

**Informed Consent during the
Intrapartum Period:
An Observational Study of the
Interactions between Health
Professionals and Women in Labour
involving Consent to Procedures.**

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Dedication.

I would like to dedicate this thesis to the memory of my late mother, Mabel, who died during the study in 1998 and whom I miss greatly. She was always the source of my inspiration to succeed in everything that I have done throughout both my professional and personal life.

Abstract of the Study.

This ethnographic study using participant observation, aimed to explore the issue of informed consent to procedures undertaken during the intrapartum period. It involved recruiting 100 healthy women, who went into labour spontaneously at term, at the point they were admitted to the labour ward. The data collection took place in a large teaching hospital in an East Midlands city from April 1997 until December 1999. The subjects (health professionals and women) were observed throughout the labour until the woman and baby were transferred to the postnatal area. Follow-up interviews were conducted with the woman and midwives, within 24 hours, using a semi-structured format based on the observations.

The study revealed that it was difficult to obtain informed consent during labour. Contrary to professional belief, not all women wanted to be fully informed about intrapartum care and procedures, or wanted anything other than a pain free and easy labour that they perceived the western medical-technocratic model of care would offer them.

Although the midwives' knowledge of legal and ethical issues concerning consent was variable and limited in the majority of cases, they attempted to empower women to make intrapartum choices. However, this was often constrained by the culture of the labour ward environment and the extent to which they adhered to policies and procedures. In cases where medical intervention became necessary, a minority of midwives felt personally disempowered. The obstetricians and paediatricians observed, appeared to be less effective communicators than anaesthetists, often leaving it to the midwife to explain issues to the woman.

It is envisaged that these findings, as well as the stereotypical models of the labouring woman and the attending midwife that developed, and the resulting recommendations, be used in partnership between maternity service and education providers to ensure that health professionals not only have effective communication and interpersonal skills, but also are more conversant with the legal and ethical implications of consent.

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Peer Reviewed Publications, Presentations, Abstracts and Awards.

Peer reviewed publications, presentations and abstracts arising from the work included in this thesis.

Peer Reviewed Publications.

Marshall J E (2000) Informed Consent to Intrapartum Procedures, *British Journal of Midwifery*, Vol:8, No:4, pp 225-227.

Marshall J E and Baker PN (1999) Informed Consent : Legal and Ethical Issues, *Health Care Risk Report*, Vol:5, No:8, pp 12-14, 24.

Oral Presentations.

Marshall J E (2002) Informed Consent during the Intrapartum Period: An Observational Study of the Interactions between Health Professionals and Women in Labour, *26th International Congress of Midwives*, Vienna.

Marshall J E (2000) Informed Consent during the Intrapartum Period: An Observational Study of the Interactions between Health Professionals and Women in Labour, *8th International Conference for Maternity Care Researchers*, University of Glasgow, Scotland.

Marshall J E (1998) Informed Consent during the Intrapartum Period: An Observational Study of the Interactions between Health Professionals and Women in Labour, *University of Nottingham School of Human Development Research Away Weekend*, Chilwell, Nottingham.

Poster Presentations.

Marshall J E (1998) Informed Consent during the Intrapartum Period: An Observational Study of the Interactions between Health Professionals and Women in Labour, *Advancing Research Conference*, University of Nottingham School of Nursing, Stoke Rochford Hall.

Marshall J E (1997) Informed Consent during the Intrapartum Period: An Observational Study of the Interactions between Health Professionals and Women in Labour. *University of Nottingham Department of Obstetrics, Midwifery and Gynaecology Away Day*, Nightingale Hall, Nottingham.

Abstracts.

Marshall J E (2002) Informed Consent during the Intrapartum Period: An Observational Study of the Interactions between Health Professionals and Women in Labour, *26th International Congress of Midwives Book of Proceedings*, Vienna, Abstract No 135.

Marshall J E (2000) Informed Consent during the Intrapartum Period: An Observational Study of the Interactions between Health Professionals and Women in Labour, *8th International Conference for Maternity Care Researchers Book of Abstracts*, University of Glasgow, Scotland, Abstract No 35.

