
technical and pharmaceutical intervention;	moderate amount of technical and pharmaceutical intervention;	psychological support; no medical intervention; birth occurs naturally;
patient is passive; virtually no decision-making by patient; physician takes control	patient takes some control and is active in some decision-making with care-giver	patient takes a very active role in decision-making with care-giver

Source (adapted from): Rothman, 1982.

The medical model supports the notion that pregnancy and birth are not merely physiological processes, but distinct medical events (Richards, 1982). This model of care is based on control, whereby obstetricians are the experts who "do the work" and "cure" problematic pregnancies. Members of the medical profession who support this model view all pregnancies as potential pathologies and "at risk." It follows, then, that births should occur in hospitals, and sophisticated technology should play a central role in the birthing process.

Artificial time-tables are also basic to the medical management of pregnancy and birth. The traditional medical model of labour is best represented by "Friedman's curve," a graphico-statistical analysis of labour which divides it into seven stages, based on the average time for each stage observed by study of a large cohort of birthing women. If a

birthing woman goes beyond the so-called "average" time for a particular phase of labour, then medical intervention is recommended to help the woman along to the next phase (Rothman, 1982: 259).

The concept of continuity of care in this model suggests continuity of medical care rather than continuity of the care-giver. The average low-risk pregnant woman can see up to forty different practitioners throughout her pregnancy. Luba Lyons - Richardson (1994: 6), aptly describes the medicalization process of reproduction:

> It begins with her physician, the nurse and technician for her now routine ultrasound exam, perhaps more nurses, technicians and an obstetrician if she has amniocentesis or chorionic villi sampling. Later on in her pregnancy she might have a biophysical profile or fluid volume measurement if her baby is determined to be small for dates or if there is some other concern. This means more ultrasound technicians, nurses and a different obstetrician. If she goes overdue, she may go to the outpatient clinic for fetal non-stress monitor tests 2-3 times a week, seeing a different nurse each time. Once labour begins the average first-time mother might labour in hospital for a period of 10-15 hours and might easily see 6-8 different nurses, interns and physicians. After the baby arrives, with a 48-hour post-partum stay, there might be easily another 6-8 different care-givers involved again.

Physicians who work within the medical model often prefer ideal type patients - patients who comfortably accept the "sick role" (Parsons, 1951), patients who believe the physician knows best (Porter and MacIntyre, 1984). Studies (Richards, 1982; Riessman, 1983; West, 1984) indicate that physicians in fact often wield power over patients. Physicians can indirectly use their power by limiting the range of options for their patients. They can deny women access to procedures such as low intervention techniques, and they can use medical jargon to confuse patients or convince them to use medical procedures, such as epidural anesthesia, which they might ordinarily oppose.

Why do physicians want to maintain control over the birthing process? Barbara Katz Rothman (1982) suggests that because men play such a small part in the reproductive process, they feel alienated from the process and therefore want to control it. Mary O'Brien (1983) proposes that inequality between the sexes is inherent within the process of human reproduction, and that the medical model of care is maintained by men because of "reproductive consciousness" - a discontinuous process for men because they are merely the providers of the reproductive seed. In contrast, women experience continuity from conception to birth. Through patriarchal underpinnings, then, the medical model of care confirms the imbalance of power between patient and care-giver by stressing the

importance of intervention, particularly the use of technology (Rothman, 1989). The behaviour of both male and female obstetricians support these criticisms of control through intervention based on the patriarchal education process inherent in medical school (Shapiro, 1978).

The ideology of technology encourages medical practitioners to see women as "objects" comprised of parts. This model is often referred to as the "body-as-machine" model (Rothman, 1982). Labour monitoring devices provide a continuous record of the mother's contractions, heart beat, and blood pressure, while nurses and obstetricians provide intermittent contact with the birthing family (Richards, 1982). Due to medical scientific advances this model supports the ability of technology to "fix" complications during the birthing process (Norman, 1989); childbirth subsequently becomes medicalized.

While the medicalization of childbirth has been beneficial for some birthing families, Margaret Bassingthwaite-Thiessen (1993) suggests that it is inappropriate for others. Birthing women are seen as patients and all other statuses they might have tend to be ignored by physicians and hospital staff. The major criteria for success of an obstetrical case within the medical model is the absence of maternal and infant mortality and morbidity (Graham and Oakley, 1981). The "hard" measures of mortality and morbidity are important in their own right and have been used to evaluate "satisfactory" childbirth outcomes (Driedger, 1993: 606). With decreased morbidity and mortality rates, however, interest has begun to focus on "soft," psychosocial outcomes as a measure of childbirth satisfaction. Two important facets of medical care that have been overlooked by the medical model are the social and emotional aspects of the birthing experience. For birthing families these too appear to be real and important concerns. As shown below, they form the core of the midwifery model of care.

1.1.2 The Midwifery Model

The central elements of the midwifery model of care are based on an integrated approach to pregnancy and childbirth, whereby the woman's perspective on human reproduction is central. This model supports an integrated approach to health care; the social, economic, psychological and biological components of a woman's life and body are all factors which affect her health, and ultimately, her birth experience (Kennedy, 1993: 1505). The midwifery model is also founded on the belief that pregnancy is neither a

pathological state nor an episodic event, and not easily separated from other life statuses, including occupational, marital and parental roles (Graham and Oakley, 1981).

The underlying philosophy of the midwifery model is based on "continuity of care" and the appropriate use of medical technology. Continuity of care refers to: (1) care by one care-giver who provides quality time with the birthing family throughout the nine prenatal months, labour and delivery, and the postnatal period; (2) consistent philosophy behind the care-giver's emotional and informational support; (3) the care-giver's advocacy role for patients, whether in hospital, birthing centre or home; a role that is consistent with the birthing family's goals set out in the prenatal phase (Ambler, 1993). The overall challenge of continuity of care is to build a personal relationship of mutual respect and trust between patient and care-giver (Ambler, 1993; Bramadat and Driedger, 1993; Hodnett and Osborn, 1989). Integrated education and counselling are, therefore, strongly supported. Midwives take into consideration not only physical changes of mother and baby, but emotional and social changes as well. Open communication ensures a flow of information between care-giver and birthing family so that informed decisions are possible and emotional and social support remain constant. This ensures both continuity with the care-giver and the philosophy of care that the midwife - patient relationship is based on (Ambler, 1993).

In the midwifery model, birthing women play an active role in choosing the place of childbirth, their style of delivery and the use of pharmaceuticals (Norman, 1989). Control, or "mastery," can then be placed in the hands of the birthing family, so long as it is not detrimental to the mother and baby (Humenick, 1981). Mastery and "being there" are two significant factors in childbirth satisfaction. "Being there" is defined by Driedger (1993: 606) as "the birth events and/or relational interactions between subjects and health care professional that had meaning for the women and ultimately contributed to their meaning of satisfaction." [2] Both mastery and "being there" are rooted in the affective base of birth (Driedger, 1993; Humenick, 1981: 80; Noddings, 1984). The goal is a live birth,

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[2]Mary Driedger (1993: 606-619) suggests there are many ways of "being there." Three categories of "being there" include: (1) "doing for" refers to the provision of holistic care by significant others and/or care-givers - includes nurturing, advocating and supporting the birthing family; (2) "doing with" means the subject and her significant other are both physically present and psychologically involved in the childbirth experience - includes togetherness and sensitivity; (3) "doing to" refers to care-givers' attending to some aspect of the woman's care in labour and delivery - includes intervening and attending to patients' based on their perceived needs and being in control.

a healthy mother and infant, and a satisfactory personal experience for the mother and the family.

Despite the seemingly positive elements of the midwifery model, studies indicate that many patients choose to have decisions made for them and do not care about birthing alternatives. Margaret Bassingthwaite-Thiessen (1993) suggests some women adhere to the midwifery model of care while others do not because of variations in behavioral characteristics. The crux of her argument is based on the orientation of control. Birthing women differ depending on whether they are "internally" or "externally" oriented individuals. The internally oriented women want to be active decision-makers. They want active participation and conversation with their care-giver and to maintain personal control throughout the pregnancy, labour and delivery. These women tend to prefer the midwifery model of care and the kinds of services which midwives tend to offer. In contrast, women with an external locus of control believe events are beyond their personal control and unrelated to their own behaviours. These women believe their care-givers know best, and are content with the belief that events are a result of change or power exerted by others (Bassingthwaite-Thiessen, 1993; Porter and MacIntyre, 1984). The women in Bassingthwaite-Thiessen's study who chose the alternate birth site were cared for by midwives and were more internally oriented than the women who chose the hospital birth site. Women with an internal locus of control believe events occur under their personal control and are a consequence of their own actions. It is important for birthing women to be aware of their needs and their orientation such that they choose a care-giver with a philosophy of care compatible with their own. Choosing the right care-giver, no doubt, contributes to a satisfactory birth experience. Bassingthwaite-Thiessen (1993: 4) concludes that, "identifying women's attitudes towards issues of choice in childbirth could provide nurses with information to allow them to adapt their approaches to care in keeping with women's expectations."

Susanne Houd and Ann Oakley (1986) examined the alternative perinatal services that lie on the margins of the official systems in Europe and North America. They suggest that there is a strong relationship between the consumer health movement and alternative perinatal services. Two themes which characterize the perinatal alternative service movement are the limitation of choice, and the lack of attention paid by the official health care providers to the importance of continuity of care for many birthing families. Houd

and Oakley strongly suggest the link between alternative and traditional perinatal care is not a nostalgic implication for a "golden age"; there have been important obstetrical advances which have spared mother and child their lives and/or ill health. Rather these authors suggest that the link between alternative and traditional perinatal care points to cross-cultural continuities in the health care needs of mothers and children which are based on a holistic philosophy and are not provided by official services. An important element in the alternative model of perinatal care provision, according to Houd and Oakley (1986: 46) is "a shared decision-making process, in other words, an absence of the hierarchy separating user and provider that is built into the official health care system of most developed countries today."

In sum, the differences between the medical model and the midwifery model of care appear to be substantial; the two models differ in care-giver philosophy, the provision of maternity services, and care-giver commitment to patient empowerment. These models of care, in fact, underlie the recent politics of maternity care in Canada discussed in detail in the thesis.

Maternity patients now occupy a key position as midwives become recognized as legitimate, self-governing health professionals in Canada. While banned from practice for nearly a century, midwives are in the process of becoming legalized in many provinces. Legislation has already been enacted in Ontario, Alberta and British Columbia, acknowledging midwifery as a legal, safe and acceptable choice for families during the birthing process.[3] Birthing families are asking themselves - who provides the best care, and who can provide it most effectively? Some birthing families are looking to alternative providers, including midwives, to answer these questions. But how "alternative" are midwives compared to physicians? How satisfied are birthing families with the care they

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[3]Much of the literature focuses only on the prospective new mother and birth itself. In many cases it is more appropriate to use the terminology of the birthing family and its relationship to the life cycle of the family. I use the two terms interchangeably. Most of my respondents were in relationships with other people. Most of the time respondents shared decision-making with their partners -- during prenatal visits, labour and delivery, and the post-partum period. This distinction makes it a family event, rather than an isolated event experienced by one individual. I am not ignoring the fact that single mothers exist, and that they too belong to families. However, when respondents were asked if their birthing experience was a family event or a personal event, more than half of them stated their birthing experience was a personal event. Hence my usage of birthing women / birthing families in the thesis.

receive from these apparently contrasting practitioners? This thesis examines the experiences of birthing women in an attempt to answer these questions regarding expansion of choice in care-givers during pregnancy and childbirth.

1.2 Organization of Thesis

Chapter two provides an historical overview of the changing roles of midwives, physicians and obstetricians in the provision of maternity care. Birthing arrangements are placed in historical and cross-national context to help determine how other industrialized countries have provided maternity services and continue to do so. Chapter three examines the sociology of medicine, the underside of medical progress, the medicalization of maternity care, and contemporary studies of maternity care. Chapter four provides an overview of the reasons for my choice of study, and why I selected a research method in the qualitative tradition for data collection. Chapter five presents the results of the research. I discuss the similarities and differences in respondents' satisfaction with the maternity care they received from either physician or midwife. In chapter six I discuss how my findings support and contradict related research. These sections are summarized in chapter seven, followed by a discussion of the problematic gaps in the provision of maternity care, and suggestions for further research.

CHAPTER 2: MATERNITY CARE IN HISTORICAL AND CROSS-NATIONAL CONTEXT

This chapter provides, among other things, an historical overview of the changing roles of midwives, family physicians and obstetricians in the provision of maternity care. The first section gives an overview of maternity care services in North America. The second section examines the particular maternity care arrangements in Denmark, Sweden, the Netherlands, Britain, the United States and Canada. These six countries have been chosen because they demonstrate the wide spectrum of maternity care services available for birthing families in comparably developed countries.

2.1 Historical Review of Maternity Care

Pregnancy and childbirth have always been significant family events. Prior to industrialization, female midwives, known for their practical skills and social and cultural knowledge of local families, were called upon to "stand by" when birth was imminent (Walker, 1972). In many countries, strong bonds developed between experienced lay midwives[4], family and friends (Donnison, 1977; Jeffrey, 1989). These early lay midwives practiced in the homes of their patients, rather than in hospitals where formal rules and regulations controlled the birthing process. Payment for midwifery services was typically made in kind. The philosophy of traditional lay midwives was similar to that of their patients -- birth was considered a normal event (Houd and Oakley, 1986). Female midwives and male physicians had played their own distinct roles in the birthing process. Physicians, most of whom were male, tended to abnormal obstetrical cases only. Birthing families experienced informal continuity of care as well as continuity of place in their own homes (Kearns, 1993).

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[4]The generic definition of midwifery means 'with woman' and includes anyone who assists a woman in childbirth. Today in North America there are two distinct forms of midwives - lay midwives and nurse-midwives. Many lay midwives received midwifery certification in the United States or Great Britain. Some, however, are self-taught and apprenticed with more experienced midwives. Lay midwives are more commonly called "community" midwives. Care is based on a holistic approach to childbirth. Payment generally depends on the economic situation of the family. In contrast, a nurse-midwife is a birth attendant who has completed nursing training, is registered with the local Nursing Association, and has completed additional midwifery training in an accredited programme (Benoit, 1991; Burtch, 1994a; Houd and Oakley, 1986).

Some of the disadvantages of this original form of midwifery were high infant and maternal mortality and morbidity rates. Midwives were also limited in their ability to alter socio-economic hardships, such as sub-standard housing conditions and domestic battery, that sometimes negatively affected their patients and the quality of the birthing experience.

In the aftermath of industrialization, populations expanded rapidly and people moved from rural to urban centres. The original sense of community gradually loosened; so too did the "neighbour network" offered by female midwives in former times (Norman, 1989). Competition between physicians and midwives escalated. There emerged a belief that natural science, including obstetrical science, was the answer to human problems. The first step in the advent of male physicians in the bed chamber during normal childbirth occurred in America in the early nineteenth century (Donnison, 1981; Litoff, 1978). It became fashionable for upper-class women to have male birth attendants; this helped elevate the attendants' previously low social status to that of emerging "male midwives," the forerunner of today's obstetricians (Field, 1993). Many elite European and British physicians originally opposed male midwifery, suggesting it was beneath the dignity of professional men; as a result, the man-midwife initially occupied a low ranking in the medical profession of the period (Donnison, 1977:42). This opposition was not as pronounced among physicians in Canada and the United States who lacked aristocratic support. For most North American physicians, the practice of midwifery meant additional income; they therefore had a vested interest in suppressing female midwives (Litoff, 1978; Starr, 1982; Sullivan and Weitz, 1988). For women with the funds to pay the practitioners of their choice, the arrival of male midwives at their bedside meant greater selection in birthing attendant and style of practice. To some, a male midwife became a status symbol that was at the time accessible only to the rich and well-placed.

The result for these privileged women patients was a change in conventional birth philosophy, type of attendants, technology, and place of birth. Despite status enhancement, the presence of male attendants in the birthing room was an added source of stress for modest women. The place of birth soon changed from the birthing room to the unfamiliar delivery room. The transition of birth to the hospital was also long in coming; birthing women of the upper and middle classes, however, eventually came to view the hospital and obstetrical technology as fundamental to better care (Ehrenreich and English, 1963). Yet scientific advances in reproduction and maternity technology led to an increase

in depersonalized care and a focus on biology, rather than on the entire birthing experience and family. Mastery of the body became paramount, and the concept of "choice" in childbirth became an illusion (Richards, 1982). Many birthing decisions were made unilaterally by maternity physicians.

The resulting medicalization of maternity care has had both positive and negative effects on birthing families. On the one hand, many early twentieth-century feminists fought for greater access to medical expertise (Lewis, 1990). This included access to "twilight sleep" - an anesthetic (scopolamine) that was developed in Germany to control pain during childbirth by allowing the mother to sleep through the birthing experience (Benoit, 1991). The use of scopolamine soon became routine in America. Feminist activists (middle and upper-class reformers) initially thought access to scopolamine gave women greater control over the birthing process (Riessman, 1983). Ironically, women wanted to alter the painful circumstances of childbirth imposed by nature. What they did not realize was the anesthetic rendered birthing women passive.

The medicalization of childbirth did not go unchallenged. By the 1930s, even earlier in the U.S., the first major challenge came from the natural childbirth movement. The movement began with responses of obstetricians on the other side of the Atlantic, particularly Grantly Dick-Read of England and Fernand Lamaze of France, to the excesses of medical management. Addressing the issue of fear and its impact on childbirth, Dick-Read argued that natural birthing techniques of breathing and relaxation could free women from dependency on anesthetic:

> The more cultured the races of the earth have become, so much the more dogmatic have they been in pronouncing childbirth to be a painful and dangerous ordeal. This fear and anticipation have given rise to natural protective tension in the body... of mind... and muscle. Unfortunately the natural tension produced by fear influences those muscles which close the womb and prevent the child from being driven out during childbirth. Therefore, fear inhibits... Such resistance and tension give rise to real pain because the uterus is supplied with organs which record pain set up by excessive tension. Therefore fear, pain and tension are the three evils which are not normal to the natural design but which have been introduced in the course of civilization by the ignorance of those who have been concerned with attendance at childbirth. If pain, fear and tension go hand in hand, then it must be necessary to relieve tension and to overcome fear in order to eliminate pain (quoted in Rothman, 1982: 85-86).

Dick-Read removed the blame of painful childbirth from women. Rather, he maintained

that the problem was the kind of care women received. If they were given continual comfort and emotional support throughout labour, fear would be eliminated and pain would cease (Rothman, 1982). North American physicians and obstetricians transformed Dick-Read's method; as a result the innovative way in which birth was intended to progress was altered. Delivery tables, routine episiotomies and strapping women onto their backs for the delivery all created tension for women. The Americanization of Dick-Read's method did not help produce peace and calm.

Fernand Lamaze elaborated on the natural childbirth approach through the promotion of "verbal analgesia" in easing labour pains (Benoit, 1991). This method grew out of Pavlovian conditioning techniques; uterine contractions were stimuli to which alternative responses could be learned. Pain and fear were considered learned responses which could be unlearned and replaced with breathing techniques (Rothman, 1988).

Lamaze's followers contributed to the North American holistic care movement of the 1970s; it was during this time that "natural childbirth" became fashionable. The Dick-Read and Lamaze childbirth developments were instrumental in providing options for birthing families. According to movement activists, so long as nature allowed, birthing women should be given the choice to be awake or anesthetized; they should have the option of being active or passive during childbirth. Yet despite the popularity of the "natural" method, medicalized childbirth remained the chosen method for many women. However, medical control over reproductive care is not always indicated nor necessary. As Jane Lewis (1990: 14-15) aptly puts it:

> The late twentieth-century medicalization of reproduction is formidable in terms of both its technological sophistication and authority. While the life chances and opportunities of women are greater than early in the century, the issue of autonomy and control remains vexed.... Rejection of medical technology in childbirth runs the risk of denying women the relief of pain and the increased safety in childbirth that was so hard won. Women need greater control over the way in which medical technology is used, but this too can only be argued for in the context of a more holistic approach to the needs of mothers.

Changes in the management of labour in hospitals, along with more personalized care and the use of less-invasive technology, are today championed by activists and feminists alike. Renewed interest in midwifery in Canada, the United States and Britain is also apparent. The next section briefly examines maternity care in general and the place of midwives in the health care systems of these countries and compares them to counterparts

in Denmark, Sweden, and the Netherlands, where midwives have long enjoyed a respected place in the provision of maternity care for birthing families.

2.2 Cross-National Comparison Of Health Care Systems and Maternity Care

National health care systems differ from one country to the next for historical, geographical and social reasons. They can be arranged along a continuum, ranging from the free-enterprise entrepreneurial health system found in the U.S. to comprehensive state-controlled health systems found in the Nordic countries and Britain. Accordingly, the type of maternity care service available to birthing women will differ across national borders. The comparative method allows us to observe that some health care systems are more successful than others in providing birthing women with the option to take a proactive role during pregnancy and birth. This section provides a cursory review of the maternity care arrangements in Denmark, Sweden, the Netherlands, Britain, the United States and Canada. The respective work situations of midwives and range of choices available to birthing families are examined in these respective countries.

2.2.1 Denmark

In 1935, 90 percent of the Danish population were insured for the available health care services; by 1961, health insurance coverage was made universal for every resident. The Danish system is today characterized by a far-reaching decentralization of responsibility for health care; health care services are distributed among three administrative levels: national, regional and local (Denmark Ministry of Health, 1993). The Danish system is unique among the countries included in this review in that the affluent minority is classified as "class 2 protected" and must pay additional charges stipulated by health care providers. The rest of the population are "class 1 protected," whereby health care is paid through general taxes (Denmark Ministry of Health, 1993).

Multidisciplinary health groups provide maternity care for birthing women in Denmark (Houd, 1988). In 1973, the reorganized health care system made it possible for autonomous midwives to be employed by the Danish government (McKay, 1993). Midwives are at present responsible for the care of women with uneventful pregnancies and births. At predetermined stages, Danish women go to the midwife (5 visits), to the general practitioner (3 visits), and to the antenatal clinic of an obstetric unit (2 visits) (Blondel et

al., 1986). Although there is a high proportion of hospital births (98 percent), women may choose to give birth at home or in hospital (Denmark Ministry of Health, 1993; McKay, 1993: 114). Care-givers also differ in their philosophy of care: physicians tend to follow a medical model of care while midwives follow a holistic model of care. Although the Danish midwife's relationship with the general practitioner and obstetrician is collegial, birthing families in Denmark often witness some dissension between midwifery and physician care-givers; birthing families are then caught in the middle (Houd, 1988; McKay, 1993).

Despite care-givers' dissension, mother and child fare quite well in Denmark. Bonding is encouraged between mother and baby immediately after birth by allowing mother and child time together in the delivery room, placing the baby on the mother's abdomen prior to the delivery of the placenta, putting baby immediately to the breast after delivery (Maratos, 1986). However, on the negative side, pubic shaving is obligatory for birthing women in Denmark. Moreover, enemas and bed confinement in the first stage of labour vary among hospitals and episiotomy rates for first births are 25-50 percent (Maratos, 1986: 13). On the other hand, Danish birthing women are given a choice of delivery positions. In 1989, the infant mortality rate was 8.4 per thousand, a rate which is above that of Sweden and the Netherlands, but lower than the United States (McKay, 1993). Examined below are the maternity care arrangements which contribute to patient satisfaction in Sweden.

2.2.2 Sweden

Sweden has a national health service that is both comprehensive and decentralized (Tew, 1992). In 1937, Swedish legislation introduced free child health and maternity care services (Diderichsen, 1990). By 1955, health insurance protection was compulsory for virtually everyone in Sweden (Roemer, 1991).

The Swedish health system today provides multilevel maternity care (Jordan, 1983). Type 1 clinics, or neighbourhood mother-care centres, are operated at the community level, and are run by salaried midwives who work as part of a midwifery team. Midwives in Sweden have the option of seeking managerial positions in the local mother-care centres where they oversee the work of younger colleagues and transmit special skills unique to the occupation (Benoit, 1991). Antenatal and postnatal care is provided at these

type I clinics, where midwives play a major role and are responsible for at least 10 out of 14 visits, and providing continuity of care for birthing women (Blondel et al., 1986). Pregnant women usually sees the same midwife throughout their pregnancy (McKay, 1993). Birthing women are also given the opportunity to be active decision-makers throughout their birthing process. Midwives are the main care-givers for uncomplicated pregnancies; physicians work as back-up.

The goal of the Swedish system is to provide women with the proper balance between the appropriate birth attendant and the needed technology. Type II hospitals in Sweden are for potentially abnormal pregnancy and childbirth. Type III hospitals employ special technology and have obstetricians close at hand to care for birthing women with serious complications. Cesarean sections are an example of the range of services provided in these hospitals. It seems that an emphasis on comprehensive preventative care reduces the need for surgical procedures. One outcome of this arrangement is that the cesarean rate for Sweden in 1990 was 10 percent, compared to Canada's 20 percent rate and 30 percent in the U.S. (personal conversation, Swedish Association of Midwives, 1995). Sweden also boasts the third lowest infant mortality and morbidity rates in developed countries of the world[5] (Diderichsen, 1990). In 1990, the infant mortality rate was 5.6 per thousand, only slightly behind Finland (which is second) and Japan (Benoit, 1994: 315; McKay, 1993: 115).

The Swedish system also provides birthing women with comprehensive educational information and preparation for the birth of their infant. Discussion among Swedish women is not whether or not to have a medicated birth, but about advantages and disadvantages of various kinds of anesthesia (Jordan, 1983). Although medical intervention in normal birth is typical, there is an appropriate, not routine, use of medication and interventions (McKay, 1993). Open communication with their care-givers empowers Swedish birthing families by giving them the essential information to make an

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[5]This is not to suggest that Sweden reports no social differences in infant mortality rates. Swedish infants of single mothers who were tenants with a low level of education had an infant mortality rate of 7.6 and perinatal mortality rate of 10.9 between 1976 and 1981. In contrast, during the same time span, highly educated cohabiting mothers living in owner-occupied houses had an infant mortality rate of 5.9 and perinatal mortality rate of 7.1 per 1000 live births. In 1985, the average infant mortality rate for Sweden was 6.7 (Diderichsen, 1990: 360). The infant mortality rate fell to 6.0 in 1989, and 5.6 in 1990 (McKay, 1993).

informed decision. A network of approximately 200 psychologists work with the maternal and child care clinics, helping birthing women, midwives and nurses to handle the emotional aspects of childbearing more effectively (McKay, 1993). All of these factors contribute to wide-spread patient satisfaction in Sweden (Benoit, 1991; Tew, 1992). Examined below are the maternity care arrangements of Dutch birthing families and the reasons why they too are generally satisfied with their care.