Marshall J E (1998) Informed Consent during the Intrapartum Period: An Observational Study of the Interactions between Health Professionals and Women in Labour. In Noon J (ed) *Advancing Research Conference Proceedings*, University of Nottingham School of Nursing, Nottingham, p 34.

Awards.

English National Board for Nursing, Midwifery and Health Visiting Research Bursary for Post-Graduate Degrees 1997, *Informed Consent during the Intrapartum Period: An Observational Study of the Interactions between Health Professionals and Women in Labour*: **Value £1,000.**

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Transcript Codes.

- *Italics* are used for verbatim transcriptions of observational and interview data.
- CAPITAL letters are used to denote specific observation of activity.
- Words in () are additional information to make the context and /or meaning clear.
- indicates where words, phrases or sentences of the extract have been omitted.
- Data have been edited to preserve anonymity: e.g. if names of individuals / places were used in conversation they have been transcribed using only the respective initial:

e.g. Susan = **S**, Dr Brown = **Dr B**.

- Each participant has been given a specific reference code:

e.g. Women = Case 1, Case 2.

Midwives / Student Midwives = Midwife 1, Midwife 2 / Student Midwife 1, Student Midwife 2.

Consultant **O**bstetricians / Consultant **A**naesthetists = CO1, CO2 / CA1, CA2.

Registrars = Registrar 1, Registrar 2.

Senior House Officers = SHO 1, SHO 2.

Anaesthetists = Anaesthetist 1, Anaesthetist 2.

Paediatricians = Paediatrician 1, Paediatrician 2.

Medical Students = MS 1, MS 2.

Student Nurses = SN 1, SN 2 etc..

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CHAPTER 1: INTRODUCTION TO THE STUDY.

In recent years, government reports have recommended that maternity care should be based on a partnership between the midwife, the obstetrician, the general practitioner (GP) and the woman, in which the woman has choice, control and continuity of care (Department of Health [DoH] 1993, DH 2000, House of Commons Health Committee 2003). Health professionals are therefore expected to supply women with sufficient unbiased information in order for them to be in a position to make informed choices about their care throughout the whole childbirth process. Furthermore, emphasis has developed that not only endorses the importance of all health professionals having competence in communication skills (DH 2003a, Universities United Kingdom [UK] 2003) but also encourages health professionals to learn and work together in collaboration and so acquire a better appreciation of each other's roles (Symonds et al 2003, DH 2001a, Marshall and Kirkwood 2000).

In practice, it has not only been personally observed, but also documented in studies, that during intrapartum care women accept what is done to them without challenging midwives and doctors, and in turn, the health professional accept this as consent to proceed. This has been highlighted by Patterson's (1994) study that explored informed consent in labour and in studies into vaginal examinations undertaken by Bergstrom et al (1992), Menage (1993) and Coldicott et al (2003), artificial rupture of the membranes conducted by Henderson (1991, 1984) and the National Childbirth Trust [NCT] (1989) and by Kirkham (1987), who examined communication and interactions between health professionals and women during intrapartum care. However, although a literature search into the subject revealed a substantial amount of research data revolving around communication and the concept of choice in maternity care, there was generally a lack of data specific to the area of intrapartum informed consent, thus supporting the rationale to undertake a study in this area. Nevertheless, as Ralston (1994) asserts, one of the fundamental issues surrounding intrapartum informed consent is the effectiveness of communication between health professionals and the woman.

The purpose of the study is to explore the issue of informed consent during intrapartum care, focussing on health professionals' understanding of the term in both the professional and legal context, the communication and language used between health

professionals and women regarding certain routine invasive procedures, e.g. vaginal examination, artificial rupture of the membranes and administration of syntometrine, and to what extent informed consent is actually obtained from women by the individual health professional. However, although Mayberry and Mayberry (2003) stress that the doctrine of informed consent has yet to be adopted in England and Wales, they do recognise that there has been a general move within healthcare in the UK towards greater involvement of clients / patients. This involves improving the information available to the individual to enable them to consequently make autonomous informed decisions.

Chapter 2 explores the available literature to inform the study by first differentiating between the concepts of informed choice and informed consent and critically appraising those studies closest to the focus of the one undertaken, whilst also presenting their findings. An historical perspective of childbirth culture and how the concept of choice, within the context of maternity care provision, has emerged over the last century to the present day is then presented. This will also include a review of recent developments in health care education and practice that serve as further challenges to health professionals working within the maternity services in the 21st century.

The complexities of informed consent during labour from a sociological, ethical and medico-legal perspective are also discussed in Chapter 2. This is undertaken alongside an exploration of the issues surrounding the disclosure of information such as, benefits versus risks of procedures, assessment of the level of a client's understanding and the timing of information disclosure within the context of maternity care. At the end of the literature review, the specific aims of the study are presented.

An attempt to examine the methodology and justify the case for qualitative research and undertake the study using an ethnographic approach: i.e. studying labour as it happens, is made in Chapter 3 with reference to previous studies undertaken in this field. The value of participant observation as a means of data collection for the study is critically examined, in particular the range of roles that the researcher may occupy: from observer to participant. By discussing the benefits and disadvantages of each role, a conclusion is drawn as to the most appropriate role to adopt in this study, taking into consideration

reflexivity and the effects that being both familiar to the labour ward environment and to many of the health professionals in the area being studied may pose.

The tools used to collect the data; i.e. field notes by participant observation followed by semi-structured interviews with each woman observed and the corresponding health professionals within 24 hours of the baby's birth are discussed. Furthermore, the rationale is presented for utilising principles of grounded theory as described by Glaser and Strauss (1967) and Strauss and Corbin (1998) to analyse the data and compare the woman's perceptions of her labour and the health professional(s) perceptions of the care given, with the data obtained in the observational field notes.

In the final section of Chapter 3 consideration is given to substantiate choosing computer assisted qualitative data analysis software (CAQDAS) packages that were available at the time the study was undertaken, over manual means to prepare and analyse the data. The debate continues with the decision to use a Code-based Theory Builder such as NUD*IST, that also has code and retrieve functions, with a brief discussion as to the reasons for also using a quantitative data analysis computer software package (Statistical Package for Social Sciences [SPSS]) at the end of the chapter.

The practicalities of undertaking the study are discussed in Chapter 4. As the study was conducted within the labour ward of a large Teaching Hospital on the outskirts of an East Midlands city, the culture of this environment is first of all examined in context. Issues surrounding approval and access to the study site and the participants are then presented. Before the main study is discussed, the pilot study that assisted in informing the appropriateness of the tools proposed to undertake the data collection and analysis in the main study is evaluated. The observational stage (including the cases where observation was either abandoned or consent to participate was refused), the follow-up interviews and the data analysis, are presented in this chapter with supportive materials supplied in the Appendices. In addition, issues pertaining to reflexivity and the personal influence that the researcher may have had on the data collection are critically explored.

Chapter 5 initially presents the findings from the statistical analysis of the demographic details of the women in the study. This provides comparative data with the total

childbearing population who gave birth at the study hospital at the time this study into intrapartum informed consent was undertaken. However, this chapter is mainly devoted to the findings arising from the qualitative data analysis of the extensive amount of data generated from the observational field notes and interview transcripts. From the data analysis, three core-categories finally emerged from a series of categories and themes. These are initially presented in a tabular format, before each is then examined in turn and supported by appropriate annotated extracts from the field notes / interview transcripts.

The penultimate Chapter 6 discusses the findings from the study in more depth and assesses the extent to which the three aims of the study were achieved by the methodology chosen. The discussion focuses on five dilemmas associated with intrapartum informed consent that consequently developed from the findings. These further assist in drawing out new theoretical perspectives that help to inform the existing body of knowledge surrounding the complexities of informed consent within the context of maternity care provision.

In the final Chapter 7, the conclusions that have arisen from the study are debated. Initially, the strengths and limitations of the research methodology are discussed so as to ascertain the appropriateness of the chosen tools in fulfilling the intended purpose of the study. The theoretical perspectives are discussed in the light of their significance to clinical practice and intrapartum care provision and a number of recommendations are finally made that could improve the process of obtaining informed consent to intrapartum procedures by all health professionals concerned.