2.2.3 The Netherlands

The Netherlands has a welfare-oriented health care system, but it does not have a National Health Service in which the state offers all health services free of charge (Phaff, 1986). In contrast to Sweden, the Dutch national health insurance system does not cover patients' hospital labour and delivery expenses, unless the attending midwife or physician predict serious medical complications (Benoit, 1991). The high home birth rate of 35 percent may reflect the patients' reticence toward the extra payment for hospital services (McKay, 1993; Phaff, 1986).

Dutch midwives have been officially recognized as health practitioners working in the area of uncomplicated maternity care since 1865. The midwife is not a nurse-midwife; she completes a three-year course and is entitled to independent practice (Phaff, 1986). In 1949, a government subsidy was implemented for families using services of Maternity Health Care Assistants (MHCA); these workers help midwives during and after the home or short-stay hospital delivery (van Teijlingen and van der Hulst, 1995). The MHCAs have a low status which therefore puts midwifery higher on the occupational ladder; this further legitimizes midwives and their services. Unlike their Swedish counterparts, independent midwives in the Netherlands are remunerated on a fee-for-service basis. This too affects patients' ability to pay based on their economic situation.

Dutch midwives attend a little over 46 percent of the women with normal pregnancies (McKay, 1993), a percentage that has remained fairly constant over the last twenty years (Smulders and Limburg, 1988). The strong influence of midwives has contributed to the belief in the Netherlands that birth is a natural event. The roles of Dutch midwives, physicians and obstetricians are more equally balanced than in other countries. Almost 65 percent of Dutch births occur in the hospital; a little over half of which are birth attended by obstetricians (McKay, 1993). The co-operation between these care-givers has

proven to be of great value (Phaff, 1986). Neither midwives nor obstetricians hold a monopoly in maternity care.[6] It is in the obstetrician's interest to meet the particular wishes of birthing women in order to maintain his or her market share of work (Smulders and Limburg, 1988). Accordingly, birthing women in the Netherlands are encouraged to take a proactive role during the birthing process.

Bonding is encouraged between mother and baby immediately after birth; this is achieved by allowing mother and child time together in the delivery room, placing the baby on the mother's abdomen prior to the delivery of the placenta, and putting baby immediately to the breast after delivery (Maratos, 1986). Enemas, pubic shaving and a fixed delivery position vary among hospitals within the Netherlands. Birthing women are given the choice of whether or not they desire bed confinement in the first stage of labour. Routine episiotomy rates for first births, depending on the hospital, range from 18-75 percent (Maratos, 1986: 13-14). The use of anesthetics is rare during birth (Smulders and Limburg, 1988: 246). The Dutch maternity system reports an infant mortality rate of 7.1 per 1000 live births in 1990, putting the Netherlands ahead of Denmark but behind Sweden (McKay, 1993: 115).

The Dutch midwife has traditionally worked alone in her practice. In 1981, 91 percent of independent midwives practiced alone (Smulders and Limburg, 1988). In the last ten years, however, more midwives have established group practices. Prenatal consultations are scheduled with a different midwife each visit so that a bond of trust is established between expectant mothers and all midwives in the group practice (Smulders and Limburg, 1988). Similar group practices are also reported in Britain; examined below are the maternity care arrangements found in Britain.

2.2.4 Britain

Premodern Britain, like Sweden and the Netherlands, depended upon lay midwives to help birthing families through the reproductive process. In 1948, Britain developed a comprehensive health system, known as the National Health Service (NHS) (Roemer, 1991). Virtually all ambulatory medical care was subsequently taken over by organized

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[6]The percentage of births assisted by obstetricians, however, has increased substantially over the past twenty years, at the expense of deliveries performed by general physicians (Kitzinger, 1988).

teams of health personnel working in health centres and hospitals administered by the government. Midwives were provided with the opportunity to become salaried government employees in the emerging maternity hospitals located in many areas of Britain. Although still legal, home birth became increasingly uncommon during the post-World War II period. Birthing patients showed a preference for small maternity centres where state-of-the art midwifery care and advanced technology were readily available (Benoit, 1991).

As a result of political and economic change, the British NHS in the 1970s was restructured in the direction of a rational efficiency model of care. In an effort towards efficiency, many of the small maternity units were replaced by large bureaucratic hospitals. Fragmentation of maternity care was a consequence of the increased centralization. Government reports during the 1980s attempted to address the issue of care fragmentation; a team approach to maternity care was recommended and continuity of caring and continuity of care-givers was supported (Murphy-Black, 1992: 115). Hospital maternity wards are now staffed by a wide variety of birth attendants. Obstetricians occupy an important role in maternity care, but the "shared care system" incorporates the work of nurses, midwives, physicians and obstetricians (Walker, 1972). Yet although midwives are present at most deliveries, they usually assume the role of assisting physicians (Donnison, 1977; Blondel et al., 1986). Thus many British birthing families receive fragmented care in the large hospitals (Walker, 1972). A small number of birthing families, who support the natural birth movement, receive maternity care in small government-funded health centres staffed by midwives who are relatively free from direct control of medical specialists. Both birthing families and midwives experience considerable satisfaction with childbirth in the few remaining smaller health centres where patients receive continuity of care; patients are encouraged to take a proactive role during the birth; and intervention rates are generally lower than in urban hospitals (Maritos, 1986).

Routine procedures imposed upon the mother in hospital, including enemas, pubic shaving, a fixed delivery position and bed confinement in the first stage of labour, vary among hospitals within Britain (Maratos, 1986: 13). Routine episiotomy rates for first births range from 5-40 percent depending on the hospital - rates which are lower than both the Netherlands and Denmark (Maratos, 1986: 14). Yet Britain has notable social differentials in perinatal mortality and low birth weight (Oakley, 1986). In 1980, perinatal

mortality was positively associated with social class[7]: professionals 9.7; intermediate 11; skilled non manual 11.8; skilled manual 13; partly skilled 15; and unskilled 17 per thousand (Oakley, 1986: 92).

Most recently, Britain appears to be moving in a direction similar to the American free-enterprise system of health care (discussed below); this could negatively impact the role of British midwives (Oakley and Houd, 1990). The discontinuity of maternity care some families experience in hospitals will not likely be rectified under an American model, and birthing families who have been dissatisfied in the past will likely continue to be dissatisfied with their birthing experience (Graham and Oakley, 1981).

2.2.5 The United States

Early developments in American maternity care and midwifery parallelled British developments, partly due to the large number of British immigrants in early America. Birthing women in colonial America were assisted by lay midwives who were restrained by few formal rules or official regulations. Most women in the original "United States" (U.S.) gave birth at home, and about 50 percent of the deliveries were by lay midwives (Anisef and Basson, 1979). By the late 18th century, however, notable differences in maternity care delivery had developed between Britain and the United States. American physicians who wanted to augment their income gained access to the lay midwife's home birth clientele and practiced as "male midwives" (forerunners of today's obstetricians). Thus began the gradual displacement of the traditional lay midwife in the U.S. (Anisef and Basson, 1979).

As the number of physicians increased, so did the competition with lay midwives for patients. The American Medical Association (AMA) embarked on a campaign, portraying midwifery as an antiquated folk occupation that had no place in modern America (Benoit, 1991). The AMA's position on midwifery had a negative influence on the popularity and use of lay midwives. In the 1920s, the centralization of maternity care that moved childbirth from home to hospital occurred at the same time as the drive for professionalism among U.S. obstetricians (Mongeau et al., 1961). By the 1970s,

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[7] Research in industrialized countries such North America and Britain indicates a relationship between social class and infant health at birth. This association between low socio-economic status and poor outcome is found world-wide (Oakley, 1986).

midwifery in the U.S. was mainly confined to rural Southern areas where lay midwives attended approximately two-thirds of the local non-white births (Dougherty, 1982; Mongeau et al., 1961).

Alongside the growth in obstetrical science was the growth of the university educated nurse-midwife. Nurse-midwives were midwives with a nursing degree. Lay midwives, who learned the "art" of midwifery from observing granny midwives, were gradually replaced by nurse-midwives who tended to work in hospital maternity wards and were influenced by the medical model of care. Nurse-midwives cared for birthing families who could pay for a hospital delivery. By 1979, only 10 percent of American nurse-midwives were employed in positions that offered full use of their training (Anisef and Basson, 1979: 368). Unlike nurse-midwives in Europe and England, the American nurse-midwife was not an independent practitioner; rather she worked largely as an assistant to the obstetrician (Anisef and Basson, 1979).

Brigitte Jordan (1983: 39) maintains that pregnancy and childbirth in the U.S. continue to this day to be defined as "medical events," and prenatal care seen as the "doctor's business." This medicalization of U.S. maternity care brings, among other things, communication problems between physicians and birthing women (West, 1984). As a result, there have been vigorous attempts to broaden caring options during pregnancy and childbirth. The choice of a midwife is one such option. Increased birthing options are also occurring in Canada.

2.2.6 Canada

In the early 1800s, maternity care in Canada was primarily in the hands of family, friends, and lay midwives. Due to the low population density and the large distances between towns and major cities, physicians lacked both number and motivation to service many parts of the country. Home births were attended mainly by lay midwives.

The type of maternity care available to birthing women and the history of midwifery in each province varies with the time of settlement by immigrants, and eventually by provincial legislation. The Maritime provinces have had a long history of midwifery (Benoit, 1991). On the prairies, where economic resources were scarce and midwives plentiful, maternity care was for a long time provided by midwives. Many of these

midwives practiced in Europe before coming to Canada. In fact, every Icelandic community in Saskatchewan had a midwife; some were formally trained and others were taught in the "school of experience" (Rushing, 1991: 13). Western Canada was populated by many Doukhobor, Mennonite and German immigrants, who preferred midwives over physicians for maternity care (Rushing, 1991).

The Canada Medical Act, passed in 1912, standardized the licensing procedures for physicians across Canada (Clarke, 1990). The Act significantly determined the nature of medical and maternity care in Canada for subsequent generations. The outcome was a safer health care system overall. Yet along with these standardizations came a male dominated medical system (Strong-Boag, 1981). By the 1960s, health care had become tightly-structured (Clarke, 1990; Grant 1992; Northcott, 1988). The fundamental principles of the Canadian health insurance plan, henceforth known as "Medicare" were laid with the Medical Care Act of 1966:

(1) **Universality of coverage** - the act stipulated that 95 percent of all residents of Canada had to be covered within two years;

(2) **Portability** - provincial governments had to ensure that the benefits would be portable from one province to another;

(3) **Comprehensive** - provincial governments had to cover all "medically necessary" services inside or outside of hospitals, as well as dental surgery performed inside of hospitals;

(4) **Accessibility** - provincial governments had to ensure medical services were "reasonably" accessible and provided on "uniform terms and conditions"; and

(5) **Public Administration** - provincial governments were to administer their health care plans directly or through a non-profit public agency fully accountable to the provincial government.

These five principles continue to form the foundation and philosophy for contemporary health care in Canada today. Despite "universal" medicare, however, not all Canadians experience the same quality of life. Health commissions have been implemented at both federal and provincial levels to address health care services (see Appendix I). Canadian health care providers have managed to reduce infant and maternal mortality rates to negligible levels for most Canadians. Yet these rates remain shockingly high for the poor and the Native population in Canada (Arnup, Levesque and Pierson, 1990). The provision

of maternity care is also compromised under medicare.

Maternity care services available in Canada differ depending on geographic location, provincial legislation, and acceptance of midwifery. Maternity services provided by physicians are covered under medicare, but alternative health services, such as midwifery, are not covered under the medicare plan in most Canadian provinces. The result has been inaccessibility of midwifery services to those women who likely need them the most. As Vicky Van Wagner (in Mason, 1990:7) suggests:

> Without legal recognition, midwives are only accessible to a well-educated group of women motivated to seek an alternative care giver and affluent enough to pay for services...Midwifery care is currently inaccessible to poor women, immigrant women, and teenage mothers... women who[sic] might benefit most from midwives' services.

In 1983, Canada was one of nine countries out of a total of 210 surveyed to have no legislation for midwifery (Biggs, 1983). In fact, Canada has been until now the only industrialized country in the world which does not legally support midwifery services (International Conference of Midwives, Vancouver Canada, May 1993). By the late 1980s, there was an increased demand for midwifery services. In 1989, the Ontario government appointed the Interim Regulatory Council on Midwifery to develop and make recommendations on the registration, regulation and practice of midwives (Seddon et al., 1993). In June 1993, Elizabeth Cull, then B.C.'s Minister of Health, expressed full support of legalizing midwifery and establishing a College of Midwives in B.C. Following Cull's announcement, a B.C. Midwifery Implementation Advisory Committee was established. By March 1995, Health Minister Paul Ramsey announced the establishment of B.C.'s first College of Midwives. Midwives are now formally recognized as legitimate, self-governing health professionals. The B.C. College of Midwives expects there will be licensed midwives in the health care system by 1996 (B.C. Ministry of Health, May 1995). The role of the new College is to set standards of practice and education, develop a code of ethics and review public complaints.

As midwifery becomes legalized in Canadian provinces and as the demand for Canadian midwives increases and their association strengthens, will midwives be able to offer a truly alternative service to physician care for birthing families? Will midwives and physicians continue to offer distinctive services, or will they compete for patients and

compromise their services in hopes of capturing more of the childbirth market? Will the new midwifery be able to reach out to all Canadian patients, not merely the vocal middle class minority? These are some of the questions which this thesis attempts to shed light upon.

2.3 Summary

This chapter described the various ways case example countries of the developed world organize maternity services. The kind of care, degree of intervention, and freedom of choice for birthing families varies between hospitals within each country and between countries. These countries also differ in the comprehensiveness of their health care systems, which in turn affects the availability of alternative services for birthing families.

Evidence elsewhere suggests the relevance of choice of maternity provider for effective care of birthing families. The general absence of a legal choice of a non-medical primary maternity care-giver for birthing families in British Columbia was the catalyst for my research topic. In turn, there is a need to develop a sociological understanding of the relationship between maternity patients and their care-givers. Birthing families seeking physicians and those who seek out midwives need to be asked about the services they receive, and why they sought those services in the first place . This has been the research task, which is reported on in the following chapters. But first it is necessary to examine the sociological literature on the topic.

CHAPTER 3: SOCIOLOGICAL PERSPECTIVES ON HEALTH CARE SERVICES

This chapter reviews various sociological perspectives on health care services, attempting to demonstrate that social science research often reflects current social issues. Sociological interest in the role of physicians, the medical profession and hospitals dominated the early literature on health care services. This was later followed by parallel inquiry in the role of non-medical (alternative) health care providers. As models of health and illness continue to evolve, so too have the different sorts of questions asked by sociologists. A more recent trend in sociological health care research involves feminist contributions that examine the concepts of patriarchy and oppression within health care systems. Feminist researchers bring women's health care and medicalization issues to the fore. Perhaps most popular of all, has been the increase in studies of maternity care provisions. These various trends in sociological research on health care services are examined below.

3.1 Sociology in Medicine

Sociological study of health care services originally began as a branch of medicine; hence the term "sociology in medicine" to describe the work of the founders of this sub-discipline of sociology. Sociology in medicine found its beginnings as part of medical schools and teaching hospitals and sociological research mainly adopted the perspective of physicians.

In the mid-20th century sociologist Talcott Parsons (1951) launched an examination of the role of the medical profession in American society. Most noted for his functionalist perspective on the dominant position of physicians and the patient's "sick-role," Parsons (1951) viewed the medical office as a sub-system within the social system in his structure of social action.[8] Parsons suggested that the working relationships between physicians and patients are based on cultural pattern-variables and moral dilemmas which

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[8]The social system is one of four systems in the information or cybernetic hierarchy of control, which functions specifically to equilibrate the "life system." Symbolic processes have primacy over social structural factors. Symbolic media - such as money, power, influence and commitment - are a major part of all cultural systems. Cultural systems have directing control over social systems, and social systems in turn control the personality systems of individuals (in Coser, 1977: 571).

guide the actors as to the correct choice of action.[9]

According to Parsons, sickness can disrupt social homeostasis because the sick may be unable to fulfil their necessary social roles. Therefore sickness must be managed and accorded a special role -- a "sick role." This legitimized role is comprised of four elements: (1) the sick person is exempt from "normal" social roles; (2) the sick person is not responsible for their condition; (3) the sick person must do everything possible to get well; (4) the sick person should seek technically competent help --ie. co-operate with the attending physician (Parsons, 1951: 436). Medical institutions are seen by Parsons as agents of social control, and medicine is responsible for providing legitimation and justification for bringing the sick back to "normality" or wellness.

While Parsons's sick role model provided an entire generation of medical sociologists with a framework or ideal type to explore the role of sick people in society, his model has been criticized for implying that patients are temporarily dysfunctional. The temporal nature of the sick person's role implies that "sickness" is an acute or short-term illness (McKinley, 1972). Pregnancy is a relatively short-term event, but it is not an illness; rather pregnancy is a natural biological part of human reproduction. Only women with paid work and formal maternity leave are exempt from "normal" working roles during the postpartum period. Full-time mothers are not excused from normal duties, unless they have the economic means to hire paid help (Lewis, 1980).

The sick-role, in addition, suggests that the afflicted person is not responsible for

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[9]Parsons' view of the physician/patient relationship can be summarized as follows. The five pattern-variables incumbent in the physician's professional role (and the patient's role-expectation) include: affect vs. affective neutrality, self-orientation vs. collective-orientation, particularism vs. universalism, ascription vs. achievement, and diffuse vs. functionally specific. These role-expectation patterns define the pattern of orientation in the role relationship. Like other professions, entry into practice must be **achieved** through educational competence. This high level of technical competence implies a specificity of function, and confines physicians to the specific sphere of their technical training and experience. Rather than diffuse, the practitioners authority is **functionally specific**. Another feature of the medical practice is the **universal** rather than particularistic focus. The physician-patient relationship is ideally independent of other social relationships with a particular person. The medical profession must be practiced with **affective-neutrality**. Lastly, the practitioner is to be **collectively-oriented** rather than self-oriented, which places the welfare of the patient above the physician's personal interests. The "profit motive" is supposed to be drastically excluded from the medical world.

his or her condition. In terms of pregnancy, it is difficult for women to claim they are not responsible for their condition unless conception was actively discouraged (McKinlay, 1972). The sick-role also suggests that sick people should seek technically competent help and co-operate with physicians. Gallagher (1976) and Honig-Parnass (1981: 616-622) suggest Parsons has a "medico-centric" professionalist bias, preventing him from paying attention to the contributions of alternative care-givers. Parsons fails to fully recognize non-medical formal professionals such as chiropractors, physiotherapists, and midwives; informal care-givers, including significant others, are likewise overlooked. Implied instead is that family physicians and obstetricians are the only competent care-givers for birthing families. Women who do not experience a "normal" pregnancy are considered sick, needing continuous monitoring by their physician, or hospitalization until they give birth and are thus "cured."

In brief, Parsons' sick-role has been criticized for, among other reasons, portraying people as passive actors seeking help from medical professionals (Honig-Parnass, 1981). Yet it has become increasingly difficult to classify patients as passive when they engage in social movements, client-revolts, self-help, or actively seek advice or treatment from lay significant others. Seeking these activities indicates that at least some citizens want to reclaim control over their bodies, indeed to take responsibility for their own health.

Despite such limitations to Parsons's sick-role model of the 1950s, it has nevertheless played an important role in the development of theory and research in the sociology of health care. This will become clear when we now turn to critics of this approach.

3.1.1 Critics of Medical Dominance: The Underside of Medical Progress and Hospital Care

From the mid- 1950s - until the 1970s, medical sociologists made a number of attempts to test Parsons' theory of medical control and the sick role. The Student-Physician (Merton et al., 1957) and Boys in White (Becker et al., 1961) examined the socialization of medical students. Timetables (Roth, 1963) described the underside of hospitalized care from a tuberculosis patient's point of view. It was found that structured time-tables, rather than the individual "case," guide physicians as to the "normal" course of

treatment and the "appropriate" time for leisure activities. These three studies (Merton, 1957; Becker, 1961 and Roth, 1963) individually demonstrate the structured nature of medical school, the influence of the medical model of care on the care provided by physicians, and the effect it has on patient care. These studies, among others, eventually led to examination of power struggles between occupational groups and ultimately, to a challenge of medicine's dominant position in the health division of labour.

Various debates emerged in the 1970s concerning the dominant status of physicians in health care (Freidson, 1970), producing concepts now familiar to the student of health and medical service: professional dominance, deprofessionalization and corporatism, proletarianization, managerial dominance, and client revolt. Eliot Freidson (1985) more recently had claimed that these notions are too sweeping to be of much practical use, suggesting instead that the medical profession and health care in general are heading towards greater rationalization and formalization. Rationalizing social arrangements in health care organizations means formalizing the relationships among participants. For patients this means care which is even more depersonalized. The importance of the patient became secondary; the primary concern is over who controls the allocation of resources to health care.

Health care research bifurcated in the 1980s into two significant areas, one based on the rise of the new health care industry which supplies services for profit; the other based on the negative effects of capitalism and medicalization on the health of citizens. Paul Starr (1982) and Arnold Relman (1980) examined the changes to the American health care system, and suggested physicians are no longer the controllers of health care services. Instead, power now lays in the hands of corporate medicine (Starr, 1982) or, more specifically, the "new medical industrial complex" (Relman, 1980). Relman (1980: 968) examined the problems brought about by corporate medicine, particularly the overuse of services, overemphasis on medical technology, fragmentation of medical care and "cream skimming"- a process whereby the most profitable services are provided to the best paying patients in private hospitals. The provision of care from this perspective has largely negative implications for disadvantaged patients. For patients that are not covered by a health care plan, their health is impacted by their inability to pay for services. Vincente Navarro (1976; 1986) examined health care services from this perspective and suggested that a contradictory relationship exists between capitalism and the health needs of society.

The capitalist medical model suggests health is a commodity to be bought and sold and that medical professionals tend to blame illness on individuals themselves.

Ivan Illich (1976) also examined the growing power of the medical system and its largely negative effect on the lives of individual citizens. Illich offered a cutting critique of medicalization, suggesting medical practice is "iatrogenic" at its core, that is it creates disease and illness while it provides medical assistance. John McKinlay (1982) has more recently argued that structural changes in the organization of medicine lead to physician proletarianization. He argued that third-party payers and advances in medical technology are forcing medical practices into bureaucratic settings, physicians are becoming over-specialized, and in many cases general practitioners are becoming salaried employees. Directors of corporate medicine rather than physicians ultimately control medicine. Yet the end result remains the same from the view of the public; others-- physicians, corporate managers--remain in control.

3.1.2 The Medicalization / Corporatization of Women's Lives

Sociological perspectives on the medicalization of women's lives demonstrate how the normal life cycles of menstruation, pregnancy, birth and menopause have been medicalized (Clarke, 1990). Control over maternity care is increasingly being taken from birthing families; in turn, medical industry representatives pressure medical specialists to use the latest drugs and technology. The effect this has had on maternity patients is an overuse of precautionary tests, such as ultra sound and amniocentesis, which are costly for the health care system and stressful for patients. What needs to be asked now is: what effect has this outside control--by medical professionals and technology--had on the health of women in general and birthing families in particular?

Much of the scholarly interest in the sociology of pregnancy and childbirth has critiqued the medical model of care and how physicians have "medicalized" the reproductive process (Weitz and Sullivan, 1985). Jane Lewis (1990: 1) refers to medicalization specifically in terms of:

> advances in technology which become the province of professionals; intra-professional issues of the status according to say, doctors over midwives; the nature of the patient/doctor relationship and the greater authority exerted by the doctor; and the place of treatment, which has increasingly become the hospital rather than the clinic or the home.

Critics of medicalization argue that some women find their childbirth experiences alienating, due not least of all to medical intervention and apathetic care-givers[10] (Norman, et al., 1993). Some researchers criticize medical dominance over patient information and decision-making during reproductive care (Porter, 1993); others argue that the principal problem is poor communication between physicians and patients (West, 1984). Ann Weitz and Deborah Sullivan (1985: 46) put it like this: "the medical model [particularly the medicalization of childbirth] emphasizes the treatment of patients' physical conditions and downplays connections between individuals' psychological, social and physical problems."

Peggy Foster (1991) explores the principles and practices of a feminist health care model espoused by British activists in the women's health movement. The goals and strategies of this model are generally supported by liberal, reformist and socialist feminists alike; health care providers are expected to work in open, egalitarian and democratic ways, and to share their knowledge and expertise with patients so as to empower them, encouraging a more active role in the maintenance of their health. This includes the sharing of personal experiences between health care providers and patients. Health care services are "holistic," such that treatment includes taking the socio-economic situation, as well as the psychological and physical aspects of the body into consideration. The final important goal is that health care is equally accessible to all women (people), regardless of race, class or sexual orientation. These various principles underlying the feminist health care model are similar to the central tenets of the midwifery model of care mentioned in chapter one. The underlying theme is based on care-givers "being there" for their patients; professional dominance and corporate control have little place in this model of care-giving. We will now turn to the next section which reviews contemporary studies on maternity care and the care-giver patient relationship.

3.2 Studies of Maternity Care

There is now a large body of maternity care literature which has drawn on all or many of the perspectives mentioned above. Only recently, however, has patient satisfaction per se become a focus of inquiry. Even so, researchers have tended to look at one or the other care-giver group when they examine maternity care - women who are

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[10]Dissatisfaction is not limited to birthing families. Similar criticisms regarding medical intervention and apathetic care-givers have been voiced by patients with many types of health concerns.

assisted by physicians in childbirth or women who are assisted by midwives. This section examines the contemporary maternity care literature in relation to the concept of effective maternity care.

The sociological literature on maternity care suggests that women's experiences of pregnancy and childbirth involves both technical and interpersonal elements. The latter include the actual circumstances of the birth itself, the presence of a support person, the type of anesthesia used for delivery, and the style of delivery. While the fundamental process of pregnancy and childbirth has changed little over the centuries, the physical and social environment in which birthing occurs has changed significantly in the past half century in most countries of the developed world. Labour and delivery units in most areas of contemporary North American hospitals, in particular, tend to be highly mechanized and the kind of care birthing families receive is affected as a result of this technological change. Some patients now question the belief held by many health professionals that medical care is synonymous with health care. Instead, what many families look for in the delivery of health services in general, and maternity care in particular, is a better balance between the technological and the caring elements of the services they received. Three decades ago, Avedis Donabedian (1966: 186) stated much the same:

> [T]he effectiveness of care... in achieving or producing health and satisfaction, as defined for its individual members by a particular society or subculture, is the ultimate validator of the quality of care. The validity of all other phenomena as indicators of quality depends, ultimately, on the relationship between these phenomena and the achievement of health and satisfaction.

Effective maternity care, then, goes beyond traditional measures of mortality and morbidity of mother and baby; it also includes interpersonal elements. Not least of these concerns attention to psychological and social aspects, including interaction between the care-giver, be it physician or midwife, and their patient. Effective maternity care must go beyond the technical, to encompass features of "being there" (Koehler, Fottler and Swan, 1992). Effective care, then, is predicated on a variety of technical and interpersonal factors, all of which contribute to birthing families overall level of satisfaction with the services they received. I will employ this framework to examine contemporary birthing literature.

3.2.1 Technical Elements of Care

Although many women prefer as little intervention as possible during birth, access to technical procedures, including episiotomies, forceps deliveries, cesarean sections, and anaesthesia, have helped save the lives and suffering of many mothers and babies. However, studies indicate that technological interventions during childbirth are also a major concern for many families. Care provided by midwives is usually accompanied by fewer interventions during the birthing process than care provided by physicians. At the same time, negative outcomes during midwife-attended births remain unchanged, if not reduced. What seems to be at issue here is the appropriate use of medical technology. Studies (Mayes et al., 1987; Norman, 1989) consistently report there are reductions in the frequency of amniotomies, epidural blocks, forceps deliveries, and episiotomies when certified nurse-midwives are the primary care-givers. Mayes et al. (1987: 217) conducted a study (n=58) which compared physician and certified nurse-midwife care and found no differences in complications but found patients experienced very different care practices, with physicians' patients receiving at least 50 percent more intervention during labour.

Episiotomies, Epidurals and Forceps Deliveries

In many areas of Canada, the episiotomy rates are as high as ninety percent[11] for women who have physician-assisted births (Hodnett and Osborn, 1989; Norman, 1989). That contrasts with those of midwife-assisted births. Holliday Tyson examined the latter in Toronto between 1983 and 1988; she found that only 14.8 percent (n=50) of 336 primiparous women had vaginal births with episiotomies (in Norman, 1989). Of these episiotomies, 2 percent were performed by midwives at home births, and 12.8 percent were performed by physicians in hospitals. These figures indicate that episiotomy rates are substantially lower when midwives attend birthing families. Kaufman and McDonald's (1988) research was based on two groups of birthing women; one group were cared for in a midwifery service and the remainder were under a physician's care. Their findings suggest the women in the midwifery group received massaging of the membranes in preparation for the birth much more often than did the other group. The women in the midwife group, however, had a greater frequency of lacerations or tears. Given the

[11]The episiotomy rate recorded in Hodnett and Osborn (1989) was 61 percent for the experimental group and 85 percent for the control group. The sample size was 103. The experimental group had continuous intrapartum professional support by a self-employed lay midwife. Eight lay midwives provided care for this group.

midwifery philosophy of care described in chapter one, it is not surprising that they would propose risking a tear rather than having an episiotomy. If a woman's membranes are well massaged with oil or if she has particularly elastic membranes, there is a greater chance the mother will deliver her baby without tearing. However, if these techniques do not work, the membranes generally tear. Most tears and all episiotomies must be sutured. While the means differ, then, the ends are often similar.

In terms of epidural rates, Kaufman and McDonald (1988) found that epidural rates differed based on care-givers, with midwives's patients receiving epidurals 15 percent of the time versus 44 percent for physicians' patients. Morgan et al. (1982) examined the concept of birth satisfaction and found that an unsatisfactory birthing experience was associated most clearly with long labours and forceps deliveries. Epidural anesthetics help birthing women cope but it can also slow the progress of labour. The longer the labour the greater the chance that there will be complications and physicians or obstetricians called to assist. If labour does not progress according to "schedule," the delivery is generally facilitated by forceps or cesarean section.

Cesarean Births

Graham and Oakley (1981) suggest most first-time mothers experience great apprehension about medicalized reproduction. The pervasive nature of technologization led Culp and Osofsky (1989: 56) to speculate that the dramatic increase in cesarean rates may itself contribute to new parents viewing the procedure as an alternative method of childbirth; for some women, sophisticated procedures, tests and treatment become the hallmarks of a "proper" pregnancy. Paula Norman (1993) suggests cesarean births are often viewed as an alternative when mothers book the procedure in advance and do not bother with a trial of labour. Michael Klein (1987: 168), a family practitioner, suggests that the rise in technological intervention is because "many specialists who have an everyday diet of complicated obstetrics inevitably see the process as risky indeed and consider normalcy only in retrospect."

In North America, the cesarean birth rate steadily increased throughout the 1970s and 1980s, to a high of approximately one in four births (Fawcett, Pollio and Tully, 1992). Cesarean rates vary substantially according to physician and hospital policy, however. Recent research suggests that cesarean rates increase with the use of fetal electronic

monitors. Women undergo repeat cesarean sections, moreover, without being informed that they are eligible for a trial of labour (Norman et al., 1993). British Columbia has higher cesarean rates than the Canadian average, with no evidence of better infant outcomes (Thomson, 1992).

Fawcett et al. (1992) suggest that women who have planned cesarean births have more positive perceptions than their unplanned cesarean counterparts. An unplanned cesarean section, which usually comes at the end of a long and complicated labour, can be particularly upsetting for birthing families because their plans for a self-controlled birth are thwarted. Birthing women, in particular, often feel that they have failed, and hold a negative self image because of it (Fawcett et al., 1992). Although birthing women express dissatisfaction with their inability to experience a vaginal birth, they also recognize the positive repercussions of their health and their baby's for having the cesarean.

Pharmacological Dependency

Morgan et al. (1982), suggest it is simplistic and incorrect to believe that effective pain relief ensures a satisfactory birth experience. Eileen McNally Hutton (1985) argues there is often an inverse relationship between the amount of pharmacological support and positive ratings of the birth experience. These positive ratings of the birth experience are often subject to the women experiencing feelings of mastery and control (Humenick, 1981). McNally Hutton (1985) found that when lay midwives are the main care-giver, the probability of using pharmacological support during childbirth is comparatively low, and the probability of women's reports of perceived control over the process is increased.

3.2.2 Interpersonal Elements of Care

Green et al. (1990) suggest that relatively little attention has been paid to the subjective features of labour and delivery that may indeed be relevant to birthing women's psychological state, including feelings of control during the labour process, and their view of the attending staff. The primary interpersonal elements discussed in the literature on maternity care are: (1) human support; (2) continuity of care between birthing family and care-giver(s); (3) personal control; (4) adequate information; and (5) effective communication.

Human Support

The importance of human support during the nine months of pregnancy, labour and delivery, and in the postpartum period has been well documented. Actual human support can be defined as: assistance made available to an individual from an outside source which may aid them in coping with stressors. Perceived human support is the way in which the labouring woman perceives her actual human support, her affective bonding with the care-giver, her partner support, and her overall support from physicians and nurses (McNally Hutton, 1985: 11). Also included within the rubric of human support are emotional support, informational support, tangible support and advocacy (Hodnett and Osborn, 1989). Human support provides an effective alternative to technological management of childbirth (Hodnett and Osborn, 1989). Birthing women's labour and delivery of their newborn in an unsupportive setting may have little effect on clinical outcomes; however, patients themselves may view the setting as highly important to their birthing experience (McNally Hutton, 1985).

Mary Driedger (1993: 606) argues in favour of human support throughout the reproduction period; she suggests that "being there" is a key factor in satisfaction with childbirth. Being there, as defined in chapter one, involves the provision of personable care by significant others or professional care-givers, who render physical, psychological, and emotional support to the birthing family. Being there also involves attendants acting as the patient's advocate during labour and delivery, helping her to feel in control of her birthing experience and to feel a "sense of mastery" during this vulnerable life event (Humenick and Bugen, 1981). Mastery, also defined in chapter one, involves birthing women (and families) continuing to be able to influence the decisions made -- that is, not surrendering all decisions and responsibilities to care providers, but rather maintaining a working alliance with care-givers. Conversely, loss of control or mastery due to care-givers not being there for the birthing woman and her family can lead to patient dissatisfaction with their reproductive experience. Both Midmer (1992) and Thomson (1992) suggest birthing women who experience more personable care, from either their physician or midwife, tend to be more satisfied overall.

Continuity of Care

The quantity of care many pregnant women receive today has increased with the number of specialists they see and the tremendous range of tests made available to them.

Yet it can be argued that the quality of the care they receive has decreased with the constant shuffling between physicians' offices, specialists' offices, clinics, labs and hospitals. Continuity of care-givers for Canadian birthing families throughout the prenatal, labour and delivery phases is often problematic. The number of Canadian physicians who include maternity care in their practices is decreasing (Klein, 1993). For many physicians the remuneration is not sufficient for the amount of time they have to spend with the patients; even more significant is the rising cost of malpractice insurance for maternity practice. Therefore, many pregnant women find themselves searching for a new physician to care for them, during pregnancy.

Hodnett (1983) suggests that "continuity of care" today is all but absent for birthing families. Continuity of care, as defined in chapter one, includes several elements: (1) care is provided by the same care-giver throughout the nine prenatal months, labour and delivery, and the postnatal period; (2) the philosophy behind the care-giver's emotional and informational support is consistent; (3) the care-giver's role as patient advocate in hospital is consistent with the birthing family's goals set out in the prenatal phase. Hodnett (1983) found that less than one-third of labouring women delivered their baby in a Toronto teaching hospital setting viewed nursing staff care as continuous throughout most or all of their labour; more than one-third of respondents reported the nurse was present for occasional brief periods only.

The continuous presence of a support person was also a significant indicator of satisfaction for the birthing women in Bramadat and Driedger's study (1993). Sporadic or discontinuous care provided by most physicians and many attending labour and delivery nurses suggests that care has become fragmented, depersonalized and regimented. Michael Klein (1993: 4) agrees that Canadian midwives provide birthing families with more continuous care than physicians and nurses. Yet the author goes on to state an even deeper issue -- that of a "struggle of the continuities," whereby physicians provide long-term continuity to families, often for many years and even over many generations. Midwives, by contrast, provide short-term continuity during a single nine-month reproductive period. Short term, intense continuity of care provides the opportunity for a more personal relationship between patient and care-giver; both parties are aware of the other's needs, and control becomes less of an issue for the care-giver.

Personal Control

Personal control is a concept that has many different meanings. In the birthing literature personal control is most often referred to in terms of either the locus of control or self-control. The locus of control can be either external or internal to the birthing woman. Women with an internal locus of control have the perception that events are a consequence of their own actions, - ie., under their personal control; birthing women with an external locus of control perceive events being unrelated to their own behaviours, beyond personal control, due to control by others or chance itself (Bassingthwaite-Thiessen, 1993; Fullerton, 1982). Self-control refers to the ability of women to develop and maintain control over their own behaviour (Green et al. 1990). Women experience personal control throughout their birthing experience when: (1) they do not surrender all decisions and responsibilities to care providers; (2) they are able to influence the decisions made; (3) they maintain open communication and a working alliance with care-givers; (4) they maintain control over their behaviour; and (5) they have an internal locus of control.

As mentioned in chapter two, the concept of personal control has evolved over time. Before the advent of anesthetics, personal control for birthing women meant maintaining composure during birth. The control that physicians traditionally have held over patients, as discussed earlier, was theorized by Talcott Parsons (1951) in his concept of the sick-role. Although birthing women did not consider themselves sick, they were in a tremendous amount of pain. Personal control became an issue of control over pain through the use of anesthetic. Women went through a phase of wanting to be passive during birth; essentially, with the use of anesthetic they would feel no pain. Many medical professionals were trained to believe that patients preferred to be passive (McKinlay, 1967).

Sheila Kitzinger (1988) reviewed letters and other sources from women in maternity wards in England in an attempt to examine the developments of medical control over various stages of pregnancy and childbirth. Kitzinger found that the women who experienced very controlling physicians likened their feelings to those associated with women who have been raped or otherwise violated. Communication between patient and care-giver was inadequate.

Finding an appropriate care-giver/patient relationship can often be very difficult when personality differences and variations in knowledge are taken into account. For

many physicians, a narrowing of the knowledge gap between patients and themselves can be very threatening. Deana Midmer (1992) contends that the unequal balance of power in the physician-patient relationship, coupled with an aggressive obstetrical management and a persistent orientation to technology, disempowers many women patients; they are placed in a position of subordination to their physician care-givers. Midmer (1992) suggests women resenting this management style of maternity care often seek midwives who want to empower their patients with knowledge, confidence and control.

The birthing women in Bassingthwaite-Thiessen's (1993) research were divided into two groups, those who chose a hospital birth attended by physicians and those who chose to give birth in an alternative site where physicians could not legitimately attend childbirth. Their care was provided by non-regulated attendants, either midwives formally trained in other countries or untrained lay midwives. Bassingthwaite-Thiessen's (1993) findings suggest that women who chose an alternate birth site had a more internal locus of control; they perceived themselves as the determiner of control, and they held significantly stronger attitudes towards issues of choice specific to their childbirth experience than did the women who chose a hospital birth (see also Fullerton, 1982).

Adequate Information

Education, another common theme in the literature on maternity care, is necessarily predicated on information and communication. Information, along with feelings of control are consistently associated with empowerment and positive psychological outcomes (Green et al., 1990). Much of the maternity literature focuses on the advantages and disadvantages of education through prenatal classes. While there is a difference in opinion on the effectiveness of prenatal classes, it is generally agreed that prenatal classes are an essential part of maternity care. The belief that the birthing family's emotional attitudes can influence outcome of labour is gaining acceptance, and that less anxious, well-supported mothers require less analgesia and have fewer complications in labour (Morgan et al., 1982). Bennett et al. (1985) suggest that the more hours women spend at childbirth classes, the less likely medication will be used during labour, resulting in greater satisfaction overall with the birthing experience.

Susan Hetherington (1990) examined the effect of prepared childbirth classes on obstetric outcomes. Her findings suggest that compared to birthing women who do not

attend prenatal classes, couples who attend Lamaze classes are more prepared for childbirth, are more likely to receive little or no pain medication, and receive less induction anesthesia. Yet Sturrock and Johnson (1990: 83) suggest a significant difference does not exist between prenatal class attendance and reduction of interventions during labour and delivery - in fact, the cesarean section rate for attenders in their study was 38 percent compared with 29 percent for non attenders of prenatal classes. Sturrock and Johnson (1990) found a significantly higher percentage of prenatal class attenders were older, better educated and of higher socioeconomic status.

On a different level, Freda et al. (1993) suggest it is essential to assess patient interest in developing effective prenatal classes because topics of interest often differ significantly between instructors and patients. Age-appropriate classes are also suggested for pregnant adolescents who are often intimidated at adult prenatal classes where most participants are in "couple" relationships, and because of the differences in age and education levels (Lena et al., 1993).

Butani and Hodnett (1980) interviewed fifty women who had delivered infants at a large teaching hospital in urban Ontario. Interviews occurred within 48 hours after birth to determine mother' perceptions of their labour experiences. They found no correlation in their study between prenatal class attendance and a positive attitude about the labour experience, but they did find a relationship between educational preparation and whether or not "control" was important to their respondents. In addition, all of the respondents in their study who did not mention control as important, did not have a university education. In fact six of the eleven women who did not mention control as important had less than a grade 11 education, and none of the eleven had university education (Butani and Hodnett, 1980: 77).

Most of the maternity literature focuses on the provision of information in the prenatal phase and communication during labour and delivery. Significantly lacking in the birthing literature is information on patient satisfaction and the availability of adequate information for mothers in the postnatal period. Everitt et al. (1993) explored the postnatal experience of new mothers in Australia. Their findings indicate that receiving consistent information from their care-givers was important during all phases of birthing, particularly in the postnatal phase. Socio-emotional issues were emphasized including support in the

transition to parenthood. These women were less concerned about postnatal complications and infant illness than taking on the parenting role (Everitt et al., 1993).

Effective Communication

Recent studies (Drew et al., 1989; Sequin et al., 1989) indicate that participation in decision-making and explanation of procedures are also important factors associated with maternity care satisfaction. A Canadian obstetric study (Sullivan, 1987: 648) concluded that, "physicians can improve satisfaction levels by improving physician-patient communication and continuity of care, by offering explanations about medical interventions and by honouring choices made by women before their delivery." The honouring of choices is predicated on establishing and maintaining open lines of communication and listening to patients' needs. Contrasting the situation with many physicians, communication between midwives and patients is often characterized as being an open, two-way process. Women who use midwives often comment on the extensive and useful information they receive; they tend as well to emphasize the counselling and supportive role their midwife performed for them (Soderstrom et al., 1990a). These findings are likewise supported by Yankou et. al. (1993), who recommend that certified nurse-midwives provide significantly more "teaching" during office hours than physicians, and that physicians rely on other staff members, such as nurses or specialists, to answer their patients' questions.

Lending further evidence to this reported difference between physician and midwife communication capabilities, Candace West (1984) and Joseph Kess (1988) found that physician-patient relationships are essentially asymmetrical and that communication between physicians and patients is often problematic. Koehler et al. (1992) found that both parties are often disappointed with the interaction. One problem is physicians who view (pregnant) women as ignorant of the birthing process (McKinlay, 1976); when expecting mothers do ask questions of physicians, they usually require much more information than physicians are prepared to give (Graham and Oakley, 1981). This, of course, leaves women dissatisfied with their medical care.

West (1984: 24) suggests that physician-patient communication can be enhanced by elimination of medical jargon, by physicians using lay terms when relating to their patients, and extension of the usual 10-15 minute physician visits so that patients are no longer rushed, thus having the time to express their concerns. These measures would encourage

conversation between physicians and their patients, better enabling patients to comprehend the information given to them, and to make informed decisions regarding treatment and care. Lucy Candib (1987) encourages physicians to offer information based on their own personal experience, so that the social distance between themselves and their patients is reduced and reciprocity enhanced. The end result is that birthing women and their families are empowered rather than constrained. These aspects of communication - open lines of communication between patient and care-giver, explanation of procedures, allowing adequate time during prenatal visits for patients to express their concerns without being rushed, answering patients' questions to the extent that patients are satisfied - are central tenets of the midwifery model.

3.3 Summary

This chapter has briefly examined the evolution of sociological perspectives on health care services, using maternity care and birthing families as a case in point. Based on this literature review, it is evident the sociological perspectives on health care services have changed greatly over the last four decades. Theories have evolved from a focus on sociology in medicine to a focus on the sociology of medicine. Sociological inquiry then moved to examination of health care services in general. Ultimately, the gender of providers and patients became an issue of sociological inquiry. Much research today is based on alternative health care services, midwifery care for birthing families forming part of this emerging literature. Various philosophies of care and the provision of maternity services by midwives are now well documented.

Technological developments in maternity care have ensured the safe arrival of babies under stress. Umbilical cords wrapped around the baby's neck, the misposition of babies in utero and the birth canal, and cephalopelvic disproportion (a mismatch of baby's heads and shoulders to the mother's anatomy), all contribute to problematic deliveries (Klein, 1994: 657; Rothman, 1982). The ability to circumvent such problems through technological intervention has greatly helped to lower mother and infant morbidity and mortality rates. Despite these laudable developments of medical science, findings indicate that a sizeable number of birthing families want alternatives to "conventional" obstetrical care, both in place of birth (Soderstrom et al., 1990b; Tyson, 1991), and in the delivery of care (Stewart and Clark, 1982). The tremendous range of technologies available today to care for birthing women, from the prenatal to the postnatal phase, present many women

with difficult dilemmas. On the one hand, birthing women want to do everything possible for their baby, yet they know many of the tests are not really necessary, some perhaps unsafe even. Social pressure tends to dictate that if they do not accept the test they are seen as acting irresponsibly; women are thus socially-pressured to "choose" questionable tests and procedures (Gregg, 1993). Yet some birthing families desire technological and pharmacological intervention, while others do not. The down-side to technological development in maternity care is the overuse of intervention. Many birthing women and midwives call for the appropriate use of intervention.

Effective maternity care also includes interpersonal elements. The literature tends to emphasize the psychological and social aspects, including interaction between the care-giver, be it physician or midwife, and their patient. Maternity care also includes features of "being there" (Koehler, Fottler and Swan, 1992). Effective care, then, is predicated on a variety of technical and interpersonal factors, all of which contribute to birthing families overall level of satisfaction with the services they receive.

In summary, the satisfaction of maternity patients has been well documented; however, there are few comparative studies on physician and midwife patients. My research project for this thesis attempts to explore patients' overall satisfaction with the maternity services received from midwives and physicians in one geographic location. The following chapters report the similarities and differences in the birthing experiences of my respondents. The underlying question asked was: how satisfied are birthing families with the maternity care they receive? But first, description of the research methods of this thesis is in order.

CHAPTER 4: RESEARCH METHOD AND DATA DESCRIPTION

This chapter describes the research process. First, I provide an overview of the reasons for my choice of study. This is followed by my selection of a method design in the qualitative tradition for data collection. The last section outlines the data collection procedures, including choice of respondents, interview process, mode of data analysis and ethical considerations.

4.1 Researcher's Point of View

Prior to returning to university, I worked for a number of years in a technical capacity in the health care field. As dental assistant in an orthodontic office, I experienced work relations within a patriarchal setting. I also saw how vulnerable many patients were, particularly when they were presented with treatment plans proposing what, in my view, was unnecessary surgery. This work experience spurred my interest in health issues, in responsibilities and relationships of care-givers, as well as in what constitutes quality care from the public's perspective.

I started my undergraduate degree in my mid-twenties and am finishing graduate school in my mid-thirties. During this time most of my peers were in their prime reproductive years; many had started their families. What particularly interested me was the wide variation in their satisfaction with pregnancy and childbirth, especially regarding their view on professional care-givers. I eventually became intrigued with one kind of maternity care-giver -- the midwife, when a close friend employed the services of one for the birth of her second child. The birth of my friend's first child was far from a pleasurable experience; the birth of her second child turned out to be very positive. My initial question was: why was one experience so much better than the other, despite the fact that both pregnancies were without medical complication? After reading the sociological literature on maternity care, it became apparent to me that birthing services and philosophies of care-givers can vary a great deal, and that there was limited sociological literature exposing how recipients themselves view the formal maternity services they receive.

I am concerned that birthing families, women patients in particular, should have fair and equal access to a range of services, as well as the right to make a personal choice about

their birth attendant. Birthing families should be provided with services which they feel are beneficial, satisfactory, and appropriate to their personal concerns. In turn, midwives and physicians should have access to better information on how their services are perceived by the public, especially concerning areas of care that require attention. I am also concerned about the wider health problems of all birthing families - those problems that go beyond the type of care-givers, and how changes in birthing services now underway across Canada will affect the overall health and well-being of pregnant women, their newborns and significant others. My curiosity about birthing families and their concerns about the maternity services they received led me to choose a qualitative method of inquiry.

4.2 Qualitative Methods

> Thinking without comparison is unthinkable. And, in the absence of comparison, so is all scientific thought and scientific research (Swanson, 1971:145).

Before the term "qualitative" was commonly employed, researchers simply called their activities "fieldwork" and their method of data collection "participant observation" (Tesch, 1992). Most of the early qualitative researchers were anthropologists and sociologists from the Chicago School (Tesch, 1992; Wallace and Wolf, 1986). Qualitative sociologists began working in various modes or "schools" such as ethnomethodology, phenomenology, discourse analysis, grounded theory and symbolic interactionism. The phrase "naturalistic inquiry" became fashionable in the 1970s and the number of researchers using qualitative methods increased (Tesch, 1992). Texts on field methods gradually devoted more space for detailed analyses such that readers could follow researchers' data reduction processes (Sieber, 1976). Twenty years later, qualitative research became a "growth industry," with innumerable conferences on qualitative issues, and several handbooks, new journals and software packages were made available for researchers (Huberman and Miles, 1994: 428). Many academics suggest research need not only be based on qualitative methods of inquiry, but rather that research methods should be chosen based on an appropriate fit with the research question and field of study (Jarantyne and Stewart, 1991). It can be useful to employ both qualitative and quantitative processes in research. By adopting a range of methods (triangulation) in data collection, validity of research findings is enhanced.

Typically, statistics and research methodology courses at the graduate level are heavily influenced by a quantitative perspective. The resulting literature tends to emphasize

the importance of generalizability. After reviewing numerous studies which used quantitative techniques, including lengthy questionnaires and large sample sizes, I found them to be indeed attractive to researchers seeking generalizability and concerned with nomothetic science (Bennett et al., 1985; Canadian Medical Association, 1987; Sequin et al., 1989; Soderstrom et al., 1990). For personal topics, however, such as the one I investigated for this thesis, the quantitative approach may not be particularly appropriate. For many women, pregnancy and childbirth is a very personal experience, not easily conducive to objective measurement. To understand what the real issues were for the birthing families in the Greater Victoria area today, it seemed to me that using the quantitative method would provide an incomplete, perhaps merely surface, picture. I wanted to dig deeper and understand underlying meanings and experiences seldom mentioned when large scale questionnaires are the chosen method.

Like qualitative research in general, a feminist social science too begins with the recognition that personal experience underlies all human behaviours (Stanley and Wise, 1993: 164). Yet feminist scholars assert that women's experiences have been either omitted or distorted. It is, therefore, not enough to supplement male-oriented research (Maguire, 1987); when the research "problem" centres around events peculiar to women, sociological inquiry should instead begin with the women themselves (Olesen, 1994). This alternative strategy necessitates a less structured relationship between the researcher and the respondent, a relationship which is trusting and where both parties are considered equal (Kirby and McKenna, 1989). Cecilia Benoit (1991) interviewed Newfoundland midwives to examine the changes in the practice of midwifery; Brian Burtch (1994a) examined birth records and interviewed community midwives in British Columbia and Ontario to offer a critical examination of the anomalous occupational and legal status of Canadian midwives; Brigitte Jordan (1983) studied birthing in four cultures, including Sweden, the Netherlands, the United States and the Yucatan; Carol Shepherd McClain (1987) interviewed birthing women in California to determine the importance of social networks and choice for birthing women and their maternity care. Following this qualitative, yet feminist-informed, tradition, I have examined birthing women's satisfaction with their maternity care-givers and the services my respondents received.

Although there are many different kinds of feminism, it can be defined in one sense as a method of analysis which places women at the centre of inquiry (McCool and McCool,

1989; Ruzek, 1986). This research project is a feminist project in that women's lives and their concerns about birthing services are the focus of inquiry. I am, however, not dealing with an individualistic notion of feminism based strictly on and for women. I am concerned about women where ever they are, and in this case, it is women's birthing experiences with their families. The inclusion of family, although ancillary, has influenced both the theory and methods of this project such that it was conducted from a woman-centred humanist perspective.