CHAPTER 2: LITERATURE REVIEW.

2.1. INTRODUCTION.

The Changing Childbirth Report from the Expert Maternity Group (DoH 1993) and the preceding Winterton Report (House of Commons Health Committee 1992) made explicit the need to develop a consumer orientation in maternity services, which it defined as woman-centred care. The reports also stressed that pregnancy should be perceived as a normal significant life event, not as a period of illness. Thus they challenged the traditional dominance of the medical model of care.

Throughout the last century up to the present day there have been many changes that have occurred within the maternity services. During this time the philosophies of respect for the individual, the market economy, individual choices, personal responsibility and consumer satisfaction intersected at a crucial point in time to bring about a climate for change. Furthermore, recent government policy has also been directed towards improving communication between health professionals and clients, including gaining consent to procedures, and encouraging a multi-disciplinary collaborative team approach in the working and learning environment (DH 2003a, DH 2003b, DH 2001a, DH 2001b, DH 2001c, DH 2001d, DH 2001e, DH 2000, DoH 1999, DoH 1998, DoH 1994).

The high priority given to health professionals possessing good communication skills has been well documented (Confidential Enquiry into Stillbirths and Infant Deaths [CESDI] 2003, Dyas and Burr 2003, Fraser et al 1996, Kirkham 1989, McIntosh 1988, Kirkham 1987 and MacIntyre 1982). Furthermore, the National Health Service (NHS) Plan (DH 2000) had stated that by 2002, it would be a pre-condition for each individual health professional to demonstrate competence in communication with patients to be able to qualify to deliver patient care. More recently, there has been further endorsement by the issuing of a joint statement from the DH, Universities UK, The Health Professions Council (HPC), the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC). This statement sets out nine guiding principles relating to the commissioning and provision of communication skills training in pre-registration

and undergraduate education for health professionals (Universities UK 2003). These issues will be discussed throughout this second chapter as the current literature to support the study on intrapartum informed consent is explored.

2.2. INFORMED CHOICE AND INFORMED CONSENT.

At this early stage in the literature review it would seem pertinent to discuss the two concepts: informed choice and informed consent within the setting of health care / maternity care. Whilst it is acknowledged that there are fundamental differences between these two concepts, in practice factors that influence one concept may subsequently affect the other as the seeking and giving of informed consent involves the individual making pertinent choices.

The work of De Vries et al (2001), Davis-Floyd and Sargent (1997) and Jordan (1993) demonstrate that globally the concept of informed choice is in fact constructed through social norms, belief systems and available resources to which the central figure (the individual client / patient) is exposed. In the context of maternity care, this involves the childbearing woman using relevant information about the advantages and disadvantages of all the possible maternity care and childbirth options that are actually available to make a reasoned decision in accord with her own personal beliefs and cultural norms. Edwards (2004) gives the example that in some cultures, home birth would be an almost impossible choice to make, whereas in others to consider an alternative would be just as unlikely. However, in reality, there may not only be resource implications to offer all women a full range of childbirth options, making an informed choice can also be difficult for some women if making decisions is not already part of their everyday lives. Leap (2000) has also found that there are many situations in which no amount of information will clarify the decision process for these women and consequently they rely on the judgment of the health professional.

In comparison, informed consent involves an individual being given sufficient information in order to make a decision to accept or refuse what an expert has offered, such as a procedure / investigation or a course of treatment (NMC 2004a, DH 2001b, DH 2001c, DH 2001d, British Medical Association [BMA] 2001, Royal College of Obstetricians and Gynaecologists [RCOG] 1997, Medical Defence Union [MDU]

1996). Within the health care setting, the concept has foundations in illness where consent relates to medically defined procedures and treatment, resulting in the implementation of a medical model of care. In this situation the dominant figure tends to be the health professional. When applying this to maternity care provision, Kirkham (2004) emphasises that informed consent disregards childbirth as a natural process as it fails to consider alternative options that may be chosen by childbearing women. She also points out that early on in pregnancy, women are subjected to a medically endorsed screening package to which it is expected they give their consent and as a consequence, the concepts of diagnosis and treatment become routine with all the implications of professional power (Kirkham 2004). Furthermore, a number of authors have indicated that in western cultures, women are expected to make childbirth choices from a pre-determined, medically orientated list over which they have limited control to define or change (Cartwright and Thomas 2001, Browner and Press 1997, Lazarus 1997, Mander 1997, 1993, Ralston 1994).