One way to do this study would be to interview midwives' patients in an effort to understand the reasons why people seek alternative care-givers. Such research might discover whether or not reasons originate in the personality of patient or, alternatively, that of care-giver. Another option would be to look at birthing women who choose physicians as their main care-giver. Despite their asset regarding detailed description, one inadequacy of both strategies is that they do not allow for comparison across care-giver groups. Charles Ragin (1989) argues for a comparative approach, not least because it makes possible systematic analysis of similarities and differences between groups. As Ragin (1989:13) states,

> when qualitatively oriented comparativists compare, they study how different conditions or causes fit together in one setting and contrast that with how they fit together in another setting (or how they might fit together in some ideal-type setting). That is, they tend to analyze each observational entity as an interpretable combination of parts - as a whole.

Examination of the similarities and differences of the various services offered by two types of maternity care-givers, then, is the route taken in this thesis.

I chose Glaser and Strauss's (1967) "grounded theory" approach to guide my research process and data analysis. In grounded theory, the research question is a statement that identifies the phenomenon to be studied - a statement such as: Perceived satisfaction with the birthing experience differs greatly among birthing families. Why is this the case? This approach does not involve independent and dependent variables, but rather is based on an inductive design, which works well when the area of study is descriptive, exploratory and unfamiliar (Huberman and Miles, 1994). A grounded theory analysis is set into motion with the first interview, when particular words or phrases are emphasized. Themes or patterns are identified inductively as the interviews evolve, rather than from a preconceived theoretical or empirical framework (Glaser and Strauss, 1967; Huberman and

Miles, 1994). I employed this "constant comparative method" (Glaser and Strauss, 1967) to gather the data for my study. I used tables to delineate the highest and lowest occurrences of themes, and matrices to aid the discovery of co-occurring themes.

What is suggested here is a need for an integrative approach to gathering social science knowledge, one which situates theory in the context of birthing families (Stacey, 1988). Consistent with the birthing literature, pregnant women themselves are often likely sources of information. For many birthing families, giving birth is such an extraordinary experience that few people have problems remembering the event. Simkin (1992: 70) suggests, "the birth of a child, especially a first child, represents a landmark event...etched in memory," and therefore, "women need not be considered unreliable sources of data on their childbirth experience" (Bennett, 1985:157). This is verified in recent research which indicates that women are able to recall, with very little confusion, their first birthing experience not just two years (Bennett, 1985), but twenty years later (Simkin, 1992).

Given the above mentioned goals, I decided on gathering data by use of in-depth interviews. This particular strategy was chosen in an effort to understand and subsequently interpret the intrinsic value of specific cases. Although this method produces limited generalizations concerning the causes of theoretically-defined categories chosen from the data (Ragin, 1989), it seemed to me to be the best method to achieve my overall goals.[12] This is for seven reasons: (1) to make women's diverse birthing experiences known (Jayaratne and Stewart, 1991; Stanley and Wise, 1991 and 1993; Smith, 1987); (2) most of the contemporary research on this particular topic is from a nursing perspective, and therefore, the particular strengths of sociological methodology have not been brought to bear on the topic; (3) my chosen method enabled the respondents to re-evaluate "the personal" and discuss their subjective experiences - their feelings, thoughts and knowledge - in a non threatening manner. This in turn reduces "response effects" - bias in participants' responses due to anxiety brought about by the presence of and interaction with

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[12]Focus groups are an alternative method of data collection which allow respondents to interact with each other (Krueger, 1988). The focus group method encourages the development of ideas, nurtures differing perceptions and points of views, and fosters understanding of diversity of human experiences (Krueger, 1988). Although it is possible that outspoken individuals may verbalize issues similarly held as important by the less forthright, there is nevertheless a danger that only outgoing and self-assured respondents gain a voice thereby silencing more timid members of the group.

the researcher (Singleton et al., 1988); (4) an unstructured non-hierarchical approach allowed unanticipated information to emerge, and reduced the likelihood that theoretical bias will distort the data (Glaser and Strauss, 1967); (5) this method allowed an opportunity to probe and clarify vague answers, while at the same time realizing specific objectives laid out in key questions (Bradburn, 1983; Singleton et al., 1988: 236); (6) this approach encouraged empowerment of respondents by awarding them some control in directing the interviews (Kirby and McKenna, 1989); and (7) face-to-face interviews provided me an opportunity to observe nonverbal behaviour of my respondents which was relevant to the research. In brief, allowing my respondents to speak freely about birthing enabled me, and hopefully others who read my thesis, to more fully understand the experiences of birthing women and the issues which affect them, both in the short and long term.

Limitations to the qualitative research method do exist. Possible problems of respondent bias, interviewer bias and reactivity error may arise in personal face-to-face interviews (Singleton et al., 1988). Respondent bias can be introduced through a respondent's reaction to the interviewer's personality (Singleton et al., 1988). This was a problem with one of my respondents who wondered how I could research issues of childbirth when I had not experienced giving birth myself. The respondent's concern was valid; had I experienced giving birth, it could indeed have been an asset. We could have then shared experiences and perhaps focused on birthing events which were or were not troublesome. However, my lack of experience in this regard left me advantaged to the extent that I was not inclined to challenge or sway respondents in a direct way (Stanley and Wise, 1993: 160). Interestingly, this was my least enjoyable interview; perhaps I was indeed biased against her, although I tried very hard not to let her personality influence my actions and questions (Locke et al., 1987). I took steps in an effort to minimize influence of possible interviewer bias: I was the only person who interviewed the respondents; I dressed for all of the interviews in a casual fashion, wearing either jeans or cotton pants, clothing typical of university students; I attempted to use lay terminology in my conversations with my respondents in the hope of reducing any ill-ease they might have due to my higher education and advantaged economic status compared to many of them (Sudman and Bradburn, 1974). Yet my use of lay terminology back-fired with the respondent mentioned above. Because I did not use the technically correct terminology employed in the literature, she seemed to wonder if indeed I was knowledgeable on the

subject.

I believe that problems of reactivity, brought about by changes in behaviour due to respondents' awareness that they are being studied or observed, were minor in this research (Singleton et al., 1988). My respondents and I initially seemed nervous. However, once we shared a cup of coffee together and began to explore general questions about pregnancy, both of us seemed to relax. My respondents appeared to enjoy talking about both their positive and negative birthing experiences, so much so in some cases, that by the time our interview was over, I no longer felt like the stranger in their kitchen that I was upon arrival.

Recent birthing literature suggests that both the timing and place of the interview are just as critical to successful data gathering as the person who conducts the interview itself (Lumley, 1985). Sequin et al. (1989:109) suggest the timing of satisfaction studies are crucial because, "in the days immediately after the birth, patients might hesitate to criticize the care they received and the professionals involved... [instead] information should be elicited when patients can discriminate between the happy experience of a birth and the care actually received, but before it all fades away." With the passage of time, the initial glow fades, and the event takes on more realistic dimensions. Bennett (1985), suggests women's recall after two years differs based on number of births. The author found that women with one birthing experience exhibited little change overall in their evaluations of the birth experience. Yet for women having a second child, their first labour was often viewed more negatively, suggesting a general loss of a halo effect after a second birth (Bennett, 1985).

Satisfaction studies conducted when maternity care-givers are in hearing range may result in abnormally high ratings by birthing families. This may be a function of social desirability (La Monica et al., 1986). In the hospital, women are captive patients; if they are critical of the care they receive from staff they tend to fear retribution in the form of neglect for themselves or their babies. Birthing families therefore tend to want to please and answer in favour of the attending physicians and nurses (Drew et al., 1989; Like and Zyzanski, 1987; Lumley, 1985). Because of these concerns of timing and place of research, I made a decision to conduct my interviews in the respondents' own homes, six to eighteen months after they gave birth. This post-partum time-frame was suggested to me

by local midwives. I became a mother myself after the interviews were conducted, and in hind-sight I believe there are both advantages and disadvantages regarding the timing of my interviews. An advantage to waiting 6-18 months postpartum was my respondents had ample time to reflect on their birthing experience. My study may have been weakened by waiting so long after the event, however. Incidents such as events, personality clashes, pleasures and disappointments, which seemed important at the time become less so with the passage of time. Despite Bennett's (1985) contentions mentioned above, I believe that my respondents who were interviewed closer to 18 months postpartum may have forgotten some pieces of information which may or may not have been significant. The birth of a first child is such an exciting event that by the time you get home with your new family, you are not only overwhelmed but exhausted. My study could have been improved by interviewing respondents at three different time intervals, during their pregnancy, immediately after birth, and eight months postpartum.

4.3 Data Collection Procedures

The respondents in my research project were twelve first-time mothers of various economic circumstances in the Greater Victoria area. With one exception, I kept to my original plan of interviewing women who delivered their babies between September 1992 and September 1993. I interviewed one respondent who had given birth in October 1993. This respondent was included in my study for convenience; the date of birth was only one month off the designated birth time-span. An equal number of maternity patients from physician and midwifery practices were interviewed.

In order to establish a baseline, eligible women were selected according to the following criteria: potential respondents must have resided and given birth in the Greater Victoria area; must have been "low risk" (no hypertension, hospitalization during the pregnancy, non-gestational diabetes); must have experienced "normal" (non-cesarean section and non-forceps) first deliveries; each birth had to be one baby only (no multiple births); the women must have delivered their babies between 6 and 18 months prior to the time of interview. I deviated from my original plan of interviewing women who experienced "normal" birthing experiences was somewhat deviated from, however. I interviewed two women who experienced cesarean sections, one woman being a midwife's patient, the other a physician's patient. The first woman I interviewed who had a cesarean delivery was one of my earliest interviews; I omitted asking ahead of time whether or not

she had a normal (vaginal) birth. This interview was particularly interesting. I was struck at how much of an impact the cesarean had on her overall experience. Subsequently I had the opportunity to interview a woman who had a cesarean delivery from the other group. I interviewed that woman as well so I could compare the two experiences. Also, one of my respondents had a forceps delivery. The size of the two groups nevertheless remained balanced. In retrospect, the two cesarean experiences and the forceps delivery provided useful data for my analysis.

By collecting data on first births only, I was able to eliminate women unconsciously comparing subsequent births to their first one (Bradburn, 1983; Simkin, 1992; Singleton et.al., 1988; Woolsey, 1986). One of my three pre-test interviews was with a woman who had experienced two births, one with a physician assisting, the other a midwife assisting. There was no doubt in this particular respondent's mind that the birth with the midwife assisting was a better birth experience. What was also interesting, however, was the respondent's inability to focus on the birth of my research interest - the first birth. This was a particularly important interview for me as a researcher because it verified the importance of interviewing only first time mothers. Due to this respondent's confusion between the two births, none of the information was useable for my subsequent analysis. Interviewing only mothers with one child precluded the possibility of them answering in terms of several birthing experiences.

4.4 Respondent Selection

Phone calls, letters of request, and fliers were the three main strategies I used to gain access to respondents. The result was two separate sample groups[13] on the basis of primary care-givers: (1) the "physician sample," which included women who experienced an uncomplicated first birth in the hospital and were **not** assisted with the services of a privately-hired midwife; (2) the "midwife sample," which included women who experienced an uncomplicated first birth in the hospital, **and in addition were** assisted with the services of a privately-hired midwife. All of the women who delivered in hospital (eleven of the twelve women in my sample) had physicians present at the birth; one woman had a home birth with two midwives assisting - no physician was present.

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[13]The use of comparative groups enabled me to use a "comparative strategy" (Ragin, 1989: 34) which centred on the use of theoretical ideal-types to guide the interpretation of empirical cases.

My first step in gathering a sample of physicians' patients was to contact the physicians themselves. I telephoned the hospital and asked for the list of practicing maternity physicians who have delivery privileges at the Victoria General Hospital (VGH). The list was not made available to me, however. I then resorted to the yellow pages of the Victoria Telephone Directory as my data base for selecting maternity physicians. I used a simple random selection procedure (Singleton et. al., 1988: 140) whereby I selected every fifth physician listed whose title indicated that their practice included maternity/obstetrics. This selection technique was followed for all physicians listed in the yellow pages. I drew forty-six names in total. Each of the forty-six names were written on individual slips of paper and placed in a basket. I chose at random twenty-five names of maternity physicians from the basket. I telephoned each of these offices. My first hurdle was getting past the receptionist. Unfortunately, a good receptionist acts like any gate keeper, in my case preventing direct talk with the physician. Surprisingly, a few receptionists did in fact put me directly through to the physician. Other receptionists, however, suggested the physician was too busy to talk with me, relating that the best they could do was to pass along my request and perhaps the physician would call me. I sent a "Letter of Request" (Appendix B) along with about six "Participants Needed" fliers (Appendix C), to the medical offices of physicians or receptionists who expressed an interest in my research. The fliers were included for the physicians to display in their waiting room, or if they preferred, to be given directly to those patients fitting my selection criteria. Either way, it would be up to the pregnant women themselves to contact me if they were interested in being interviewed.

Given a possible 60% response rate (Rossi, 1983: 360), I anticipated 15 physicians might respond and provide at least 2 patients each. This would have provided a good sample from which to draw approximately 6 respondents. However, only two physicians eventually answered my request. Even with these two physicians, there were difficulties. One of them wanted to know how I was able to examine maternity patient's quality of care without 8 years of formal obstetrical training. This particular physician did agree that it was possible for me to examine patient satisfaction; however, he offered to provide me with some women to interview only as long as he could be present for the interview. This seemed to me like patriarchal control. Given potential problems of bias and social desirability (Bradburn, 1983; Singleton et al., 1988), I chose after all, not to include that

physician's patients because with him present during the interview I presumed the women may not have felt comfortable and/or able to discuss freely any dissatisfactions they may have had with the care they received, in fear that future care may be in jeopardy. The other physician who responded was extremely positive and provided me with a list of patients which his receptionist put together to avoid any biases the physician may have had when choosing patients (ie. only choosing patients who had positive birth experiences). I put the eight names from this list into a hat and randomly selected one woman's name at a time until they fitted all the criteria. Unfortunately, after calling each of them, none fitted the criteria. In the final analysis, half of my physician-assisted sample was not generated from the "letter of request" at all. Some women actually phoned me and volunteered to be interviewed; these women heard about the research through other women who had participated- a technique known as "snowball sampling" (Singleton et. al., 1988). Given the extremely poor response from Victoria physicians, I accepted their offers with much relief.

The other half of the "physician sample" group came from community pregnancy outreach programs and "Best Babies" programs, located in areas of the city where predominantly disadvantaged single female-headed families reside. A local midwife provided me with the names of the program coordinators, whom I subsequently phoned to explain my research project, asking if they would be able to provide me with the names of women who fitted my specific criteria. A similar "letter of request" was sent to the program coordinators following this phone call, in hope that the letter would jog their memory if they had not already created a list of names of potential respondents. One of the program coordinators phoned and provided me with a list of names of women with whom she had discussed the research. I randomly selected three names from the list and phoned the women. After I explained the purpose of my research, the first three women I called agreed to participate. Three women were chosen from this program, in my attempt to ensure women from a lower socio-economic strata were included.

Collecting the "midwife sample" was not such an onerous task. In January 1994, I was invited by a local midwife to attend the monthly meeting of the Victoria Chapter of the Midwives Association of British Columbia. At that meeting, I introduced myself and gave a brief overview of my research project. The midwives were very supportive of my research and proceeded to give me a list of all fee-for-service midwives working privately

in the Greater Victoria Region. Prior to sending each of them a "letter of request" (Appendix B) for respondents, I contacted all ten of the practicing independent midwives in Victoria by telephone. Many of the midwives were not at home at the time of my call; I left a message on their answering machines. Within two days, all of the midwives had called me back! Due to the birthing time span that I was interested in, many of the midwives were either not practicing yet in Victoria, or they were out of town taking midwifery courses so they were not able to provide me with patients; they said, however, that they were truly sorry that they could not help, and looked forward to my report. In the end, four midwives[14] provided me with patient lists. Two of them provided me with a long enough list of patient's names so that I could make a random selection. Similar to the process used with my physicians' lists discussed above, I put all names in a hat and pulled out two names for each responding midwife. I took steps to make sure no more than two respondents used the same midwife. All of the women whom I approached through midwife contacts listened to my research plans and expressed an interest in being interviewed.

It should be emphasized that respondents in the midwife group are a self-selected group in that they chose to employ a midwife. These respondents wanted to take an active role in decision-making and to establish and maintain open lines of communication with their care-giver from the prenatal phase through to the postpartum phase at home. As shown below in the report of my data findings, respondents who wanted this kind of patient - care-giver relationship generally received it from their midwife. As also shown below, and what is perhaps more interesting, is that the physician respondent group was not self-selected and yet expressed a desire for a model of care not unlike that received by patients in the self-selected midwife group.

4.5 Demographic Characteristics of Respondents

The twelve women who participated in my research project all live in the Greater Victoria Region (see Table 4.1 for respondents' demographic characteristics). At the time of the birth, women's ages ranged from 17 to 36 years, with physicians' patients ranging

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[14]Although I received data from the women based on four different midwives, two of them work in a partnership and shared all clients. For all intents and purposes, therefore, I accessed three midwives only.

from 17-36 years of age and midwives' patients ranging from 18 to 36 years. The mean age in each group was 26 years for the physician group, and 29 years for the midwife group. Nine of the twelve respondents completed high school. The range in education was the same for the two groups. However, the midwife group was represented quite evenly across the levels of education, while the physician group tended to represent the higher end of the range. At the time of the interview there was little difference between the groups in house ownership, rentalship and income assistance. One respondent in the physician group was Native; the other eleven respondents in my study were Caucasian. Table 4.1 demonstrates that there is little variation between the two groups; demographically at least, the two groups are quite homogeneous (see Appendix G).

TABLE 4.1: RESPONDENTS' CHARACTERISTICS

Characteristics	Physician Group	Midwife Group	Total
Mean Age	26	29	27.5
Completed High School	5	4	9
Own Home	2	3	5
Rent Home/Apartment	4	3	7
Income Assistance	2	1	3

4.6 The Interview Process

I executed a pre-test with three friends who were also mothers. The first two mothers were similar to those who were sampled later in the research; the third mother in the pre-test group, as mentioned above, had two children. The pre-test enabled me to practice qualitative interviewing, to test my preliminary interview schedule, to get an approximation of the expected time-frame for my subsequent interviews, and to gather input from the women in the pre-test group, regarding pertinent data by-passed in their interview. All respondents, including the pre-test group read my letter of request to

participate (see Appendix D), and signed a letter of consent (see Appendix E) which guaranteed anonymity.

My interviews focused on the experiences of each respondent before, during and after their birthing experience. In an effort to decrease the probability of socially desirable answers, I reinforced the fact that there were no incorrect or correct answers; all issues and answers were equally important. Given that people are more responsive at different times in the day, all of the respondents determined the date, time and place of the interviews (Singleton et al., 1988). All of the women chose to have the interview conducted in their own home. So that my energy could be focused on them, rather than on scrupulous note taking, with the approval of my respondents, all the interviews were tape-recorded. I was the primary investigator, and I conducted all interviews myself. My respondents were free to conclude the interview at any time, and to refuse to answer specific questions without prejudice or explanation. None of my respondents, in fact, refused to answer my questions; nor did any of them choose to terminate the interview process. Only one respondent exhibited signs of fatigue, and this was only when the interview was almost finished. I quickly asked the remaining questions and the interview drew to a smooth closing.

"Saturation" in qualitative research occurs when no new information emerges (Glaser and Strauss, 1967). This occurred in my case upon concluding the twelfth interview. Had saturation not occurred I had a back-up list of names of women who had contacted me and wanted to participate in my research project; these potential respondents were mainly friends of those whom I had already interviewed.[15] Each respondent was formally interviewed only once. I phoned a few of my respondents to clarify particular pieces of information when questions surfaced during the process of transcription and data analysis. On one occasion, I ran into one of my respondents in the supermarket, so I took that opportunity to ask her a few questions.

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[15]It was a relief to actually end up with extra names should I need them. One phone call was particularly interesting. This woman wanted to participate in my research project because she had a fabulous birthing experience. She had a physician assisting her birth and thought that her input would be necessary because she believed most of the women would have only negative things to say and she wanted to help "equal out" my findings!

The anticipated time for each formal interview was 60-90 minutes, but in reality each lasted on average from one-and-a-half hours to three hours. It was quite evident to me that the women enjoyed talking about their birthing experiences. After the interview, each respondent was given my phone number so they would feel free to contact me if they forgot to mention something which was important to them, or if they had any further questions. I recall thinking every time the phone rang at home in the evening after an interview that it was my respondent. I was a bit disappointed when none of them called; I thought there might have been a significant event they had previously forgotten and wanted to tell me.

All respondents received a hand written note following our interview (for an example see Appendix F). I thanked them for sharing their experience, their knowledge and their time with me.

The tape-recorded interviews were transcribed verbatim within a week of the interview. Given my particular interest in the satisfaction of maternity care provided in the distinct categories, prenatal, labour and delivery, and the postnatal period- I decided it would be best if I manually examined the data for thematic content, using the grounded theory approach (Glaser and Strauss, 1967), rather than with the help of a software package. Although I chose a laborious process, it gave me the opportunity to relive the interview.

For simplicity, the women who had midwife assisted births are called midwives' patients or the midwife group, while the women who did <u>not</u> hire a midwife are called the physician group or physicians' patients. The transcripts from the two groups were analyzed separately. I read and re-read each transcript, highlighting key words as I went along. I entered the key words for each category on separate pages of paper designated as prenatal phase, labour and delivery phase, postnatal phase, and overall. Each page had three columns; one for responses from the midwife group, one for the physician group and one for the total number of responses for each key word in the four categories. Similar key words were condensed, and themes began to emerge. Huberman and Miles (1994) suggest that counting key words or themes enables the researcher to see "what's there" and to keep herself honest. Therefore, all of the key words within each theme were quantified, and

arranged within each of the four categories (see Appendix H). Lastly, the themes were ranked according to dominance in each category.[16] Tables were constructed to make the information manageable.

Quotes from each transcript were chosen to support the themes. Pseudonyms are used in this text to ensure respondent anonymity. In an attempt to assist the reader, all of the pseudonyms for respondents in the midwife group start with the letter "M," while the pseudonyms of respondents in the physician group start with "P." As mentioned earlier, one of the goals of this research is to empower women by giving them "voice," a chance to be heard (Kirby and McKenna, 1989); quotes from the interviews are therefore used extensively throughout the report of my findings in chapter five. If the respondents can recognize their voice in the research it is a form of validity. In an effort to confirm my findings from the in-depth interviews and to try triangulation, I attempted to arrange a postnatal focus group in my home to include all of my respondents. However, due to work schedules and the inadequate postnatal support many families received it became apparent that it would be impossible to gather all respondents together at any one time and place. The focus group was a good idea in theory, then, but it did not bode well with the demands of parenthood placed on my respondents.

4.7 Ethical Considerations

Prior to contact with potential respondents, my research proposal was examined and approved by the University of Victoria's Human Subjects Committee. Given the exploratory nature of my research project, I explained both verbally and in written form the nature and purpose of the research to the respondents. All respondents read the "letter of request to participate." I also asked them to read and sign the "letter of informed consent" before the interview began. I used no form of inducement, such as money or gifts, to obtain volunteers for my research project because I wanted women to participate for altruistic reasons rather than for reasons of financial or material gain. By giving women voice it gives them recognition as individuals. It may bring up both positive and negative experiences but it is important that they know their story is recognized and worthy of being

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[16]Despite the laborious nature of this process for data analysis I believe it was extremely useful for me. I felt much more familiar with the actual data and confident with my subsequent analysis. According to Kirby and McKenna (1989), the findings are reliable if the description truly represents what was found, and valid if the respondents are able to see their experience in the research report - these were my objectives.

heard.

I attempted to reduce personal harm to my respondents by avoiding embarrassing questions. I kept interview tapes, notes, and transcripts in a locked area in my office. Upon successful defense of my thesis, I plan to erase all interview tapes.

4.8 Summary

My readings of articles on research designs influenced my decision to follow the qualitative tradition. In an attempt to understand what the real issues were for the birthing families, it seemed to me that in-depth interviews were the logical instrument of inquiry. The data in my thesis were generated from in-depth interviews with twelve women of various economic standings in the Greater Victoria area. Six of the women were in the "midwife group"; each of these women privately hired a midwife to be their main care-giver. The six women in the "physician group" used their maternity physician as their main care-giver, and did **not** hire a midwife. All twelve of my respondents had experienced giving birth only once. Eleven of the twelve women delivered their babies in hospital, while one woman experienced a planned home birth. Midwives assisted the birthing woman during labour and delivery in the midwife sample; nurses assisted the women in the physician sample. All of the hospital-born babies were "delivered" by physicians.[17]

The interviews took place 6-18 months after they gave birth so that respondents had time to reflect on the entire process. Each interview lasted on average from one-and-a-half to three hours. Throughout the interviews and during data analysis I was influenced by the humanist-feminist perspective. I wanted to give my respondents the opportunity to speak about their birthing experience and to give them the opportunity to freely express both the satisfactions and the shortcomings of their maternity care without fear of retribution. I believe that by interviewing respondents in their own home it helped facilitate a less structured non-hierarchical approach to data collection and allowed unanticipated information to emerge. This method helped empower my respondents and allowed them some control in directing the interviews. I was also awarded an opportunity to observe

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[17]Midwives were not yet legal in British Columbia at the time these women gave birth; due to hospital policy,therefore, midwives were not legally allowed to "catch" the baby at birth. The home birth respondent had two midwives assisting her throughout the birthing process; she did not have a physician present.

nonverbal behaviour of my respondents which was relevant to the research. Allowing my respondents to speak freely helped make women's diverse birthing experiences known.

All of the interviews were transcribed and later divided into categories based on the prenatal phase, labour and delivery, postnatal phase and "overall." The transcriptions were then examined using the grounded theory approach. Key words were quantified, similar concepts were amalgamated and themes emerged for each phase of birth. Matrices and tables were created to make the information manageable. In the following chapter I discuss most frequently discussed themes for each group of respondents, followed by an analysis of the similarities and differences of my respondents' birthing experiences.

CHAPTER 5: PREGNANCY AND BIRTH: MY RESPONDENTS' PERSPECTIVES

This chapter examines my research findings on women's satisfaction with the maternity care they received from either midwives or family physicians throughout their birthing experience. The time-span of inquiry includes the prenatal, labour and delivery, and postnatal phases of the birthing experience. The chapter is divided into four sections. The first section examines the most frequently counted themes for respondents in the physician group for each phase of maternity care; section two examines the main themes for respondents in the midwife group; section three compares the similarities and differences between the dominant themes of the two groups; section four provides a summary of the full research findings.

5.1 Physician Group Respondents

In general, respondents in the physician group were fairly satisfied with the care they received. The degree of satisfaction differed, however, between phases of care. This group was most satisfied with the care they received during the prenatal phase. Patient satisfaction decreased during labour and delivery when respondents' physicians were not at their bedside to provide information, psychosocial support and/or tangible support. These respondents were most dissatisfied with their care-givers during the postpartum phase.

The main themes and sub-themes expressed by my respondents have been arranged in a detailed frequency distribution table (see Appendix H), according to phases of maternity care. Respondents also suggest barriers which they believe hinder quality maternity care as it presently exists in Victoria. Table 5.1 lists the most frequently occurring themes for respondents in the physician group according to phases of maternity care.

5.1.1 Prenatal Phase

Three main themes emerged in the prenatal phase of care for all respondents: (1) conversation and active participation; (2) woman-centred care; and (3) distress. (See Appendix H for detailed list of frequencies and sub-themes). In the prenatal phase, the most frequently counted theme for respondents in the physician group was woman-centred care.

TABLE 5.1: MAIN THEMES OF PHYSICIAN GROUP RESPONDENTS

Phase of Maternity Care	Main Theme	Responses
Prenatal	Woman-Centred Care	23
Labour and Delivery	Fears	17
Postnatal: in Hospital	Breastfeeding	15
Postnatal: at Home	Motherhood/Being a new mom	27
Overall	Care-Giver/Patient Relationship	6
Barriers	Problems with Physicians	9

Woman-Centred Care

This theme is called "woman-centred" because it involves respondents taking control over personal aspects of prenatal care (Midmer, 1992). Respondents in the physician group expressed a need for individual choice and decision-making in the prenatal period, particularly with regard to their own health and that of the fetus. Respondents exercised daily, attended prenatal classes, participated in the hospital tour, and monitored their nutrition.

The health of fetus and self were important for these women. Five out of six respondents in the physician group viewed prenatal classes as worthwhile. The interest in daily exercise and health of the self differed only slightly. Four out of the six women viewed the health of the fetus as important. Five of the six women expressed keen concern about nutrition. All of the respondents stated their physicians took only a perfunctory interest in this area, maintaining that their physicians were mainly concerned with bodily weights and measures.

Whether or not women attend prenatal classes, all birthing women and their coaches[18] were offered a tour through the labour and delivery areas of the hospital during

[18]In this thesis, a birthing woman's coach refers to the support person who helps them during labour and delivery. The coach is generally an unpaid lay person. My respondents used their partner, friend or mother as their coach.

the third trimester of pregnancy. The tour apparently helps to alleviate fears of the unknown and is particularly good for first time mothers who dislike or fear hospitals. All of the respondents who went on the hospital tour believed it was worthwhile.

The active participation and conversation theme was not discussed as much by respondents in the physician group as was the need for woman-centred care. In fact, only one of the six physician patients considered herself an active participant with her care-giver during the prenatal phase. The average prenatal appointment was fifteen minutes during this phase. As research has shown (West, 1984) appointments of such short duration do not facilitate in-depth conversation.

5.1.2 Labour and Delivery

In general, most respondents in the physician group liked the care provided during this stage. When patients perceived that their physician failed to make their patients' needs a priority, patient satisfaction decreased. The themes in labour and delivery include: fears, problems with communication, power, and coping strategies. The first three themes are negative themes which birthing families had to contend with during labour and delivery. In contrast, the fourth theme is considered positive because it involves the coping strategies used by birthing families during labour and delivery. Personal management of labour and delivery can help patients feel in control of the birthing event. Respondents in the physician group experienced problems of communication with care-givers because their personal physicians were either sporadically present or not at all. Respondents in this group did not have one specific professional care-giver at their bedside throughout the birthing experience. Perhaps because of this, the most frequently counted theme for respondents in the physician group during labour and delivery was fears.

Fears

During labour and delivery, respondents in the physician group were most fearful of the birthing event, of intervention, and of their physician not "being there" at the birth. Table 5.2 lists the pharmacological and technological interventions the respondents experienced. Except for tear and suture, the physician group received much more intervention than the midwife group. Respondents in the physician group were less fearful of labour and childbirth pain than they were of intervention(s). Perhaps the short-term pain of the intervention was easily overridden by the long-term benefits of pharmaceutical pain

relief. Many of my respondents in the physician group did not use natural methods of pain management, such as showers and massage, because they were invariably attached to monitors and machines. As Paddy stated:

> It wasn't as I had pictured it. I couldn't have a shower like I thought I would want to during labour because you are hooked up to all these tubes right, and once you get the epidural you can't even get out of bed to pee; they catheterize you.

TABLE 5.2: INTERVENTION DURING LABOUR AND DELIVERY

Intervention	Physicians' Patients (n=6)
oxytocin	4
nitrous oxide	4
demerol	3
epidural	4
episiotomy	2
forceps	1
tear and suture	1
cesarean section*	1

*one woman from each group who experienced a cesarean section was consciously chosen for comparative purposes

Two women in the physician group had drug-free births and were very proud of it. It appears that as the amount of intervention increased in labour and delivery, respondent satisfaction with the birth decreased. Like many women, Pam (in physician group) wanted to use as few interventions as possible. But,

> we ended up having all sorts of interventions. They ended up giving me an epidural which allowed me to sleep, and through the epidural they put in oxytocin to help you dilate... But my water still hadn't broke, and so they did that and then things sped up a bit...They ended up calling the obstetrician and doing a forceps delivery.... In the end, they said, 'oh good for you, you worked so hard and you didn't need a cesarean.' And I said, 'is that good, why didn't they just do a cesarean 10 hours ago?' But the staff, the nurses seemed to think that wouldn't have been a good thing.

Pam was disappointed that she had to have so many interventions; in the end, however, she

all but gave in, expressing a "why stop" kind of attitude.

Penny, however, had a cesarean section; of all respondents in the physician group she was the least satisfied with her birth experience. Penny felt like a failure for not being able to give birth naturally. Later, in the postnatal phase Penny and Pam lamented their misfortune and stated, "why me?, why didn't it work out the way I wanted?" Many of the women blamed themselves for their failure to deliver the baby as planned and the disappointment of not experiencing a natural birth.

Physicians are often able to tell patients ahead of time if they might not be there for the birth; alternative arrangements are then made for another physician to take their place. Four women in the physician group expressed fear that their physician would not be there for the birth. This particular fear contributed to fear of the birthing event for these women when their physician, whom they know and trust, was not there to guide them through the birthing process. Although not a great deal of time was spent with maternity physicians throughout the nine prenatal months, a relationship still developed and great trust is typically placed on physicians to help the women through the birthing process. As a result, women expect their physicians to be there.

Pam had to change physicians during her pregnancy. Then, after settling in with her new physician she was told there was a very good chance he would be away on holiday when she was giving birth. Pam expressed disappointment when neither her physician nor his locum were present during her labour and delivery. In actual fact, more times than not in my study, a woman's physician was not present during this peak event. Only half of my respondents in the physician group had their own maternity physician present at the delivery.

Labour and delivery for first-time mothers is often a long hospital-based process. As a result, they generally experience multiple shift changes of nurses, interns and attending physicians. Respondents in the physician group were less fearful of pain and the number of unfamiliar professional faces they encountered in the labour and delivery room than they were of interventions. None of the physician group mentioned fear of being in the hospital.

5.1.3 Postnatal Phase - In Hospital:

The postnatal phase is divided into two sections. I first examine the most common themes voiced by my physician group respondents while in the hospital setting, followed by the themes after they returned home with their newborn babies. There was quite a difference in the reality of the situation for respondents while in hospital compared to when they returned home. Soon after the birth, respondents were often overwhelmed; they would say: "Is this real?"; "Am I really a mother?" In hospital most of the respondents' needs were met. Respondents would panic as the check-out time grew near; they would say: "Do I have to take this baby home?"

The six emerging postnatal sub-themes most often voiced by respondents while in hospital were: (1) being encouraged to learn the "art" of breastfeeding; (2) coping with the physical and emotional recovery of giving birth; (3) coping with minimal support from over-worked nursing staff; (4) when reflecting on the birth experience, respondents often wondering "why me," "why did the birth experience not go as planned"; (5) the tender moments following the birth were often disrupted by hospital routine; and (6) the need for infant immunization. Of the six themes, breastfeeding was the central concern for respondents in the physician group.

Breastfeeding

Breastfeeding was the most frequently counted theme for in-hospital postnatal care for respondents in the physician group. The breastfeeding theme consists of three sub-themes: breastfeeding was a main concern; being encouraged to breastfeed; and learning the "art" of breastfeeding. Five out of the six respondents in the physician group expressed breastfeeding as their main concern following the birth. Respondents were overwhelmed by the fact that the little baby must be physically cared for, no longer does it simply co-exist inside mother. The new mothers felt a need to provide nourishment to their baby, but were unaware that after birth most babies are exhausted and need sleep. Most of the babies were not hungry nor were they interested in breastfeeding. Not surprisingly, most respondents panicked when their baby did not take immediately to the breast. Fortunately for most of the new mothers, nurses and lactation consultants were available to help them. All but one respondent in this group expressed concern that breastfeeding was not easy for her; that it was a "learned art." As one respondent stated:

> I was fighting with her [baby] in the hospital trying to get her to breastfeed from me. She didn't like it. So then one of the nurses saw what was going on. She got a bottle nipple and cut the nipple and made it like a real nipple that I had to stick on my breast to feed ____. And she liked that I tried sneaking it off of me and putting the baby back on my breast. But you couldn't trick her, you could not trick her at all. (Phyllis)

Although two other respondents, Paddy and Pam, were finally successful at breastfeeding, they felt there could have been more information and help:

> I had one lactation nurse come in the first time they brought him [baby] to me in the morning. She basically just showed me what to do and then left. I was on my own from then on... I mean they just kind of said, 'here's your kid, this is what you do, see ya.' (Paddy)

> She [nurse] wasn't helpful. She just complained all the time about how overworked she was, and she was unable to deal with everything. I would buzz and ask for something and she wouldn't come and I would buzz and she wouldn't come, and then when she finally did come she would just complain about how hard she was finding it. But all the other nurses were wonderful, and very supportive of breast feeding... I think that if it hadn't have been for some of them [nurses] I may have given up. (Pam)

While some of the women persevered on their own, other mothers admitted that if the nurses had not been so encouraging and supportive they might have given up trying to breastfeed. Two women from the physician group did not breastfeed in the end; for one woman the baby would not take to her breast, and for the other the breast was not full with milk when the baby needed to nurse and vice versa, so mother and baby gave up.

5.1.4 Postnatal Phase - At Home:

The transition to motherhood was difficult for many of my physician-attended respondents. Community support is available for mothers at Capital Regional District (CRD) offices throughout Greater Victoria. All women who have a hospital birth have access to at least one home visit from a CRD nurse. The need for help went beyond that which the CRD offers, however.

Transition to Motherhood

The transition to motherhood is divided into four sub-themes: (1) being a new mom is a big responsibility; (2) feeling scared, nervous and overwhelmed after arriving home from the hospital; (3) bonding with the baby; (4) coping with restructuring one's life.

My physician group respondents experienced numerous problems with the transition to motherhood. All six respondents related that they did not receive sufficient postnatal support. Five of them said they felt like they had no one to back them up when they returned home; they often felt alone. These five respondents felt alienated from the birthing experience; they no longer had the nurses from the mother-and-babe unit nor the other mothers in hospital of whom to ask questions; many of these respondents felt at a loss for support. All of the women in the physician group said they were scared, nervous and overwhelmed when they returned home. Five of the respondents were concerned about bonding with and keeping their baby content.

One of the greatest transitions, when the women were back home in a familiar environment, was coping with the restructuring of their own life, a life which was no longer their own. A comment which aptly explains how many of the physician-attended respondents felt was, "will I ever be my own woman again." Some of these respondents, without the professional help they desired, found it difficult to cope:

> If I could have had my postnatal care at home. It would have made a tremendous difference. I found being a new mom absolutely overwhelming...when I had to go out for my 2 or 3 week check up to the doctor with my baby, he cried all the way there and cried constantly in the doctor's office. We had a long wait and I wasn't fully healed [from the episiotomy]... I will never forget the experience, standing in the hall with him, trying to nurse him so he would stop crying, and he wouldn't stop, and people looking at me. (Pam)

Five of the respondents in the physician group experienced problems with restructuring their lives, a problem that the women had to deal with regardless of their social support network. Some household chores were provided by spouses or partners. They helped with the making of meals, doing laundry, and cleaning house while the new mother tended the baby. Yet the extra support for many of these respondents was short term only.

5.1.5 Overall

I asked my physician-attended respondents to recall the entire birthing experience and comment on the events or issues which stood out most in their mind and contributed to either a positive or negative birthing experience. Four main comments surfaced, varying by type of attendant: respondent being "in control"; respondent perceiving the patient/care-

giver relationship unequal or hierarchical; care-giver providing continuity of care and "being there" for the respondent (Table 5.6 see page 84); and infant immunizations.

The most frequently counted theme for respondents in the physician group was the perceived inequality of the relationship. All six of the women in the physician group felt that the care-giver patient relationship was hierarchical. The traditional medical model of care is based on an unequal physician-patient relationship, so when they said they felt like they were not being treated like an equal it was not surprising. Physicians are usually very busy and do not have the time to provide patients with the needed emotional energy to facilitate a non-hierarchical relationship.

The themes and frequencies from Appendix H are represented at a higher level of analysis in Appendix J (and Appendices K and L). Appendix J displays a matrix of the frequencies of co-occurring themes for respondents in the physician group. Only the themes with frequencies greater than five are included in the matrix, however. The matrix indicates the cell with the highest frequency is "being a new mom" (transition to motherhood) along with woman-centred care (frequency of 50). Due to space limitations in Appendix J, the transition to motherhood is referred as "being a new mom." The matrix indicates that six to eighteen months after respondents in the physician group had given birth, they were most preoccupied with receiving woman-centred care and the transition to motherhood. The self-assured feelings these respondents experienced with personal control over woman-centred care is contrasted with strong feelings of inadequacy during their transition to motherhood. This is followed by the transition to motherhood combined with fears of labour and delivery (frequency of 44). The postnatal transition to motherhood and respondents' fears during labour and delivery indicate two themes which represent negative experiences for respondents. The desire for active participation and conversation and "being a new mom" (frequency 38) is fairly high, which indicates a need for support. Frequencies of co-occurrence are also high for "being a new mom" along with: poor communication, poor nurse support, the need for help with breastfeeding, postnatal recovery, the need for postnatal social support, and problems experienced with physicians. The co-occurrence of these themes further supports my more general finding that these respondents did not receive continuity of care-giver support and social support during labour and delivery and the postpartum phase of the birthing experience. The transition to motherhood in the postnatal period was the most problematic for these respondents.

Overall then, respondents in the physician group were least satisfied with the human and social support they received from their care-giver, particularly in the postnatal phase.

5.1.6 Barriers

The perceived barriers which hindered effective maternity care and a positive birthing experience for respondents in the physician group were related to the caring labour provided by their primary attendants. These respondents perceived a distance between themselves and their physician, a distance which did not facilitate a trusting relationship. The lack of physician support during labour and delivery was viewed by many of my respondents as a form of uncaring. Here is how Pam put it:

> I'd have to say the major barrier hindering maternity care for me was the level of personal attention and personal connection with my physician. If it was someone I felt a really close personal connection with I would have trusted them more. I think I would have been more relaxed, more confident and uh, would have felt less alone in the birthing experience.... I needed someone that I wouldn't hesitate to call for help during the pregnancy... during the labour and delivery [,] feeling like someone was really concerned about your personal care and the health of the baby and afterwards, especially afterwards[,] someone that I could call when I was having trouble... To have someone come into the house and be able to just check the baby... to say yes don't worry... It would have saved so much trouble, rather than me packing myself and the baby up and having to drive somewhere and sit in the waiting room, and um if I thought a midwife could offer all of that, I would really think it would be perfect... I certainly couldn't call my physician for any emotional support... I don't know why I didn't seriously consider a midwife... But at the time I didn't know enough about it and, I guess, partly the fact that they are not um widely accepted in this province. I don't even know if they are licensed to practice or what ever...if they were though, I think that would have made a big difference for me, I think I would have gone that route because, emotionally, I feel that the potential for a better, more personal connection is there, and with that would maybe go a higher level of trust. (Pam)

And for Paddy:

> I would say the major barrier is over-worked staff. It's a busy place. For me I think it was my doctor's stand-offish attitude. It wasn't the actual birth itself, I don't know if it hindered the actual care itself. He was there and competent enough. It's just that there wasn't the connection with him that maybe a midwife could have developed. (Paddy)

5.2 Midwife Group Respondents

Overall, respondents in the midwife group were very satisfied with the care they received from their main care-giver - the midwife. A strong bond of trust was developed

between respondent and midwife early in the pregnancy for most of these women. Satisfaction with the care these respondents received seemed to increase with each phase of care. Respondents were very satisfied with the personalized care they received during labour and delivery and in the "at home" postpartum phase. The mothers in the midwife group seemed to enjoy the transition to motherhood.

The main themes and sub-themes expressed by my midwife-attended respondents have been arranged in a detailed frequency distribution table (see Appendix H). For simplicity, Table 5.3 lists the most frequently occurring themes for respondents in the midwife group according to each phase of maternity care.

TABLE 5.3: MAIN THEMES OF MIDWIFE GROUP RESPONDENTS

Phase of Maternity Care	Main Theme	Responses
Prenatal	Active Participation and Conversation	27
Labour and Delivery	Coping Strategies	16
Postnatal: in Hospital	Breastfeeding	15
Postnatal: at Home	Social Support during Transition to Motherhood	12
Overall	Continuity of Care/ "Being There"	6
Barriers	Problems with Physicians	11

5.2.1 Prenatal Phase

Respondents in the midwife group were very satisfied overall with their midwives' care during the prenatal phase. As mentioned earlier, the three main themes in the prenatal phase of care for all respondents include: (1) conversation and active participation; (2) woman-centred care; and (3) distress. Of the three themes, distress, the one negative theme, was the least significant for respondents in this group. Woman-centred care was important for this group, but at a slightly lower level than their need for active participation and communication with their primary attendant. In fact, as indicated in table 5.3, the most frequently counted theme for respondents in the midwife group in the prenatal phase was active participation and conversation (see Appendix H for detailed list of sub-themes and

frequencies).

Active Participation and Conversation

Respondents in the midwife group highlighted the positive aspects of interpersonal care they received from midwives during the prenatal phase. Human support from their midwife, especially informational and emotional support, was also appreciated. Included within this theme was: active participation of respondents in their prenatal care; respondents never felt rushed during scheduled appointments; midwife care-givers' provided respondents with extra information; respondents read books on pregnancy first and later confirmed the information with midwives; midwife met respondents' partner or labour coach more than twice, thus indicating the care-giver was interested in the family unit and not just the birthing woman.

All six of the midwifery patients believed they were active participants. One respondent from this group, Marla, put it like this:

> She [midwife] approached it from the point of view that I wanted the information, that I wanted to be an active participant in this whole process and not just going to my doctor and having him pat me on the head....Somebody in my prenatal class commented that I was the calmest pregnant woman and I swear that was because of _____ [my midwife].

None of the six women in the midwife group expressed feeling rushed during their prenatal visits. The average length of each appointment was 60-90 minutes. Many of the midwives would provide respondents with photocopied articles on fetal development and maternity care, information on nutrition, and videos on birthing. The open lines of conversation and sharing of information led to the development of friendships between respondents and midwives. A great deal of trust developed as a result of the time spent together during the prenatal months.

> Each visit was an hour to an hour and a half... [I] never felt rushed and we wouldn't talk only about the pregnancy; a friendship built up. (Marla)

Most respondents in the midwife group were accompanied by their partner / coach to their prenatal visits. The midwives help facilitate a family approach to prenatal care; midwives often came to their patients' home for prenatal appointments. When labour coaches meet and familiarize themselves with the attending midwife they become accustomed to the wants and needs of all three individuals. When labour begins everyone is aware of their

roles; they know the birthing woman's views on pharmaceutical intervention, whether she wants to attempt a natural birth; they also know the midwife's philosophy of care.

Given the active pursuit of woman-centred care and active participation and conversation with their midwives, these respondents were not particularly distressed during the prenatal phase. These respondents felt 'in control' and looked forward to the birthing event with anticipation.

5.2.2 Labour and Delivery

Respondents in the midwife group were very satisfied with the care they received during labour and delivery. Labour and delivery was divided into four themes: fears, problems with communication, power, and coping strategies. The most frequently counted theme for respondents in the midwife group was coping strategies. This theme is considered positive because it involves the coping strategies used by respondents during labour and delivery. All respondents in the midwife group indicated their midwife helped them to personally manage their labour and delivery such that they, the patients, experienced a sense of mastery or control. As noted in chapter one of the thesis, mastery is considered by some researchers to be the key to childbirth satisfaction (Humenick and Bugen, 1981). Humenick (1981) argues that the mastery model is an alternative to the implicit but commonly held notion that pain management is the key to satisfaction in childbirth. Personal control was defined by the women in Humenick's (1981:80) study as, "continuing to be able to influence the decisions made, not surrendering all decisions and responsibilities to care providers, but rather maintaining a working alliance."

Coping Strategies

Respondents in the midwife group tended to use non-pharmaceutical coping strategies more often than pharmaceutical strategies during labour and delivery. The five kinds of coping strategies in this theme include: (1) showers; (2) massage; (3) pharmaceutical pain relief; (4) family support; and (5) multiple birthing positions.

As indicated in Table 5.4, there are a myriad of ways to cope with pain and fear. The table indicates that more than half of the respondents in the midwife group tend to rely on non-pharmaceutical intervention for pain relief. Respondents in the midwife group often received interpersonal elements of care, particularly tangible support such as massage

and showers. In addition to frequent massage, showers were a common coping

TABLE 5.4: RESPONDENTS' COPING STRATEGIES FOR LABOUR AND DELIVERY

Pharmaceutical Coping Strategies	**Midwives' Patients (n=6)**
oxytocin	2
nitrous oxide	0
demerol	0
epidural	2
Non-Pharmaceutical Coping Strategies	
massage	4
showers	4
family support	3
multiple birthing positions	5

mechanism for four women in the midwife group. Marissa found warm showers to be a particularly useful coping mechanism when managing with labour contractions both at home and in hospital:

> It [having contractions under the shower] was really good actually, having the hot water pouring on you.... I would just tap my foot and I just kind of zoned and concentrated. If you are on a bed I think you would be thrashing about and stuff but I kind of had a purpose, it was having a shower...I had this whole sort of routine that I would do. (Marissa)

In addition, all respondents in the midwife group phoned their midwife in the advanced stages of labour. Midwives offered practical advice in the comfort of the womens' homes during the early stages of labour; they would sit and talk and pass time together.

> When I phoned her [midwife] she came right over. With a doctor, you might see them for five minutes. But they are not going to sit with you for twelve hours or whatever... She sat here from nine o'clock in the morning, she left for about twenty minutes at twelve o'clock; then she drove us to the hospital about three. She just sat there and read [in the bedroom] and talked to us and stuff, and checked

to see how much I'd dilated. She measured me herself. (Marissa)

Although in the end only one woman in the midwife group experienced a home birth, during the early stages of labour, four of the six women in the midwife group were open to trying a home birth. The women laboured as long as possible at home because they knew that once they were in the hospital their midwife would no longer be their sole care-giver. As Mona put it: "in a way I felt funny because it seemed like the minute we got in the hospital the midwives got put aside."

Three respondents in the midwife group appreciated the nurses who allowed family members to remain in the room to help them through labour and delivery. All of the women in the midwife group were permitted to try multiple positions during the birthing process. Allowing birthing women to experiment with positions gives them a sense of mastery and personal control. Given the respondents' need for control in the prenatal phase, it is understandable that they wanted to exercise personal control during labour and delivery as well. Communication between respondents and their midwives was characterized as being very open and supportive. This in turn reduced their fears. Respondents' fears were with the natural management of pain because they wanted to experience birth without technical and pharmaceutical intervention. Four of the six women in this group gave birth without pharmaceutical interventions; only two respondents did not deliver their baby as planned. All six of the women in the midwife group were supported by their midwife throughout labour and delivery. Thus overall, respondents in the midwife group were very pleased with the care they received from their midwife.

5.2.3 Postnatal Phase - In Hospital:

The six emerging postnatal sub-themes most often voiced by respondents while in hospital were: (1) being encouraged to learn the "art" of breastfeeding; (2) coping with the physical and emotional recovery of giving birth; (3) coping with minimal support from over-worked nursing staff; (4) reflecting on the birth experience, wondering "why me?," "why did the birth experience not go as planned?"; (5) the tender moments following the birth were often ruined by the nurses' need for adhering to the clinical routine; and (6) the need for infant immunization. Mastering the "art" of breastfeeding was the primary concern for respondents in the midwife group.

Breastfeeding

Breastfeeding was the most frequently counted theme for in-hospital postnatal care of the midwife group respondents (see Appendix H). Five respondents in this group expressed breastfeeding as their main concern following the birth. Similar to the physician group, these respondents were uncertain of their ability to breastfeed their newborn. Although these mothers had their midwife, nurses and lactation consultants available to help, all but one woman expressed concern that breastfeeding was not easy for her. In fact, Marissa was annoyed at the lack of support she received from the nurses when she first tried to breastfeed:

> I wanted to breastfeed her. I called the nurse and she was too busy to come help me so I had to figure it out for myself. I guess I wasn't on the high priority list... I definitely didn't get too much attention after the birth from the nurses. (Marissa)

While some of the women persevered on their own, other mothers admitted that if the nurses and midwives had not been so encouraging and supportive they might have given up trying to breastfeed. Respondents in the midwife group disliked the nurses' need for adhering to the "hospital routine." The tender moments following the birth were often ruined by washing and weighing the baby. Later, when respondents' midwives were gone and the new mothers needed support from the nurses, they were often not available.

5.2.4 Postnatal Phase - At Home:

The transition to motherhood was not overly difficult for respondents in the midwife group. In addition to CRD nurses and La Leche League, a non profit organization run by mothers who promote the benefits of breast feeding, respondents in the midwife group reported ample social support from their midwife. The main theme for respondents in the midwife group emphasized the positive aspects of midwife support during the postnatal phases.

Social Support

Respondents in the midwife group used various coping strategies in an attempt to deal with their transition to motherhood. For most of the women I interviewed, they were the first of their social network to have a baby. Their friends, therefore, could not be depended upon for advice nor to provide social support during this new life stage.