Regardless of the woman's personal beliefs and opinions concerning childbirth choices during pregnancy, Machin and Scamell (1997) suggest that the medical model in a hospital setting during labour is difficult to resist. Obstetric ideology is especially coercive and the medical definition of safety and risk indicates that while minor choices exist, conceptual choices cannot. As a consequence, Romalis (1985) states that such coercion implies the childbearing woman should privilege professional opinion over her own. This may indeed also involve the woman being coerced into giving her consent to procedures as ultimately she is motivated to do the best for her baby.

2.3. PREVIOUS STUDIES RELATING TO INFORMED CONSENT.

Very few studies have been undertaken that examine the process of obtaining consent to procedures that are undertaken in labour and those that have, have tended to focus on a specific intrapartum procedure, such as vaginal examination and artificial rupture of the membranes, rather than examining all procedures that may occur during the course of a woman's labour. It could therefore be assumed that their interpretations may only be a snapshot of intrapartum informed consent.

Over 20 years ago, in 1984, Henderson conducted a study using intrapartum observation and interviews to examine the practice of amniotomy. This involved observing a total of 28 labours within a hospital setting serving a multiracial community followed by interviews with the 28 women and 22 midwives. Henderson (1984) observed that there was generally no discussion with the woman before midwives proceeded to rupture the membranes as consent was only obtained in two instances. Furthermore, there appeared to be a misconception on the part of the majority of midwives as they believed that they had more autonomy than they actually demonstrated in the real world that Henderson (1984) observed. Consequently they felt they were using their own judgment to rupture the membranes when in fact they were unintentionally following a routine influenced by medical pressure. The fact that the majority of women passively accepted the practice of amniotomy without asking any questions, further served in reinforcing such a routine. Although this study may be criticised in terms of its small sample size of which the findings may have been pertinent to the culture of one hospital, it has been widely quoted in the literature (Clements 2001, Chadwick 1992, Lupton 1992, NCT 1989), to the extent it may have had an influence on intrapartum practice.

The NCT undertook a large survey of womens' views on rupture of the membranes in 1989. The results revealed that of the 3,000 women who responded, the majority did not want an amniotomy performing during labour. If these women had requested to keep their membranes intact, they were generally met with a negative reaction from the midwives. The study also found that women giving birth in a hospital setting, be it a General Practitioner (GP) or consultant led unit or within a domino scheme, were more likely to experience an amniotomy, regardless of their wishes. It could be argued that, as women belonging to NCT groups tend to be well informed and articulate, their views may have been unrepresentative of the whole childbearing population. Their responses could have been considered biased towards natural childbirth and non-interventionist midwifery and may not necessarily have been a true reflection of what actually happened in practice: such are limitations of using the questionnaire survey method.

An observational study of vaginal examinations during the second stage of labour was carried out by Bergstrom et al (1992) in four different birth settings in the United States: ranging from a university / consultant led hospital, a private community hospital, a birth centre and in private homes. The study involved 23 women of mixed parity and data

were collected using videotaping. Each videotape recorded at least two vaginal examinations, although Bergstrom et al (1992) claim most women experienced many more: one tape having a total of 17 examinations recorded and another where one woman experienced a vaginal examination during every contraction. The study found that only rarely did caregivers explicitly ask women for their consent to undertake a vaginal examination during the second stage of labour for in most cases, the examination was simply announced and then carried out. Often there was no mention of the examination until it was already in progress and any talk, before and during the procedure, was initiated and controlled by the caregiver. Furthermore, when women displayed explicit responses such as the procedure causing them distress or it being painful, these were generally ignored. The findings however, do not refer explicitly to the place of birth, thus it is questioned as to whether they applied to all four sites involved in the study, including the woman's home. Nevertheless, what the study did highlight was the ritualistic manner in which all caregivers undertook the examination and the way that the ritual was enacted repeatedly demonstrated the power of the caregivers over the women.