Most of my midwife group respondents used the CRD services offered to new

mothers. Three of the five women who had a midwife-assisted hospital birth had the CRD nurse come to their home. Some of the respondents found the CRD nurses helpful. Yet, surprisingly, there were a number of negative comments regarding the nurses' visits. Many of the new mothers, for example, felt like the nurses were intruding in their family. Pam sums up the midwife group respondents' mixed feelings:

> I think... that was kind of nice... you could phone her with questions... she came quite soon after [the baby] was born, and it was nice for the peace of mind. If I new she was coming, I would save up any questions. Although I didn't really like her [the nurse] personally, there was something about her, I felt she was patronizing... so it wasn't a perfect experience, but just the fact that they are out there in the field I think is nice.... In some ways I felt like it was a bit of an intrusion in my home... but I was glad that she was there to answer my questions.

Women who have home births are not on hospital records and consequently, are not placed on the CRD visit list. This did not concern Monica, however: "I didn't have any CRD nurses come to my house because I had a home birth... [I] wasn't on their list so they didn't pester me so that was kind of nice."

All six of the women in the midwife group approached their midwife, not the back-up attending physician, for advice regarding their newborn babies. The La Leche League was accessed in an attempt to cope with breastfeeding problems (see Appendix H).

A common theme voiced by my midwife group respondents was the lack of family support and advice from friends. None of these respondents relied on friends and family for support when they returned home from hospital. For many of them, extended family is no longer a strong support system; their families tend to be spread out geographically, well beyond immediate reach. Many of the respondents in this group indicated a friendship was established with their midwife. The midwives tended to take over the "helping" role traditionally occupied by family members, thus signifying changing models and definitions of family.

5.2.5 Overall

As mentioned in chapter one, a significant theme for respondents in the midwife group was continuity of care or "being there" - a theme which is misrepresented in Appendix H where it is listed as a single category. Continuity of care includes several

elements: (1) care is provided by the same care-giver throughout the nine prenatal months, labour and delivery, and the postnatal period; (2) the philosophy behind the care-giver's emotional and informational support is consistent; (3) the care-giver's role as patient advocate in hospital is consistent with the birthing family's goals set out in the prenatal phase. Care-givers "being there" for birthing families is an expansion of the concept continuity of care. As mentioned in chapter one, "being there" involves the relational interactions between birthing families and their primary birthing attendant, including the provision of holistic and tangible care (Driedger, 1993). The concept of "being there" includes all categories of positive support provided by main care-givers from the prenatal through to the postnatal phases of maternity care. The most significant positive relational interactions which represent "being there" for respondents in the midwife group include: (1) active participation and ample communication with midwife; (2) midwife provided a range of natural coping strategies; (3) they were encouraged and supported to breastfeed; (4) midwife provided social support during the prenatal and labour and delivery phases, and most importantly, during the postpartum at-home phase; (5) the midwife-patient relationship was perceived to be equal, and there was an element of trust between patient and midwife; (6) the midwife cared for the respondent in such a way that she felt like both herself and her baby were special. Together, these categories of positive support are seen to affect patient satisfaction with the maternity care they received.

At a higher level of analysis, the frequencies of co-occurring themes most often voiced by respondents in the midwife group are displayed in a matrix in Appendix K. Only themes with frequencies greater than five are shown in the matrix. The highest co-occurring themes for this group were woman-centred care combined with active participation and conversation with their midwives (frequency of 49). Both of these themes were represented in prenatal care. The co-occurrence of these themes indicates that respondents in the midwife group wanted to take an active role in the birthing experience at every stage in the childbearing cycle. The second most frequent co-occurring themes for the midwife group were active participation and conversation with coping strategies. This relationship indicates these respondents were active participants with their care-givers during the prenatal phase and during labour and delivery. Midwives provided their patients with coping strategies by communicating different options and by massage. The social support and tangible support received by these respondents enhanced their positive feelings of satisfaction with their care-giver and their birthing experience. The six highest co-

occurring themes for respondents in the midwife group involved active participation and conversation along with: learning the "art" of breast feeding (frequency of 42); fears in labour and delivery (frequency of 40); postnatal recovery (frequency of 39); and problems with physicians (frequency of 38). Based on these themes, receiving interpersonal elements of care and building a trusting relationship were important factors which contributed to patient satisfaction.

5.2.5 Barriers

Problems with physicians were considered by midwife group respondents as the primary barrier for maternity care (see Appendix H). These respondents expressed dissatisfaction because: (1) only physicians can legally deliver a baby; (2) only physicians' services are covered by medicare; (3) there are no legal alternatives to hospital births. Respondents in the midwife group suggested the need for midwifery services to be covered under medicare, the need for birthing centres, and the option for midwife-assisted home births. Mary and Monica believe the central hindrance to quality maternity care is the lack of birthplace options:

> Not having midwives being paid for um, not enough support for home birth, not enough support for home care... I think we need to take birth out of the hospital and bring it home. (Mary)

> We need birthing houses... Some people need the security of going to a professional establishment to have their baby but, ... they want to have the kind of care that a midwife gives as opposed to a doctor... You have to have the happy medium for those kind of people. But, at the same time, it should be legal to have a home birth; I mean essentially me having him at home is illegal you know... Western medicine treats pregnancy like a disease and they want to have a treatment for the disease. Well, it is not a disease and it doesn't need a treatment; it is normal. (Monica)

However, for Marla the barrier is physicians who see birth as their domain and turn it into a medical process. Mona suggests the main barrier lays in the care-givers' inability to work harmoniously together, specifically physicians refusing to work with midwives.

> I think there are not enough doctors willing to work with midwives. And I think that if they don't want to support home births, then they should have birthing centres. (Mona)

All but one woman in this group had to change physicians and find one willing to work with midwives. As Mary put it: "It sure makes a difference when you have doctors who are willing to work along side with midwives." When physicians and midwives work

harmoniously together it reduces undue stress for birthing families. Mona points out that:

> the fact that they [her physician and midwife] worked together a lot, I think was helpful. I think... stressful antagonistic situations would happen more if they [birthing women] had a doctor that was not open to working with midwives.

5.3 Similarities And Differences

Findings emerging from my work indicate both similarities and differences in the themes voiced by the two patient groups and their overall level of satisfaction / dissatisfaction with the services they received.

Similar Themes

Although the theme "why me" was not significant based on frequency, the tone of respondents' voices indicated that it was an issue that particularly troubled them. The theme "why me" relates to the women's postnatal comments on their birth experience. Three women in the midwife group and two in the physician group expressed the concern: "why didn't it work out the way I wanted." Many of the women blamed themselves for their failure to deliver the baby as planned, and personal disappointment of not experiencing a natural birth. Pam was most disappointed about a long labour and childbirth by forceps. The biggest disappointment for the women in the midwife group was the use of labour-enhancing drugs. For Penny and Marla, it was the cesarean section. These two respondents were the most disappointed of all.

> They decided that it needed to be a c-section. It was quite devastating. I still grieve over that. (Marla)

Table 5.5 lists the ten most prominent themes voiced by the women based on all emerging categories. The themes of the two groups differ in many of the categories; but, surprisingly there are similarities. Eight of the ten themes in each column in Table 5.5 are the same. Three of these themes are ranked alike and have similar frequencies. These three themes indicate that the desire for woman-centred care during the prenatal phase (second ranked theme); the commitment to mastering the "art" of breast feeding (ranked fourth); and problems with physicians (ranked eighth) are comparable.

Although both groups expressed a desire for woman-centred care, the two groups differed in the length of time and the degree to which they wanted to maintain personal

TABLE 5.5: Top Ten Themes Voiced by Each Group of Respondents

Rank	Physicians' Patients		Midwives' Patients	
1	Motherhood/ being a new mom	27 (3)	active participation and conversation	27 (1)
2	woman-centred care	23 (1)	woman-centred care	22 (1)
3	fears	17 (2)	coping strategies	16 (2)
4	breastfeeding	15 (3)	breastfeeding	15 (3)
5	problems with communication	14 (2)	fears	13 (2)
6	active participation and conversation	14 (1)	recovery	12 (3)
7	recovery	9 (3)	coping strategies/ social support	12 (3)
8	barriers: problems with physicians	9 (4)	barriers: problems with physicians	11 (4)
9	lack of support from nurses	8 (3)	problems with communication	6 (2)
10	coping strategies/ social support	8 (3)	"being there" pre to post natal (single category)	6 (4)

Legend: the number of responses for each theme is followed by the phase of maternity care in brackets.

i.e. 6 (1) represents **six** responses in the **prenatal** phase
6 (2) represents six responses in the labour and delivery phase
6 (3) represents six responses in the postnatal phase
6 (4) represents six responses in the "overall" category

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control. Both groups of respondents took an active interest in their own health and that of the fetus by exercising daily, attending prenatal classes, participating in the hospital tour, and monitoring nutrition. However, respondents in the physician group were less adamant about taking and maintaining personal control than were respondents in the midwife group.

Respondents in the latter group engaged in active participation and conversation with their midwife and used various non-pharmaceutical coping strategies in an effort to maintain personal control. Together these strategies and services are indirect indicators which support Bassingthwaite-Thiessen's (1993) concept of internal locus of control. Respondents in the midwife group, moreover, voiced a desire for a deeper relationship with their care-giver than that voiced in the physician group. Respondents relayed that their midwives were supportive of sharing control, whereas respondents in the physician group perceived their physician as not having the time nor the interest in sharing control.

Commitment to breastfeeding and difficulties accompanying mastering it successfully were similar for both groups. Although respondents in the midwife group had added encouragement and help from their midwives, it too was a stressful period for most of them. Respondents indicated the postpartum ward was often under-staffed and nurses over-worked. Nurses were repeatedly unavailable to assist new mothers who were eager to learn the art of breast feeding. This indicates a need for more lactation consultants, for breastfeeding videos, and for the availability of more literature on the topic.

Respondents from both groups also expressed concern over problems experienced with their physicians. For respondents in the midwife group this included the inability of many physicians to work congenially with midwives, and in the lack of their physicians' support for alternate, non-hospital, birthing arrangements. For the women in the physician group the hierarchical relationship with their care-giver was a significant barrier. Coupled with the unequal relationship was the feeling like appointments were rushed. Marissa's prenatal visits with her physician were quite different than with her midwife:

> [W]ith____ [midwife] I felt, she was even more help than I thought she would be. [At each appointment] she was a wealth of information. An hour was good and [the appointment] would even go over an hour. With my Vancouver doctor it was the minimum of care, but with the Victoria doctor I had, I never felt rushed when I asked him a question. Never felt like 'I'm running behind, you guys better go' kind of thing. He wouldn't just quickly answer something, even if I knew he was running behind. He'd say, 'oh by the way' and he'd stop and sit down and just go on and on.... But when you are pregnant and you have questions... if they are willing to sit back and answer, I shouldn't worry about them being on time.

As Pam put it: "you know if I expressed fears about things I always felt like he [physician] was pretty rushed - there wasn't time to talk about things." Communication with their attending physician was brief during the prenatal phase. Moreover, respondents'

physicians were often not present for their birth. Lastly, verbal support from physician care-givers was almost nonexistent for many respondents, especially during the postnatal period.

The similarities between the two groups are explored further based on the frequencies of co-occurring themes voiced by respondents in both groups. The frequencies are displayed in the matrix in Appendix L. Only themes with frequencies greater than ten are shown in the matrix. The highest co-occurring themes for the two groups are woman-centred care combined with active participation and conversation with primary care-givers (frequency of 83). The next highest co-occurring themes are woman-centred care combined with being a new mom (frequency of 78); breastfeeding combined with woman-centred care (frequency of 75); fears with woman-centred care (frequency of 75); active participation and conversation with being a new mom (frequency of 71). These theme combinations indicate that birthing women want to maintain a certain degree of control throughout the reproductive experience as indicated by woman-centred care and active participation. But at the same time they need to be reassured with physical and emotional support. The provision of support helps to: (1) reduce fears so birthing women can progress through labour; (2) facilitate breastfeeding after birth ; (3) facilitate the transition to motherhood in the postpartum period.

Dissimilar Themes

The most notable differences between the two groups were the first ranked themes, and the four dissimilar themes (see Table 5.5). The two themes in this table unique to respondents in the physician group include the negative experiences of: (1) poor care-giver support during the postnatal transition to motherhood, and (2) lack of support from postnatal nurses. In contrast, the two themes unique to respondents in the midwife group focus on positive experiences: (1) human support and tangible nonmedical coping strategies in labour and delivery, and (2) "being there" for respondents throughout the entire birthing experience.

Not only was the transition to motherhood a theme unique to respondents in the physician group but it was also the top-ranked theme. The transition seemed to be particularly problematic for respondents in the physician group. Most of the comments regarding the transition to motherhood were not positive, with twenty-seven comments

from the women in the physician group and six negative comments from the midwife group (see Appendix H). It is a negative theme in that respondents had trouble restructuring their lives after the birth, they felt nervous and overwhelmed by their new role, and they were concerned about bonding and keeping the baby content. These women felt unsure of themselves when emergencies arose. They questioned how to care for their newborn baby and their own personal recovery. No longer were the events beyond their control; instead the care of their infant was their own responsibility. The women stressed the need for help and confirmation that they were caring for their baby the "right way."

Physician group respondents reported postnatal support was not sufficient. Respondents in the physician group voiced repeatedly the inability to reach their physicians for information and support. Some of the women called their physician for advice; in every case, however, the call was either returned too late or not at all. Neither the women from La Leche League nor the CRD nurses could provide these new mothers with the support they needed. The lack of care-giver support fuelled the womens' anxiety and their low level of satisfaction with their new role as mothers. By comparison, the transition to motherhood presented few problems for respondents who had the assistance of midwives. One of the reasons for this difference is that midwives were available for their patients any time, day or night.

> The midwives came every day for the first 3 or 4 days and then they slowed down to once every 2 or 3 days for a while and then that was about it. But they made it very clear that if I had any questions I could call. (Mary)

As mentioned earlier, the postnatal support available to respondents was adequate but tended to vary, based on such factors as availability of staff and the number of beds occupied by new mothers. Both groups noticed the mother-babe unit seemed under-staffed and the nurses over-worked. The women in the physician group, however, seemed to notice the lack of support from the nurses more than respondents in the midwife group; this may be simply because physician group respondents did not have the additional support and encouragement from a primary care midwife.

The two themes from Table 5.5 unique to respondents in the midwife group were: (1) the provision of various natural coping strategies which help them progress through labour and delivery, and (2) the importance of midwives "being there" for respondents from the prenatal phase through to the at-home postnatal phase. Physicians were unable to

provide coping strategies for the women during labour and delivery because they were not at their patients' bedside most of the time. By contrast, midwives provided their patients with a variety of natural, non-medical coping strategies.

The themes mentioned earlier which represent "being there" are indicators of positive support, which according to my respondents, are seen to affect patient satisfaction with the maternity care they received. Table 5.6 provides a comparative analysis of the indicators of "being there"; it is quite clear from this table that the respondents in the midwife group received much more positive support from their midwives, than the respondents in the physician group did from their attending physician.

In contrast to the physician group, the top ranked theme for the women in the midwife group was active participation and conversation with care-giver, particularly during the prenatal phase; it is a positive theme based on proactive involvement with care-givers. These women felt it was most important to take an active role in the birthing experience, which in turn gave them a sense of empowerment. For these women, active participation began in the prenatal phase and was based on the give and take of information and open conversation, which laid the foundation for a trusting relationship. Birthing families who were active participants in prenatal classes and communicated with their care-givers not only empowered themselves with knowledge but were also more aware and self-assured throughout the birthing process.

In sum, these findings suggest that when birthing women do not receive continuity of care from their primary care-giver and share a similar philosophy of care throughout pregnancy, childbirth and postnatal care, their satisfaction with the birthing experience decreases, as does the level of trust they feel towards their main care-giver. My findings also suggest that the biggest difference in the womens' overall satisfaction with maternity services lay in the provision of postnatal care. The women in the physician group stressed that once the baby was born they felt like their physician no longer took an interest in their care. These women felt stranded and without reliable support systems. It is also interesting to note that both groups suggested the attitudes of the physicians and nurses had a negative impact on their birthing experiences. Most often these professionals were too busy to provide the needed services, particularly the interpersonal elements of care, including psychological and social interaction, courtesy, caring, promptness and

TABLE 5.6: "BEING THERE" - PRENATAL TO POSTPARTUM SUPPORT

Categories of Positive Support	Care-Givers	
	Physicians	Midwives
1. Maternity physician delivered their baby	3	1
2. Communication and Active Participation		
-active participant	1	6
-time: never felt rushed	2	6
-provided extra information	2	6
-care-giver met labour coach more than two times	2	5
3. Care-giver offered a range of natural coping strategies		
-family	2	3
-massage	0	4
-showers	0	4
-flexibility in birthing positions	3	5
4. Encouraged and supported breast feeding	5	6
5. Social support and coping strategies once at home	8	12
6. Patient felt like an "equal" in the relationship with their care-giver	0	6
7. Patient felt like they received pre to postnatal support from their care-giver	1	6
8. Patient felt like they and their baby were special, not like they were one of many birthing families	1	6
9. Patient trust care-giver throughout the entire birthing process	4	6
Total	**34**	**82**

comfort for the women. These care-givers sometimes lost sight of the fact that these birthing women were living human beings, and not simply a number such as "bed 28." As Penny said, "I think sometimes that they just forget that you are actually human and you're scared, and you know, sometimes they forget to explain everything because they are doing

this all the time." Moreover, the services and treatment the women received from hospital personnel seemed to differ based on the age of the birthing woman. The younger women in my research felt they were not treated as well by the nurses and specialists; this was less the case for older women.

5.4 Summary

The central purpose of my research project was to attempt to discover how satisfied birthing women were with the professional services they received from their maternity care-givers in Greater Victoria. Overall, respondents were satisfied with their birthing experience. The biggest difference between the two groups was in the provision of postnatal care. Midwives place an emphasis on the interpersonal elements of care. The provision of such care evokes a sense of trust with the care-giver, and it empowers birthing women. If the birthing experience proceeds according to plan, the birthing women are able to maintain a sense of mastery and control regardless of the care-giver. If women have a negative birthing experience, it is essential that they receive postpartum support. Based on my respondents' comments, the women who received ample social support in the postpartum period were the most adjusted to their new motherhood role. Respondents who did not receive adequate postpartum support experienced great difficulties in the transition to motherhood and in understanding why their birth experience did not go according to plan. For a few of my respondents, such unresolved feelings temporarily affected the bonding of mother and baby. Respondents in both groups indicated that physicians and nurses focus mainly on medical care, ignoring social-psychological needs of new mothers. As Polly says,

> I didn't have a good birthing experience... It was the post care that stands out the most, the nurses they were very harsh and cold and uninformative. They didn't care... The nurses focused more on medical care... and caring for the baby. I guess now a days, like I said, we don't have our families to give us that information other than how do we wrap a baby. Well, where do we get it? And then they complain about child abuse! I can really see that happening especially with young moms, that lack of knowledge... You know, your baby cries for 15 minutes, it is pretty upsetting; it is a life you are talking about, not a pet! Not knowing what to do or who to call, it can be very distressing... It is almost like they need a 911 hot line for new moms.... In our parents days there were always grandparents around, even to just reassure you like, 'that's normal', 'try this, try that, oh let me hold the baby - go and sleep.' Now a days, there are a lot of young families that don't have traditional family support or network. The hospital is just a place where the birth takes place and then you come home. Moms... are in and out the next day. The hospital is really just there for the safety aspect of it, to make sure the birth went OK, the medical controls are there - 'I'm fine, the baby is fine and

out you go.' (Polly)

Finally, the personal services and care offered by midwives were considered essential by respondents in the midwife group, in some cases services which respondents in the physician group stated they would have liked to have received.

In chapter six, I discuss how the findings from this study both support and contradict other contemporary studies on maternity care and the birth experience. Also included are suggestions for change in the provision of maternity services as voiced by the women I interviewed. The thesis concludes with an outline for future research.

CHAPTER 6: DISCUSSION

This thesis has provided an historical and cross-national account of maternity care for birthing families and the types of services they receive from maternity care-givers. The comparative analysis demonstrates some similarities but notable differences in maternity care provisions. The literature highlights two general models of care - the medical model and the midwifery model. Many countries in the developed world, including most of those surveyed in this thesis, provide choice of maternity care-giver during normal obstetrics. In Canada, however, choice until recently has not been available.

My study set out to examine patient satisfaction with maternity care and whether or not the ensuing birthing experience differed according to care-giver. My respondents spoke freely about their birthing experiences; this helped me determine what the real issues were for each group of respondents during the prenatal, labour and delivery and postnatal phases of care. I determined: (1) patients' overall satisfaction with the maternity care received; (2) which services were particularly useful for the birthing families and which services they considered inadequate; (3) whether or not patient satisfaction differed based on care-givers and their philosophy of care. My findings indicate that the two groups of birthing women expressed similarities and differences with the services they received, the services they desired, and the services they were denied. In this chapter, I discuss how my findings relate to those reported in my literature review on maternity care.

In chapter three, it was determined that effective maternity care goes beyond traditional measures of infant and maternal mortality and morbidity. Effective maternity care, then, is predicated on a variety of technical and interpersonal factors, all of which contribute to birthing families' overall level of satisfaction with the services they received (Koehler, Fottler and Swan, 1992). The framework used to explore effective maternity care in chapter three is utilized again in this chapter to examine my general findings in relation to the contemporary birthing literature.

6.1 Technical Elements

Mayes et al. (1987) and Norman (1989) reported reductions in the frequency of amniotomies, epidural blocks, forceps deliveries, and episiotomies when certified nurse-midwives are the primary care-givers. Mayes et al. (1987) conducted a study which

compared physician and certified nurse-midwife care. They found no differences in complications but found patients experienced very different care practices, with physicians' patients receiving at least 50 percent more intervention during labour.

Although my study is based on a small sample size (n=12), Table 5.2 (see previous chapter) lists the pharmacological and technological interventions my respondents experienced and shows that my findings support the conclusions of Mayes et al. (1987) and Norman (1989). Not only did the women in my study's midwife group receive less intervention during labour and delivery, but twice as many of them experienced drug-free, non-technologically assisted childbirth compared to the women who used physicians as their main care-givers.

6.1.1 Episiotomies, Epidurals and Forceps Deliveries

Kaufman and McDonald's (1988) research was based on two groups of women similar to mine; one group were cared for in a midwifery service and the remainder were under a physician's care. Their findings suggest the women in the midwifery group received massaging of the membranes in preparation for the birth much more often than did the other group. The women in the midwife group, however, had a greater frequency of lacerations or tears. In my study, twice as many women in the midwife group tore compared to the women in the physician group.

Kaufman and McDonald (1988) also found epidural rates differed based on care-givers, with midwives's patients receiving epidurals 15 percent of the time versus 44 percent for physicians' patients. My findings also support this finding as twice as many physicians' patients received epidurals as did midwives's patients.

Morgan et al. (1982) found that an unsatisfactory birthing experience was associated most clearly with long labours and forceps deliveries. One of my physician group respondents had a long labour followed by a forceps delivery; she expressed strong dissatisfaction with her birthing experience.

6.1.2 Cesarean Births

Culp and Osofsky (1989: 56) speculate that the dramatic increase in cesarean rates contributes to new parents viewing the procedure as an alternative method of childbirth,

and that some women view sophisticated tests and treatments as the hallmarks of a "proper" pregnancy. Klein (1987: 168), suggests the rise in technological intervention is because many obstetric specialists assist complicated pregnancies daily and therefore see birthing as risky and consider normalcy only in retrospect. Some of the women in my study regarded cesarean sections as an alternative method of childbirth but none would go so far as to call it a "normal" alternative. The word alternative suggests choice, when in fact the women who had cesareans were not given a choice of having the surgery; the obstetrician deemed the procedure as urgent for the mother, baby or both. All of my respondents made a distinction between giving birth naturally and birth by cesarean surgery. All of my respondents also planned on having a natural birth.

My findings support Graham and Oakley (1981) who suggest most first-time mothers experience great apprehension about medicalized reproduction. All of my respondents recalled being apprehensive about medicalized childbirth. All of them had wanted to try giving birth naturally first, before being assisted by any interventions, particularly birth by cesarean section.

My findings support Fawcett et al. (1992) who suggest unplanned cesarean births can be particularly upsetting for birthing families because their plans for a self-controlled birth are thwarted. Birthing women, in particular, often feel that they have failed, and hold a negative self image because of it (Fawcett et al., 1992). The two cesarean women in my study expressed feelings of this sort. One of these women maintained that she had also failed her spouse and midwife for not having a "normal" birth. Although birthing women express dissatisfaction with their inability to experience a vaginal birth, they also recognize the positive repercussions of their health and their baby's for having the cesarean.

6.1.3 Pharmacological Dependency

Morgan et al. (1982), suggest it is simplistic and incorrect to believe that effective pain relief ensures a satisfactory birth experience. One woman in my study firmly believed that pain control was a simple case of mind over matter: "If you could control pain this way you will have a satisfactory birth experience." She apparently did. The literature and some of my other respondents lend support to Morgan's (1982) perspective.

Eileen McNally Hutton (1985) argues there is often an inverse relationship between

the amount of pharmacological support and positive ratings of the birth experience. These positive ratings of the birth experience are often due to the women experiencing feelings of mastery and control (Humenick, 1981). My findings support this inverse relationship in that the women in my study who did not experience pharmacological (or technological) intervention were the most satisfied with their birth experiences; the women who experienced the most pharmacological intervention were the least satisfied. McNally Hutton (1985) found that when lay midwives are the main care-giver, the probability of using pharmacological support during childbirth is comparatively low, and the probability of women's reports of perceived control over the process is increased. This finding, as shown in the previous chapter, is also supported by my own data.

In summary, some birthing families desire technological and pharmacological intervention, while others do not. My findings support other evidence that a sizeable number of birthing families want alternatives to "conventional" obstetrical care, both in place of birth (Soderstrom, et al. 1990b; Tyson, 1991), and in the delivery of care (Stewart and Clark, 1982). The down-side to technological development in maternity care is the overuse of intervention. Many birthing women and midwives call for the appropriate use of intervention. Respondents in my research emphasized the desire for such a choice.

6.2 Interpersonal Elements

My findings support Green et al. (1990) who suggest that more attention should be paid to the subjective features of labour and delivery, including women's psychological state, their feelings of control during the labour process, and their view of the attending staff. The primary interpersonal elements discussed in the maternity care literature in chapter three and those emerging from my findings are: (1) human support; (2) continuity of care between birthing family and care-giver(s); (3) personal control; (4) adequate information; and (5) effective communication.

6.2.1 Human Support

The importance of human support during the nine months of pregnancy, labour and delivery, and in the postpartum period has been well documented. Actual human support can be defined as: assistance made available to an individual from an outside source which may aid them in coping with stressors; perceived human support is the way in which the labouring woman perceives her actual human support, her affective bonding with the care-

giver, her partner support, and her overall support from physicians and nurses (McNally Hutton, 1985: 11). Included within the rubric of human support are emotional support, informational support, tangible support and advocacy (Hodnett and Osborn, 1989). Human support provides an effective alternative to technological management of childbirth (Hodnett and Osborn, 1989). Birthing women's labour and delivery of their newborn in an unsupportive setting may have little effect on clinical outcomes; however, patients themselves may view the setting as highly important to their birthing experience (McNally Hutton, 1985).

My findings support Driedger (1993) and Humenick and Bugen (1981) who suggest that "being there" and mastery are a key factors in satisfaction with childbirth. All of my respondents expressed anxiety about their reproductive passage. However, anxiety for those in the midwife group was predominantly because of fear of hospitals, of losing control while confined there, and of managing the pain of childbirth without medication. The anxiety of my midwife group was reduced by their midwife being there throughout labour and delivery, and by providing physical, psychological, and emotional support to the birthing family. The midwives acted as their patient's advocate during labour and delivery and they helped their patients to feel in control of their birthing experience and feel a sense of mastery. My respondents in the physician group, on the other hand, were more anxious about the actual act of giving birth, about interventions, and about their care-giver not being there for the delivery. Midwives were always there for the birthing families but could not always help them control the events taking place in hospital; physicians were often not there for their birthing families, and thus also unable to help them gain control over the experience. I suggest that familiar human support to birthing women during labour and delivery can be extremely helpful in countering anxiety and facilitating a more positive birthing experience.

The general findings of my thesis support those of both Midmer (1992) and Thomson (1992); women who experienced more personable care during the childbearing cycle are more satisfied overall. All of my respondents who had technological interventions during childbirth were dissatisfied not only with the birth, but also with physicians and nurses who paid more attention to the technical apparatus than to themselves. A common complaint was also voiced about dissociated interest of their physicians, as indicated by reading the newspaper at the bedside during the patient's

labour, arrival at the last moment before they deliver, or not arriving at all.

6.2.2 Continuity of Care

The continuous presence of a support person was a significant indicator of satisfaction for the birthing women in Bramadat and Driedger (1993) and Hodnett's study (1983). Those respondents in my study who received continuity of care from their care-giver were most satisfied with their birthing experience. Respondents who received physician care found most of their care to be sporadic simply because their physicians were not there for them throughout the birthing process. Only one respondent in the physician group reported she received continuity of care. Respondents in the physician group found their prenatal care to be quite satisfactory. Despite the short prenatal visits, they believed they received adequate information. Yet physician care lacked in content and continuity during labour and delivery; for half of the women in this group their physicians were not present during their labour nor their delivery. The most traumatic experience for respondents in the physician group was the transition to motherhood in the postnatal period. All six respondents in the physician group related that their physicians did not provide the postnatal support they needed. In contrast to the physician group, respondents in the midwife group were very satisfied with the professional care they received. All six respondents in this group stated they received continuity of informational, emotional and tangible support from their midwife throughout the nine prenatal months, through labour and delivery and into the postnatal period. All respondents in this group commented on the benefits of their midwife acting as patient advocate throughout labour and delivery. The end result was that the postpartum transition to motherhood was less of an adjustment for respondents in the midwife group because of the social support they were given by midwives.

6.2.3 Personal Control

As stated in chapter three, personal control is most often referred to in terms of either the locus of control or self-control. Bassingthwaite-Thiessen (1993) suggests that women who choose an alternate birth site have a more internal locus of control; they perceive themselves as the determiner of control, and they hold significantly stronger attitudes towards issues of choice specific to their childbirth experience than do the women who choose a hospital birth. Although my research did not specifically test locus of control (see also Fullerton, 1982), my respondents did hint at issues which can be loosely

categorized along the lines of personal choice and control. My findings suggest that respondents in the midwife group were similar to those in Bassingthwaite-Thiessen's alternate group; they held stronger desires than their counterparts in the physician group regarding personal control over their birthing event. This was achieved through active participation and conversation with their midwife.

My findings support Kitzinger (1988) who suggests that women who experienced very controlling physicians likened their feelings to those associated with women who have been raped or otherwise violated. Two women in my research expressed very similar feelings. These respondents believed the obstetrician and anesthetist were so preoccupied with hospital procedures that they failed to adequately inform respondents as to what they were about to do. Communication between patient and care-giver was inadequate. The concept of control was one way - the professionals' way.

Finding an appropriate care-giver/patient relationship can often be very difficult when personality differences and variations in knowledge are taken into account. Respondents in my study who were active participants in their care regime and desired to share control and decision-making with their physicians, were generally happy with their care. Not all maternity physicians, however, were comfortable with this type of relationship. My findings support Deana Midmer (1992) who contends that the unequal balance of power in the physician-patient relationship, coupled with an aggressive obstetrical management and a persistent orientation to technology, disempowers many women patients; they are placed in a position of subordination to their physician care-givers. My physician group respondents suggested they received basic information from their physicians during the prenatal phase. These respondents would read additional information and cross-check with their care-giver during appointments. Prenatal check-ups for this group were structured more on weighing respondents and measuring the baby's growth than on maternal needs. Respondents in the physician group generally did not have the opportunity to share decisions and control with their care-giver. Midmer (1992) suggests women resenting this management style of maternity care often seek midwives who want to empower their patients with knowledge, confidence and control. Essentially, respondents in the midwife group sought and received the latter type of care.

My findings support Burtch (1994a) in that individual acts of personal control and

empowerment against medicalization occurred when some of my respondents deliberately delayed their entry to hospital to thwart the interventionistic approach by hospital staff to managing birth. Some of my respondents attempted to empower themselves by taking extended showers or walks in hospital to obtain greater privacy and motion during labour. More respondents in my midwife group exerted personal control in hospital and sought tangible support such as showers and massage from their midwives than the other group did from their physicians.

6.2.4 Adequate Information

For the most part, my findings support Morgan et al. (1982) who suggest that less anxious, well-supported mothers require less analgesia and have fewer complications in labour. My findings also support Bennett et al. (1985) who suggest that the more hours women spend at childbirth classes, the less likely medication will be used during labour, resulting in greater satisfaction overall with the birthing experience. All of the women in my study attended childbirth classes. The women in the midwife group, however, received additional knowledge from their midwives at their privately-organized prenatal appointments. The women in the midwife group also received much more support during labour from their main care-giver (midwives) than the women in the physician group; in turn midwives' patients expressed greater overall satisfaction with their birthing experience. It may in fact be that increased knowledge through prenatal classes and other channels, including midwives themselves, and receiving continuous support by a single care-giver, reduces the likelihood of dependence on pharmacological drugs and technological intervention.

Susan Hetherington (1990) examined the effect of prepared childbirth classes on obstetric outcomes. Her findings suggest that compared to birthing women who do not attend prenatal classes, couples who attend Lamaze classes are more prepared for childbirth, are more likely to receive little or no pain medication, and receive less induction anesthesia. As all of the women in my study attended prenatal classes of some sort, I do not have any non-class attenders to compare, but in general my data support her findings; the more educated the women in my study were with birthing knowledge, the less likely they were to allow interventions. My findings do not support Sturrock and Johnson (1990: 83) whose findings suggest a significant difference does not exist between prenatal class attendance and reduction of interventions during labour and delivery - in fact, the

cesarean section rate for attenders in their study was 38 percent compared with 29 percent for non attenders of prenatal classes. Sturrock and Johnson (1990) also found a significantly higher percentage of prenatal class attenders were older, better educated and of higher socioeconomic status. Again, in contrast, the prenatal class attenders in my study were of various ages, socioeconomic statuses and levels of education.

My findings support those of Lena et al. (1993) who suggest age-appropriate classes are needed for pregnant adolescents because of the differences in age, education levels and in their domestic relationships. Two respondents maintained it is important that prenatal classes be designed for women of various ages and backgrounds, including teen soon-to-be mothers. Both respondents related that pregnant adolescents are often hesitant to ask questions because of the general knowledge gap between them and older more educated women in the prenatal class. Ten of my respondents viewed their prenatal classes as more appropriate for "traditional" families. Moreover, they felt excluded because they tend not to be in a "couple" relationship. Transportation is often another barrier for teenage single pregnant women, many of whom do not have a drivers license and/or access to a vehicle. The younger unattached respondents in my study experienced problems getting to and from prenatal classes and the pre-arranged hospital visit; this was particularly so when the prenatal classes were late at night when buses are less frequent, which often meant waiting alone in the dark.

Butani and Hodnett (1980) found a relationship between educational preparation and whether or not "control" was important to their respondents. All of the respondents in their study who did not mention control as important, did not have a university education. Based on my findings, I am inclined to agree with Butani and Hodnett (1980) in that educational preparedness and a woman's desire for control are related; both appear to be significant variables in contributing to a positive birth experience. Regardless of age, socioeconomic status and formal education, most respondents in my study attended prenatal classes to increase their birthing knowledge, and to reduce their feelings of fear, doubt, and ignorance. In turn, this provided them with a perceived sense of control, a better ability to communicate with their care-givers, and enhanced their chances of a humanistic birthing experience. In my study there were differences between physician and midwife assisted groups in regard to overall knowledge. Respondents in the midwife group received from their midwives information beyond that provided at prenatal classes.

This was particularly crucial for respondents who were young, unattached, less educated and/or timid in large public group settings. The midwives of my respondents typically scheduled each appointment for 60-90 minutes, which greatly contrasts to the 15-20 minute physician group's appointments. Thus, time spent with care-giver has a bearing on patients receiving adequate information and building a trust relationship.

Everitt et al. (1993) explored the postnatal experience of new mothers in Australia. Their findings indicate that it was particularly important for patients to receive consistent information from their care-givers during all phases of birthing. These women were less concerned about postnatal complications and infant illness than taking on the parenting role. Socio-emotional issues were emphasized including support in the transition to parenthood (Everitt et al., 1993). My findings support Everitt in that many of my respondents desired socio-emotional support and many of them also found the postpartum period to be the most difficult phase of adjustment. Neither group received much support from family members. As discussed in chapter five, the transition to motherhood was particularly problematic for respondents in the physician group. These women were less able to cope with their new role than the women in the midwife group because they did not have the social support from friends or their physician. In contrast, the transition to motherhood was not as difficult for respondents in the midwife group; these women received much social support from their midwives well after their babies were born. Midwives provide home visits to check mother and baby. As the frequency of the visits decreases, mothers have the option to call their care-givers any time, day or night. Although the mothers related that they were careful not to misuse this option, they experienced peace-of-mind knowing help was only a phone call away.

6.2.5 Effective Communication

Recent studies (Drew et al., 1989; Sequin et al., 1989) indicate that participation in decision-making and explanation of procedures are also important factors associated with maternity care satisfaction. A Canadian obstetric study (Sullivan, 1987: 648) concluded that, "physicians can improve satisfaction levels by improving physician-patient communication and continuity of care, by offering explanations about medical interventions and by honouring choices made by women before their delivery." The honouring of choices is predicated on establishing and maintaining open lines of communication and listening to patients' needs. In contrast to the situation of many maternity patients who use

physicians, communication between midwives and patients is often characterized as being an open, two-way process. Women who use midwives often comment on the extensive and useful information they receive; they tend as well to emphasize the counselling and supportive role their midwife performed for them (Soderstrom et al. 1990a). These findings are likewise supported by Yankou et. al. (1993), who recommend that certified nurse-midwives provide significantly more "teaching" during office hours than physicians, and that physicians rely on other staff members such as nurses or specialists to answer their patients' questions.

Lending further evidence to this reported difference between physician and midwife communication capabilities, Candace West (1984) and Joseph Kess (1988) found that physician-patient relationships are essentially asymmetrical and that communication between physicians and patients is often problematic. West (1984: 24) suggests that physician-patient communication can be enhanced by physicians using lay terms when relating to their patients and extension of the usual 10-15 minute physician visits so that patients are no longer rushed, thus having the time to express their concerns. These measures would encourage conversation between physicians and their patients, better enabling patients to comprehend the information given to them, and to make informed decisions regarding treatment and care. The end result is that birthing women and their families are empowered rather than constrained. These aspects of communication - open lines of communication between patient and care-giver, explanation of procedures, allowing adequate time during prenatal visits for patients to express their concerns without being rushed, answering patients' questions to the extent that patients are satisfied - are central tenets of the midwifery model, and according to my respondents, they are the elements of care that contribute to patient satisfaction and a positive birthing experience.

Respondents in my midwife group did in fact receive adequate information, communication, and human support from their midwives. These women enjoyed the benefits of continuous care between themselves and their midwife, and the desired degree of personal control from the prenatal through to the postnatal period of their birthing experience. Respondents in the physician group received adequate information in the prenatal phase; these women, however, did not receive the human support or continuity of care throughout all phases of care as they would have liked. Communication between respondents in the physician group and their care-giver was not particularly effective

overall.

6.3 Summary

Both the literature and my findings suggest maternity patients desire a positive birthing experience that includes on the one hand, safety for mother and infant, but also a rewarding birthing experience for the family. Birthing families differ in the degree to which they require technical and interpersonal care, and indeed in regard to locus of control. This appears to be the case for care-givers as well. Physician care-givers tend to place less emphasis on the interpersonal elements of care during pregnancy and birth than do midwife care-givers. Women who received physician-care emphasized the need for more human support and continuity of care from their care-giver during labour and delivery, and especially postpartum. The lack of physician support and attendance during labour and delivery created undue stress for birthing families. The lack of human support, information and communication in the postpartum period made for an anxious transition to motherhood for mothers under physician care. Birthing women who received midwife-care were generally guaranteed care which emphasized interpersonal elements of care; technical elements of care were provided only when deemed necessary by either their patients or the attending obstetrician. Regardless of care-giver, birthing patients are most satisfied with their birth experience and ultimately their care-giver when their needs are met. It is the social context of the care and birth that is important. Match between care-giver services and patient needs and concerns is the fundamental point; hence respondents' desire for a particular **model** of care rather than a particular care-giver.

CHAPTER 7: SUMMARY AND CONCLUSION

7.1 Summary

Sociological studies of maternity care have traditionally focused on the central role of physicians (Parsons, 1975) and hospitals (Starr, 1982), overlooking to a large extent alternative care-givers (Benoit, 1991) and ultimately the perspective of patients themselves (Everitt et al., 1993). These gaps in the research literature on maternity care are now being addressed. This thesis addresses the gaps related to studies of midwives as alternative primary attendants to birthing families. A number of studies have also highlighted the dilemma patients face during uncertain events such as pregnancy and childbirth which are typically organized within a medical model (Rothman, 1982). Yet very few studies attempt to examine the patient's views of care-givers not merely during birth itself, but across all stages of the birthing cycle. This has been the research project upon which this thesis has been based.

The birthing stories of two groups of women from Victoria, British Columbia were examined to determine their relative satisfaction with existing maternity care services. Birthing families in Victoria have only two options in terms of care-givers and place of birth. Physicians are the dominant maternity care-givers in B.C.; they care for approximately 99 percent of the birthing women and deliver babies in the hospital (Burtch, 1994). The alternative alegal option since the 1970s has been maternity care by private community midwives; these primary maternity care-giver deliver approximately 1 percent of B.C. births. Provided there are no complications, most midwives and their patients prefer to have birth take place in the home, although only about .1 percent actually do so (Burtch, 1994). Home births are sanctioned neither by the medical profession nor the general public. Consequently, very few women experience a planned home birth. Almost all pregnant women in cities follow physicians and their choice of workshop, the hospital. Yet there can be a substantial difference between one hospital birth and another; the difference can be attributed both to the birthing woman and the primary care-giver. Midwifery care in B.C. is currently undergoing a process of legalization.

My study examined both of these types of care. The models of care which were examined do not support one model over the other, but were used to exemplify a certain kind of care. These models of care were included as theoretical ideal-types used to guide

the interpretation of the themes generated from the data. The findings indicate there are significant differences and overlap in the maternity care services birthing women receive, some of which are attributable to the care-giver option that they choose. This is not a thesis promoting midwives' care over physicians' care. Rather the preferred style of maternity care voiced by my respondents matches many of the elements of the midwifery model outlined in chapter one of this thesis.

My findings suggest the two groups of women were generally satisfied with the services provided by their care-givers. The two groups were similar in the emphasis placed on the need for assistance in mastering the "art" of breastfeeding and the importance of postpartum support. Significant differences between the groups surfaced, however, concerning other aspects of respondents' care. Physician-assisted women tended to be most satisfied with their prenatal care. These women did, however, notice gaps in the medical care they received. Women in the physician-assisted group pointed out that communication with their primary attendant was a problem, as was lack of tangible and psycho-social support. They experienced decreasing satisfaction with their care-giver as they progressed through labour and delivery and into the postpartum period. Most respondents with a physician as primary care-giver felt they did not have a patient advocate during this vulnerable yet significant life event. Many of the women in the physician group, in brief, complained that their physician was not "there" for them. Care-giver support was significantly lacking during the at-home postpartum phase, which in turn, made the transition to motherhood particularly problematic for the mothers in the physician-assisted group. In contrast, the midwife-assisted group tended to stress positive themes, reflecting the relatively strong support they received from midwives. Respondents reported that midwives were "there" for them; not just during labour and delivery, but across all stages of the reproductive cycle.

My research findings suggest that private Victoria midwives provide maternity services that differ in many ways from those provided by maternity physicians. By collecting data from two different groups of birthing women, the comparative midwife group shows that the gaps mentioned by the physician group are filled by the care provided by midwives. The main difference between the two groups was in the provision of postnatal care by their primary care-giver. These findings are not highlighted in the contemporary birthing literature.

Over the past few years certified midwives in Canadian pilot projects have been particularly successful in demonstrating their skills and mastery in supporting women during birth. The result has been a shift in the public view of midwives as primary attendants to birthing families in B.C. and Canada at large. It is evident that birthing women want a choice of care-givers, including the option of midwives as primary attendants.

7.2 Conclusions

The delivery of health care services is an issue of interest to patients, researchers, and providers alike. During the last decade, provincial governments across Canada have placed an increasing emphasis on restructuring health services so that they are both sensitive to the public's needs and cost efficient. The preceding chapters have demonstrated that although other developed countries may be similar to our own, the provision of maternity care, in particular, differs significantly across national borders. Chapter two explored the differences between maternity care services provided for birthing families in Canada, the United States, Britain, the Netherlands, Sweden, and Denmark. At the time of the research reported in this thesis, the elements of care my physician-assisted respondents desired are in fact provided by midwives who work in health services surveyed in most of the case studies mentioned above. The Swedish, Danish, Dutch and to a lesser extent the British systems of maternity care provide different models from which Canadian maternity care-givers and health policy makers can gain insight for a better system of maternity care.

Britain restructured its National Health Service in the 1980s in the direction of a rational efficiency model. Many small maternity units were closed or replaced by large centrally located hospitals. One result was increased fragmentation of maternity care services, with birthing women receiving care from a variety of professional strangers. In an attempt to address the problem of fragmentation, a "shared care system," which incorporates the work of nurses, midwives, physicians and obstetricians, was recommended (Walker, 1972). However, the changes to date have not proven favourable for birthing families nor for British midwives, both of which are affected by lingering medical dominance. British midwives are often forced to assume the role of assistant to physicians rather than an equal role in patient care. The "share care system" appears to

have had better results in the Netherlands, where midwives and obstetricians each have their allotment of maternity patients, and maternity assistants help midwives' patients during the postpartum period. The down side of the Dutch system is that patients have to pay personally for unanticipated hospital services. The increased prominence of obstetricians in the Dutch system, moreover, may mean more birthing women will be diagnosed with medical complications (as mentioned earlier about the Canadian and U.S. cases), thereby placing reproduction in the medical model. Obstetricians have less centrality in normal reproduction in the Danish case. Yet dissension nevertheless exists there between midwives and physicians concerning the boundary between normal and abnormal.

In sum, the "shared care system" is attractive in principle, but it does not always ensure harmonious work relationships among maternity providers. When patients recognize the animosity between care-givers, it can be stressful for the patients and ultimately can compromise the care they receive-- a theme which became evident in this study. The comprehensive state-organized health system provided in Sweden is decentralized and exemplary. There is little reported tension between obstetricians and midwives in Sweden. The neighbourhood mother-care centres are operated at the community level by salaried midwives. There is, however, no provision for home-births and there are few birthing centres. These are options which some of my respondents articulated, as have Canadian midwives and activists in Canada at large.

Various royal commissions in Canada have, indeed, attempted to address problems in the provision of health care directly, and the provision of maternity care indirectly (see Appendix I). Most recently, in B.C. a Royal Commission on Health Care and Costs recommended maternity care "closer to home." The first step for maternity services is the legal recognition and support of registered midwives in all Canadian provinces and territories. The provision of midwifery services in decentralized care centres would also address the fundamental principles of the Canadian Health Act. Salaried midwives would ensure universality and comprehensive coverage; neighbourhood mother-care centres would ensure accessibility; the legal status of midwives in all Canadian provinces and territories would ensure portability of care; and provincial public administration would ensure that these services are covered under Medicare.

Restructuring of maternity care in this way would likely help to demedicalize normal life events, including pregnancy and childbirth. Provision of demedicalization would also likely empower women by granting them an element of control over their reproductive experience.

7.3 Further Research

Given that one of the recommendations emerging from these findings is greater choice of maternity services for all Canadian women, sociological investigation of emerging midwifery styles across Canada is timely. As mentioned above, other Western countries provide examples of health care systems where midwives are held in high regard, in fact appearing to provide superior maternity care than that presently provided by Canadian physicians.

Further research is also recommended in order to correct shortcomings of my exploratory study, including its small-scale design and expanding the temporal dimension to include interviewing women during pregnancy, immediately after birth, and eight months postpartum. Longitudinal research would be able to capture women's expectations and their actual experience. Canada has a tremendous variation in landscape and ethnic diversity among its' people. My research was conducted in a city that has a comparative high standard of living and relatively little ethnic diversity. This urban population is not representative of the rest of the province, let alone the rest of Canada. The birthing experiences of different ethnic groups would allow a future researcher to gain insight into complex issues shaping the public's view of maternity services.

Further research is also suggested on the birthing experiences of teen mothers. The few younger respondents in my study mentioned that they were not treated with the level of respect they desired from the nurses and physicians that attended them. These respondents also stated their need for prenatal classes tailored to meet their own concerns.

My findings indicate an urgent requirement for an extension of formal professional care into the postnatal period. Midwives or even maternity assistants, similar to those common in the Dutch system, could provide a beneficial service for birthing families in Canada during this vulnerable period of transition into parenthood. Further inquiry is needed into the viability of such assistants in the Canadian context. Given the need

expressed by my respondents for continuity of care throughout the birthing experience and for social support in the postpartum period, it is possible that birthing families in British Columbia, and the rest of Canada, could be well served if such services existed.

It is clear that some birthing families, including many in my study, desire effective care based on a midwifery model. Yet there is a danger that midwives' services may become part of the lower rung of a two-tier system. If midwives are able to provide cheaper care, they may end up caring for the disadvantaged women only (as with most nurse-midwives in the United States today), while physicians care for wealthier patients (Blair, 1995). Native women of B.C., for example, have expressed this fear. On the other hand, legalized and fully-funded midwifery services could expand choice and move Canada closer to counterparts in Europe regarding effective maternity care.

A College of Midwives has been established in B.C. and it is creating licensure programs. Midwives in B.C. may soon be a part of the Medicare Plan. In light of these developments, future research should document whether or not midwives do indeed provide maternity care services that fill in the gaps left by physicians, particularly in a more cost effective manner. There exists a central contradiction between the government's and the public's perceptions of the long range goals of health care and maternity care. Governments will be increasingly challenged to provide a higher level of care desired by its citizens, at the same time those same citizens want balanced provincial budgets.

7.4 Policy Suggestions

Based on the findings from this study, it is clear that there is need for a process of change. This thesis suggests empowerment of women begins with enabling them to take control of their body and with the passing on of information. It is essential, then, to redesign reproductive health care in order to acknowledge women's strength, to diminish women's oppression, to give them a sense of mastery, and to give them choice of maternity care-giver. As stated earlier, further inquiry is needed regarding the provision of postnatal care for new mothers. Therefore, I suggest that mothers receive a higher level of postnatal support, the form of which could be determined from additional research. Most first-time mothers expressed a need for only the information that is immediately required. In prenatal classes, birthing families only want to know how to get through the birthing process. I suggest that care-givers give their patients a ready-made package of postnatal

information when they are transferred from the birthing room to their room in the "mother-babe" unit.[19] The packages should include tips and information on the following: patient postnatal recovery, such as bleeding and clotting after birth; the care of episiotomies; the care of cesarean stitches; strategies to enhance success at breastfeeding; how to care for the newborn on a daily (and nightly) basis. Although there are numerous books available in stores, many first-time mothers are so overwhelmed by their new role that going to bookstores seems like an impossibility. Some women do not like to read, others are illiterate. Lastly, it is important that, in the future, the services rendered are as effective and supportive of birthing families as possible.[20] Both midwives and physicians should be informed if their services are satisfactory and/or which services could be improved.

In conclusion, this is no doubt an exciting time in the evolution of the provision of maternity care in Canada. Many outdated traditions are coming under increasing challenge and new ways of providing more effective care are emerging to take their place. The medicalization of care which characterized the majority of this century is giving way to a more patient-centred model, delivered in a manner responsive to the individuals' needs and desires. This thesis has attempted to give voice to birthing women regarding the choice of maternity care-givers. It is clear that they find satisfaction with midwives in private practice and hope that other patients will receive a similar level of care when midwives enter the provincial public health system.

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[19]The "mother-babe" unit in the Victoria General Hospital is particularly good in terms of supplemental information. They have informative videos available for all patients on various topics such as crying, bottle feeding, breastfeeding, and infant development. The hospital also has a special channel on the television which continuously plays similar but shorter postnatal information programs. They also provide a television guide for this special information channel so that patients can schedule their day and choose programs which suit their needs. Yet sleep deprivation often hampers patients' ability to take advantage of these services. Moreover, not all of my respondents knew about this service. This indicates a need for better communication between patients and nurses in the mother-babe unit of this particular hospital.

[20]At other times and places seeking out family members would be another option but given the urbanized and mobile character of present-day Canadian society, this option is unlikely to be viable for many families.