The physical and psychological consequences of traumatic gynaecological / obstetric procedures on future pregnancies and gynaecological procedures were investigated by Menage (1993) using 500 women volunteers recruited through advertising in local and national newspapers and in women's magazines and newsletters. These women completed a preliminary questionnaire on their experiences of obstetric and gynaecological procedures, their biographical details and their feelings associated with the procedures at the time they occurred and at the time of their participation in the study. Out of this convenience sample, 100 gave a history of the procedures being traumatising and were then sent further questionnaires: 30 of these women consequently fulfilled the criteria for a diagnosis of post-traumatic stress disorder. Only nine women of the 30 had a past history of sexual abuse or rape in addition to obstetric or gynaecological trauma. Menage (1993) refers to the explicit accounts from the women as being reminiscent of assault that highlight feelings of powerlessness, lack of information and consent, physical pain and an unsympathetic attitude by the midwife or doctor: similar features having been found in Bergstrom et al's (1992) study.

In 2003, Coldicott et al undertook a survey of 452 medical students in an English medical school to elicit whether their practice of undertaking intimate examinations (vaginal and / or rectal examinations) including the level of consent obtained, adhered to accepted policy. A total of 386 medical students responded (85%) ranging from second to fourth year students. The study found that where the patient was sedated or anaesthetised, in only 24% cases had written consent been obtained, with a further 24% of examinations being carried out by the medical student without either written or oral consent. Such findings did not reflect the accepted policy and best practice. Not only did some students appear unaware of their legal and ethical responsibilities of obtaining informed consent, but also on many occasions more than one medical student examined the same patient. Furthermore, the students were unaware that in the absence of explicit consent, they would be liable to a legal charge of assault. Many students also reported that they found it difficult to express their discomfort to the supervising doctor and consequently felt compelled to perform the examination. Although Coldicott et al (2003) only examined practice within one medical school their findings could be considered to be only a small snapshot of contemporary practice and may not be totally representative of all medical schools. Nevertheless, as a consequence of the findings of this study, a medical school working party with student and health service representation was set up to develop advice and guidelines in order to ensure the situation was redressed.

The research evidence regarding the practice of episiotomy does not however relate specifically to the practice of obtaining informed consent from the labouring woman. In the main, the studies that are documented concern either comparing liberal and restricted practice of episiotomy (East and Webster 1995, Sleep et al 1984), or analysing the effect that an episiotomy may have on a woman's experience of labour including consequential rectal injury and long-term maternal morbidity (Way 1996, Greenshields and Hulme 1993, Sleep and Grant 1987, Kitzinger 1986, Kitzinger and Walters 1981). However, as Barwise (1998) highlights, the decision to perform an episiotomy when the second stage of labour is progressing normally is arguably one of the few decisions left solely to the midwife and thus it is important that decisions are made that are based on contemporary research. Following a review of the research literature, Thorp (1995) states that the practice of episiotomy is often effectively bundled with the birth of the baby and as a consequence, specific consent is not sought from the woman resulting in a

violation of her autonomy. Furthermore, he argues that if women were fully informed of the lack of efficacy and frequency of complications, few would consent to the procedure (Thorp 1995).

In an attempt to explore the process of informed consent to a variety of intrapartum procedures, Patterson (1994) conducted interviews with 10 primigravidae and 13 midwives in the maternity unit of a hospital within 24 hours of the baby's birth. Although the participants were interviewed about a variety of procedures only data pertaining to vaginal examinations, amniotomy and episiotomy are provided. Compared to Henderson's (1984) study, Patterson's (1994) study involved a smaller sample and used only one tool to collect the data. Nevertheless, the study revealed similarities, thus indicating there had been no real change in practice for ten years. In her sample of research participants, Patterson (1994) found that the majority of midwives did not seek consent when carrying out midwifery procedures and as the women did not refuse or challenge such practice, they accepted this as consent to proceed. Despite midwives in this study acknowledging their responsibilities in gaining informed consent to intrapartum procedures and expressing that they wanted to give individualised and women-centred care, Patterson (1994) also discovered that the pressures on the midwives' time and the influence of medical policies led to them continuing to follow a routine. As a result the women were not encouraged to make or take decisions themselves. Patterson (1994) admits that the interviews with the midwives were less in depth lasting between 15 – 30 minutes, compared to those undertaken with the women that lasted up to 1½ hours. It could therefore be considered that the analysis of the data may have produced findings that are biased towards the women's experience.