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APPENDIX A: INTERVIEW GUIDE

Number of Respondent _____

Date of Participation in qualitative interview:
day/month/year _____

Time began _____ Time ended _____

Place of Interview: _____

Date baby was born: _____ (month/day/year)

Section 1: Client's Perspective on the Care Received

- Primary maternity care-giver
  Probe: -how did you decide
  -partner/friends/informal contacts
  -if midwife
  -reason for choosing
  -payment
  -if physician, was (s)he a GP or an OB

- Prenatal Care
  Probe: -time per visit
  -main concerns
  -adequate information
  -decision making
  -expectations met
  -partner's relationship to care-giver(s)

- Labour and Delivery
  Probe: -main concerns
  -adequate information
  -decision making
  -flexibility in birthing position and place of delivery (ie. birthing rm or delivery rm)
  -expectations met
  -partner's relationship to care-giver(s)

- Postnatal Care
  Probe: -main concerns
  -adequate information
  -expectations
  -problems not met by care-giver(s)

• Overall: -pleasurable experience?
-based on this experience what will you do next time?
-critical incidents
-what do you perceive are the major barriers hindering maternity care?
-if you had a choice of care-givers, would this solve your major health concerns re:mat.care?
-would you classify birth as a medical event or a natural event?
-prenatal classes: were they worthwhile?
-was your reproductive experience a personal experience or a family event?

Section 2: Personal Background and Education

• Date of respondent's birth: _____ (month/day/year).

• Where were you born?

• Marital status?
-significant other/partner; or alone

• Education
Probe: -highest level completed
-partially finished programs?

• Do you belong to any professional associations, health groups, or informal "new moms" groups? If yes, what ones?

Section 3: Participant's Family History

• How many children were in your family of origin?

• How many children do you want to have?

• How many children do you (and your partner) support?

• What is your occupation?
Probe: PT/FT/Non-Employed

• What is your spouse/partner's occupation?
Probe: PT/FT/Non-Employed

• What is/was your mother and father's occupation(s)?
Probe: PT/FT/Non-Employed

• Have you been working (paid labour) since the birth of your baby?
Probe: if yes: FT or PT
if no: why

•• Is there anything else you would like to add?

Thank you for participating in the interview and sharing your experience

APPENDIX B: LETTER OF REQUEST

Physician's / Midwife's Address

To Whom It May Concern;

I am a graduate student at the University of Victoria in the Department of Sociology. I am conducting a research project as part of my Master's Degree. The research project is funded, in part, by a studentship grant awarded by the BC Health Research Foundation. The research is focused on the quality of maternity services in Victoria, BC. Changes have been proposed by the government in the delivery of maternity care in British Columbia. As you are aware, one area of possible change is the legalization of midwifery in BC. The views of birthing families on existing physician and midwifery services is the focus of this study.

Qualitative interviews are the chosen method of data collection for this project. I am writing to you because I need to interview women who experienced giving birth (non cesarean), to their first child between September 1992 and September 1993. I ask that you explain the proposed research to your patients who have given birth between these dates, to determine if they would be interested in participating in such a study. I will be the primary investigator, and will carry out all interviews myself. The anticipated time for the interview will be 60 minutes. If your patients are interested in participating or finding out more about the research, they can phone me. When birthing patients contact me, further information can be clarified, and if they are interested in being interviewed a date and time for the interview will be arranged at their convenience.

All information will be treated in a confidential manner. All maternity birthing attendants and respondents will be guaranteed anonymity. If a woman does not wish to take part in the study her wishes and privacy will be respected. This project has been approved by the University of Victoria's Committee on Research Involving Human Subjects. (See attached letter of approval).

I will share my research findings with the British Columbia Medical Association and its members, and the British Columbia Midwifery Association and its members. I will also share the research findings with the women who participate in the study.

This research is part of a larger project attempting to understand maternity care in British Columbia today. The other part is being investigated by my supervisor, Dr. Cecilia Benoit, ("Envisioning Quality Care: Views of Midwives and Complementary Health Care Professionals"). The findings from these two projects will be analyzed together to get a better understanding of maternity care organization in the province.

I would like to thank you for your time and consideration on this matter. I would be happy to answer any questions you might have concerning my study. Please phone me at (604) 595-1863; or please write a note to me, Beverly MacLean-Alley in care of:

Sociology Department, University of Victoria
Box 3050, Victoria, BC, V8W 3P5

Yours Sincerely,

Beverly MacLean-Alley

APPENDIX C: PARTICIPANTS NEEDED FLIER

Research Project
Mothers' Perspectives on Maternity Care

Participants Needed!

The BC Health Research Foundation is funding a study in Greater Victoria on the perspective of the care that mothers receive during the birthing event. This study is being conducted by Beverly MacLean-Alley, a graduate student in Sociology at the University of Victoria.

If you have given birth (non cesarean), to your first child, between September 1992 and September 1993 and are interested in participating in this study, you can contact Beverly at 658-0816.

If you volunteer, a private interview of approximately one hour in length will be scheduled at a time and place of your convenience. All interviews will be in strict confidence and you will be assured of your privacy. This research has been reviewed and approved by the University's Committee on Research Involving Human Subjects (project number 111-94).

The results of this research will assist the women of Greater Victoria by providing health care planners and other researchers with new insights into the maternity care that mothers receive.

If you are interested in participating or would like additional information please contact:

Beverly MacLean-Alley
4685 Boulderwood Drive, Victoria
658-0816

APPENDIX D: LETTER OF REQUEST TO PARTICIPATE

Dear (Participant's Name);

I am a graduate student at the University of Victoria in the Department of Sociology. I am conducting a research project as part of my Master's Degree. The research is focused on maternity services in Victoria, BC. Changes have been proposed by the government in the delivery of maternity care in British Columbia. As you might be aware, one area of possible change is the legalization of midwifery in BC. The views of birthing families on existing maternity services is the focus of this study.

I am writing to ask if you would consider taking part in my research project. You would be asked to participate in an interview, conducted by myself. I will ask you questions about your birthing event - including the prenatal, labour, delivery, and postnatal experiences. The interview will range from 45-90 minutes. The interview will be competed at a place of your choosing and at a time that is convenient for you. However, if you wish, the interviews can be conducted at the University of Victoria or in my own home. I would like to tape record the interviews if you give your permission. I will be the only person listening to the tapes.

All information received will be treated in a confidential manner. You will be guaranteed anonymity and your privacy respected. This project has been approved by the University of Victoria's Committee on Research Involving Human Subjects and is funded, in part, by the BC Health Research Foundation.

I will share my research findings with you and all the other women who take part in the study. I would be most happy to answer any questions you may have. Please write or call.

Beverly MacLean-Alley
4685 Boulderwood Dr.
Victoria, BC
V8Y 2P8
telephone: 658-0816

Please take a moment to fill in the form provided and return it in the envelope supplied. Thank you for your time and consideration. Sincerely, Beverly MacLean-Alley

PARTICIPANT RESPONSE FORM

PLEASE INDICATE WITH AN "X" WHAT YOUR PREFERENCE IS:

- YES, I would like to be part of the study. _____

- NO, I do not wish to take part in the study. _____

If **yes**, you would like to be part of the study, please write your name and home phone number on the line below. Please indicate a preferable time to call.

Name: _____

Home Phone Number: _____

Please call at approximately: _____ in the a.m. / p.m. (please circle).

APPENDIX E: LETTER OF INFORMED CONSENT

Investigator: Beverly MacLean-Alley (Graduate Student), 658-0816 (home)
Department of Sociology
University of Victoria
P.O. Box 3050
Victoria, B.C. V8W 3P5

INVESTIGATOR'S STATEMENT

Purpose and Benefits: The main purpose of this project is to investigate client satisfaction with maternity services in Victoria. It is hoped that the results of this project will lead to a better understanding of the level of satisfaction birthing families have with existing maternity services. It is also hoped this research will help inform care-givers (physicians, midwives, and significant others) as to what maternity services are lacking or need improvement.

Procedures: The respondents will be asked to complete an interview session, lasting approximately one to one and one half hours. Semi-structured interviews will inquire about respondent's experiences of their birthing experience. The date, time and place of the interview will be arranged at the convenience of the respondent. Interviews, if permission is granted, will be tape recorded. The respondent's comments will be kept **absolutely confidential**. Interview notes and tapes will be kept in a locked filing cabinet accessible only to the researcher, and will be erased after conclusion of the research. The researcher will not reveal the respondent's identity under any circumstances. Only the investigator will have access to the file containing names and identification codes. The respondent is free to refuse to answer specific questions without prejudice or explanation to the researcher. Respondents may withdraw from the study at any time, for whatever reason.

[redacted] April 18/94

Signature of Investigator Date

RESPONDENT'S STATEMENT

The research described above has been explained to me. I understand that this research project is a study on client satisfaction with maternity services and that I will be asked about the maternity services I received during the prenatal, birthing and post natal phases of my birthing experience. I understand that given my approval, the interview will be audiotaped. I understand that all data collected in the study will remain confidential and that my anonymity will be protected at all times during the research project.

I understand that my participation is completely voluntary and that I can refuse to answer specific questions, and can withdraw from the study at any time, for whatever reason. I understand that whether I choose to participate or not, will have no bearing on the care I will receive from my physician or midwife. I understand that my physician or midwife will not have access to the tapes, notes or transcriptions.

I voluntarily consent to be a participant in this research. I have had an opportunity to ask questions and understand my rights as a participant, and that any questions I may have about the research now or in the future will be answered by the investigator.

_____	_____	
Signature of Participant	Date	Copies to: Participant and Investigator

APPENDIX F: DEBRIEFING LETTER

Department of Sociology
University of Victoria
P.O. Box 3050
Victoria, BC
V8W 3P5

DEBRIEFING LETTER FOR:

PATIENT SATISFACTION WITH MATERNITY SERVICES - 1994

I would like to thank you once again for participating in the interview for my study on client satisfaction with maternity services. If you are interested in the findings from that data I will be happy to mail them to you. Your participation in the interview was very much appreciated and the information that you provided will be used to supplement the existing birthing literature. It is hoped the results of this research may prove to be enlightening for future birthing families, for midwives and physicians, and for health policy planners. The information may also serve as a base for future university research on this topic.

As I stressed before, all answers will be kept strictly confidential and at no time will answers be identified with individuals. If you have any feedback you would like to share with me, please write on the back of this letter and mail it to me.

If you have any further questions or would like to meet with me to discuss the research any further, please contact me at: (604) 658-0816.

Sincerely,

Beverly MacLean-Alley

APPENDIX G: BIOGRAPHICAL SNAPSHOTS OF THE BIRTHING WOMEN*

#01

Polly is a married, university educated woman who had her first child at 36 years of age. She is in a stable relationship and owns a house in a middle class neighbourhood. Polly is an older first-time mom, yet seems comfortable with motherhood. She will probably only have one child because of her age. Her physician-assisted birth was uncomplicated, taking place in the hospital as planned. Polly believes birthing is a family experience and a natural event. A false positive error in a laboratory blood test gave her and her partner some reason to worry initially about the viability of the baby, but in the end there was no reason for concern. Other than that, Polly's pregnancy and birth were not problematic. Polly is a full-time mom, who continues to do contract work out of the home on a part-time basis. Polly is very calm and quiet and is patient with her child. She mentioned that, if she were younger and was going to have another child, she might consider using a midwife.

#02

Pam and her husband are university-educated and own a house in a middle class neighbourhood. Pam was 30 years old when she had her first birthing experience. Pam had a physician-assisted hospital birth and will probably not have any more children; but if so, she too would consider using a midwife. Pam considers pregnancy and birth a personal experience; yet because of all the complications and interventions, she personally considers it a medical event. Pam is a full time mother who does contract work on a part-time basis at home. She has a quick wit, is very aware of issues relating to child development and really appreciates her child.

#03

Both Marla and her husband are university-educated and own a house in a middle class neighbourhood. Marla was 36 when she gave birth to her first child. Although funds were tight, there was no question in Marla's mind that she would employ a midwife as her main care-giver during her pregnancy. Her midwife accompanied her to the hospital, where after a trial of labour she ended up having a cesarean section. Marla is a firm believer in doing

things the natural way and is interested in holism and homeopathic care. Because of this philosophy of health care, Marla believes birth should be a natural event. Because of her cesarean birth and other medical interventions used, she believes what she experienced was a medical event. Given her husband's previous marriage with children, this will probably be their only child. If they do have another child, the same midwife will be contacted immediately. Marla is a very calm, easy going person who puts out a tremendous amount of energy for her child. She also does some free lance work in addition to being a full-time mom.

#04

Mary and her husband rent a small basement suite in a working class neighbourhood. Mary has a grade 8 education. She was 24 when she experienced her midwife assisted hospital birth. They hope to have one or two more children. Mary is an experienced nanny, and would like to be a midwife. Mary would like to experience another midwife-assisted birth, which she hopes will be a home birth. Mary and her husband consider pregnancy and birth a family experience and a natural event. There is no doubt in their mind that the next birth(s) will also be midwife assisted, and if possible, it will be a home birth.

#05

Monica is a single mother who had a midwife assisted home birth at 18 years of age. Monica has a grade 10 education, is on welfare, and lives in a rental suite with her boyfriend (who is not the biological father) and her mother. Monica is strong willed, is very interested in naturopathic medicine, and lives a healthy lifestyle. Monica suggests pregnancy and birth are personal, natural events. She plans on having one more child and if possible, it would be another midwife assisted home birth.

#06

Paddy is a university-educated married woman who rents a house in a working/middle class neighbourhood. Paddy had a physician assisted hospital delivery at 26 years of age. Pregnancy and birth are considered a family experience; yet her actual birthing event is defined by Paddy as a medical event because of the interventions and various pharmaceuticals which were used to augment the process. She said, "next time I'll be a little more assertive, but you know I didn't know what to take control of." Paddy appears

to be a calm, passive person and is currently pregnant with her second child.

#07

Mona is married and has a college education. She had a midwife-assisted hospital birth at the age of 34. Mona and her partner are currently restoring their own home located in a working class neighbourhood. Mona believes that birthing is a natural event, having both personal and familial elements. Mona also has post college training in traditional chinese medicine and is very conscientious about health and nutrition. Mona has an easy going nature and from what I observed, she appears to be very good with her child.

#08

Marissa is married and has a grade 12 education. She had a midwife-assisted hospital birth at the age of 28. Marissa and her partner rent a well kept house is a middle class neighbourhood. Marissa had a nonproblematic pregnancy and a natural birth. She considers birth a family experience and a natural event. Marissa is looking forward to having at least one more child, and will probably employ the services of a midwife again.

#09

Phyllis is a native single mom. Phyllis has a grade 8 education, is on social assistance and lives in a two bedroom apartment in a subsidized housing complex. She had a physician-assisted hospital birth at 20 years of age. Phyllis considers pregnancy and birth to be both a natural and a medical event. Because she was single during the entire process, it was a very personal experience. Overall it was a pleasurable experience, and Phyllis is currently pregnant with her second child. She was dissatisfied with her physician for the first birth and has since changed physicians.

#10

Penny is a single woman. She has a grade 12 education and lives with her middle class parents in a new subdivision in a somewhat rural area. Penny had a physician-assisted hospital birth at 17 years of age. Penny's family was very supportive during her pregnancy and birth; she defines the birthing process as a family event. Because Penny had a cesarean delivery she considers birth a medical event. Penny appears to be very mature, calm and even tempered, and really seems to enjoy her baby. According to Penny, pregnancy and childbirth have been a learning experience. She is employed by her parents

and works at home. She hopes to get married and have two more children.

#11

Patricia is not married but lives with the baby's biological father in a two bedroom apartment in the downtown area. Patricia has a grade twelve education. Both Patricia and her boyfriend have slight learning disabilities and are on welfare. Patricia had a physician-assisted hospital birth at the age of 24. They are uncertain if they will have another child. Patricia had a problematic pregnancy with many interventions; she now considers pregnancy and birth a medical event. For Patricia, the reproductive experience was a personal one.

#12

Marilyn has been married for four years and is college-educated. She and her partner live in their own home in a middle class neighbourhood. Marilyn had a midwife-assisted hospital birth at the age of 31. She classifies birth as a natural event and considers her pregnancy a personal experience. Marilyn expressed an interest in having two more children.

*** the names of the respondents have been changed to ensure anonymity**

APPENDIX H: MAIN THEMES OF THE RESPONDENTS

Theme	Physicians' Patients	Midwives' Patients	Total
Prenatal			
• Active Participation and Conversation	**11**	**27**	**38**
- Active Participation	1	6	7
- Time: never felt rushed	2	6	8
- Provided with extra information	2	6	8
- Read books first; then asked care-giver to cross check	4	4	8
- Care-giver met labour coach more than twice	2	5	7
• Woman-Centred Care (Self)	**23**	**22**	**45**
- attended prenatal class	5	5	10
- nutrition	5	5	10
- daily exercise/health of mother	4	3	7
- health of the fetus	4	4	8
- hospital tour	4	6	10
• Distress	**4**	**5**	**9**
- fear of losing the baby	3	1	4
- smoking	1	1	2
- fear of unnecessary intervention and in-hospital care	0	3	3
-(had to change physicians because he/she would not work with midwives)	(0)	(5)	(5)

Theme	Physicians' Patients	Midwives' Patients	Total
Labour and Delivery			
• Fears	**17**	**13**	**30**
- of pain: how much will it hurt; will I manage	2	5	7
- of hospitals	0	4	4
- of the birthing event	4	1	5
- of intervention	4	0	4
- of number of unknown people	3	2	5
- of physician not being there for the delivery	4	1	5
- (physician present at the birth)	(3)	(1)	(4)
• Problems with Communication	**13**	**6**	**19**
- poor relationship with nurses	6	2	8
- physician ignoring patient "felt like I wasn't being heard"	3	1	4
- multiple shift changes and poor continuity of care	3	1	4
- poor communication between care givers	1	2	3
• Coping Strategies	**5**	**16**	**21**
- massage	0	4	4
- showers	0	4	4
- support from family	2	3	5
- flexibility in birthing positions	3	5	8
• Power	**4**	**3**	**7**
- felt intimidated by staff in L&D	2	0	2
- felt powerless in hospital	2	3	5

Theme	Physicians' Patients	Midwives' Patients	Total
Post Natal - In Hospital			
• Breastfeeding	**15**	**15**	**30**
- breastfeeding was a main concern	5	5	10
- breastfeeding is a learned art	5	4	9
- were encouraged to breastfeed	5	6	11
• Support From Nurses	**8**	**4**	**12**
- different nurses all the time; poor continuity of care; conflicting tips	3	1	4
- not listen to me	2	0	2
- nurses were lousy; too busy for me; over worked	3	3	6
•Recovery	**9**	**12**	**21**
- from bleeding	1	4	5
- from episiotomy or rip	4	4	8
- from cesarean section	4	4	8
• "Why Me"	**2**	**3**	**5**
- Why didn't the birth work out the way I planned	2	3	5
• The Clinical Routine	**1**	**4**	**5**
- the clinical focus of hospital "routine" (washing and weighing the baby and drops in the eyes) does not allow enough time for families to enjoy the tender moments following the birth	1	4	5
•Immunization	**0**	**5**	**5**
- automatic immunization policy of infants is unnecessary	0	5	5

Theme	Physicians' Patients	Midwives' Patients	Total
Post Natal - At Home			
• Coping Strategies	**8**	**12**	**20**
- walking	1	0	1
- social support from friends or family	1	0	1
- social support from La Leche League	1	3	4
- social support from physicians	0	0	0
- social support from midwives	0	6	6
- social support from CRD	5	3	8
• Motherhood/Being a new mom	**27**	**6**	**33**
- a big responsibility and felt like I had no one to back me up	5	0	5
- I felt scared, nervous and overwhelmed	6	1	7
- concerned about bonding with the baby and keeping the baby content	5	0	5
-coping with restructuring my own life	5	3	8
-overall the post natal support was not good	6	2	8
Overall			
• Client in Control- "I was in control"	1	4	5
• Hierarchical Relationship between Care-Giver and Patient	6	0	6
• Continuity of Care - "being there" includes 9 items - see Table 4)	1	6	7
• Immunization	0	5	5

Theme	Physicians' Patients	Midwives' Patients	Total
Barriers	**18**	**25**	**43**
•Problems with Physicians	9	11	20
•Antagonism Between Physicians and Midwives	1	3	4
•Baby Treated Like One of Many	5	0	5
• Lack of Trust	2	0	2
•Concerned that Midwifery care is not Covered Under Medicare	1	6	7
• Birthing Centres are needed	0	5	5

APPENDIX I: FEDERAL AND PROVINCIAL COMMISSIONS ON HEALTH

Commission/Report	Year	Federal	Provincial (BC)

Foulkes **1973** **X**

Health Security for British Columbians. The Foulkes report suggested: the need for more public participation and for integrated health services which could be delivered in community health centres in all (7) regions of BC (only one survived- Victoria, the James Bay CHC). The medical profession was vehemently opposed to many of Foulkes' recommendations, and thus not many came to pass.

Lalonde **1974** **X**

A New Perspective on the Health of Canadians. Lalonde's "health field concept" divided the health field into four equally important elements: human biology, environment, lifestyle and health care organizations. Lalonde's perspective went beyond the biomedical disease model of sickness, and made the public aware of socio-ecological impacts, ie. the environment (pollution) and lifestyle (smoking, drinking) on health. The result was proactive policies which focused on health promotion.

Hall **1980** **X**

Canada's National-Provincial Health Program for the 1980s. The Hall report suggested: the need for revisions to the Medical Care Act, because no province ensured the five health care principles; an elimination of extra-billing by physicians; and an examination of the conflicts between the medical profession and the Provinces. The result: the Canada Health Act (1986); the Stoddart-Woodward study (re: extra-billing); and the Barer-Stoddart Commission (1990).

Epp **1986** **X**

Achieving Health For All: A Framework For Health Promotion. Health was defined as a resource for living. Strategies for new health policies and health promotion include: greater public participation, strengthen community health services by promoting healthy public policy and preventing disease. A proactive and preventative approach to health care.

Barer-Stoddart **1990** **X** **X**

Toward Integrated Medical Resource Policies for Canada. Barer and Stoddart examined: physician resource policies in Canada; the oversupply of physicians; the number and mix of residency positions; the geographic maldistribution of physicians in Canada; and the role of fee-for -service remuneration. The results are yet to be seen.

Seaton **1991** **X**

British Columbia Royal Commission on Health Care and Costs. The report suggested: bringing health care "closer to home"; services must improve health outcomes; community involvement; the need for an integrated health care system (including midwifery); stop "over-credentialization"; freedom of health(care) information for researchers and the public. The report suggested health is affected by the interaction of the individual, the social and economic environment. The goal for BC: to ensure all 5 health care principles (universality..).

APPENDIX J

FREQUENCIES OF CO-OCCURRING THEMES FOR RESPONDENTS IN THE PHYSICIAN GROUP*

	APC ±	W-Ctr C'r	Fears	Comm'n	Nurse Sup	Breastfd.	Recovery	Support	New Mom	Inequality	Physician
APC	11	34	28	25	19	26	20	19	38	17	20
W-Ctr C'r	34	23	40	37	31	38	32	31	50	29	32
Fears	28	40	17	31	25	32	26	25	44	23	26
Comm'n	25	37	31	14	22	29	23	22	41	20	23
Nurse Sup	19	31	25	22	8	23	17	16	35	14	17
Breastfd.	26	38	32	29	23	15	24	23	42	21	24
Recovery	20	32	26	23	17	24	9	17	36	15	18
Support	19	31	25	22	16	23	17	8	35	14	17
New Mom	38	50	44	41	35	42	36	35	27	33	36
Inequality	17	29	23	20	14	21	15	14	33	6	15
Physician	20	32	26	23	17	24	18	17	36	15	9

* Only themes with frequencies greater than five are shown.

± **Key to Abbreviations**

APC = Active Participation and Conversation
W-Ctr C'r = Woman-Centred Care
Fears = Fears
Comm'n = Communication
Nurse Sup = Nurse Support
Breastfd = Breastfeeding
Recovery = Recovery
Support = Social Support
New Mom = Being a New Mom
Inequality = Hierarchical Relationship
Physician = Problems with Physicians

APPENDIX K

FREQUENCIES OF CO-OCCURRING THEMES FOR RESPONDENTS IN THE MIDWIFE GROUP*

	APC ±	W-Ctr C'r	Fears	Comm'n	Cope Strat	Breastfd	Recovery	Support	New Mom	Be There	Physician
APC	27	49	40	33	43	42	39	39	33	33	38
W-Ctr C'r	49	22	35	28	38	37	34	34	28	28	33
Fears	40	35	13	19	29	28	25	25	19	19	24
Comm'n	33	28	19	6	22	21	18	18	12	12	27
Cope Strat	43	38	29	22	16	31	28	28	22	22	27
Breastfd.	42	37	28	21	31	15	27	27	21	21	26
Recovery	39	34	25	18	28	27	12	24	18	18	23
Support	39	34	25	18	28	27	24	12	18	18	23
New Mom	33	28	19	12	22	21	18	18	6	12	17
Be There	33	28	19	12	22	21	18	18	12	6	17
Physician	38	33	24	27	27	26	23	23	17	17	11

* Only themes with frequencies greater than five are shown.

± **Key to Abbreviations**

APC = Active Participation and Conversation
W-Ctr C'r = Woman-Centred Care
Fears = Fears
Comm'n = Communication
Cope Strat = Coping Strategies
Breastfd = Breastfeeding
Recovery = Recovery
Support = Social Support
New Mom = Being a New Mom
Be There = "Being There"
Physician = Problems with Physicians

APPENDIX L

COMBINED FREQUENCIES OF CO-OCCURRING THEMES FOR RESPONDENTS IN PHYSICIAN AND MIDWIFE GROUPS*

	APC ±	W-Ctr C'r	Fears	Comm'n	Cope Strat	Nurse Sup	Breastfd.	Recovery	Support	New Mom	Physician
APC	38	83	68	58	59	50	68	59	58	71	58
W-Ctr C'r	83	45	75	65	66	57	75	66	65	78	65
Fears	68	75	30	50	51	42	60	51	50	63	50
Comm'n	58	65	50	20	41	32	50	41	40	53	40
Cope Strat	59	66	51	41	21	33	51	42	41	54	41
Nurse Sup	50	57	42	32	33	12	42	33	32	45	32
Breastfd.	68	75	60	50	51	42	30	51	50	63	50
Recovery	59	66	51	41	42	33	51	21	41	54	41
Support	58	65	50	40	41	32	50	41	20	53	40
New Mom	71	78	63	53	54	45	63	54	53	33	53
Physician	58	65	50	40	41	32	50	41	40	53	20

* Only themes with frequencies greater than 10 are shown.

± **Key to Abbreviations**

APC = Active Participation and Conversation
W-Ctr C'r = Woman-Centred Care
Fears = Fears
Comm'n = Communication
Cope Strat = Coping Strategies
Nurse Sup = Nurse Support
Breastfd = Breastfeeding
Recovery = Recovery
Support = Social Support
New Mom = Being a New Mom
Physician = Problems with Physicians

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Beverly MacLean-Alley

September 6, 1995