Whilst examining the studies concerning the practice of intrapartum informed consent, although there were data pertaining to labour ward routines, data relating specifically to how the culture of the labour ward may influence health professionals seeking consent from women was limited. Much of the literature revolves around the concept of choice. In the following sections government health care reforms throughout the last century and up to the present day will be examined in the light of their effect on childbirth culture and the choices available to women.

2.4. CHILDBIRTH CULTURE AND CHOICE: AN HISTORICAL PERSPECTIVE.

Although birth is a physiological event that is both intimate and of crucial social significance, in reality it is rarely treated merely as a physiological process by those involved in it. Historically, the midwife (which means "with woman") has been the person with the labouring woman. However, many authors such as Garcia et al (1991), Towler and Bramall (1986), and Donnison (1977), have clearly related that over the last two centuries, the history of childbirth has been characterised by a struggle between the male dominated medical profession and female midwives for the control and care during pregnancy and birth. In addition, official recommendations and statistics for the place of birth have tended to reflect the victory of the medical model of childbirth.

At the beginning of the last century the majority of women had their babies at home with the continued presence of their local midwife to support them, unless they could afford the services of the medical profession in an institutional setting. In 1900 the infant mortality rate was at a staggering rate of 154 babies per 1000 live births, compared to 5.3 babies per 1000 live births in 2002 (Office of National Statistics [ONS] 2003). The policy of institutional birth that subsequently developed throughout the last century as a means of attempting to reduce the mortality among childbearing women and their babies, was, as Campbell (1924) claimed, first considered in 1924, at a time when the home birth rate was 84%. However, despite a small increase towards hospital birth, ten years later, the maternal mortality rate actually peaked to 4.6 women per 1000 live births in 1934, (compared with 0.131 women per 1000 live births in the triennium 2000 - 2002 [Lewis and Drife 2004]).

It could be assumed that, at this time, the financial implications of birth outside their own home was a major consideration for those families on a limited income, and thus restricted their choice. Following the inception of the NHS in 1948, maternity care, along with health care in general, was provided free at the point it was delivered, and so a more rapid shift towards births in hospitals / maternity homes was experienced. As a result, by 1958, the home birth rate had fallen to 34%.

There has been a succession of Government reports on the maternity services over the past half century, beginning with the Guillebaud Committee in 1956 (House of Commons 1956) that was set up to review the cost of the Obstetric Services under the NHS. It recommended that the ultimate aim was to provide obstetric beds for all women who needed them, or who accepted them. In 1959, as a result of this report, the Maternity Services Committee, under the Chairmanship of the Earl of Cranbrook, further assessed the organisation of the maternity services. Their final recommendation was to achieve a 70% hospital birth rate (which was achieved by 1965), as well as affirming the right of the midwife to participate in the maternity care of her patients to the fullest extent (Ministry of Health 1959).

The Peel Report (Maternity Advisory Committee 1970), recommended in 1970 that there should be sufficient beds to provide for a 100% hospital birth rate and that small isolated obstetric units should be phased out and be replaced by consultant / GP units in general hospitals. However, there was no substantial evidence in support of these recommendations. Not only would there be little choice if any, for women regarding the place of birth, it could also be argued that the midwife's autonomy would be eroded even further.

The Second report on Perinatal and Neonatal Mortality from the Social Services Committee (House of Commons 1980), under the Chairmanship of Renee Short, agreed unequivocally with the Peel Committee's report of 1970. Although this committee further recommended that not only should home births be totally phased out, they did support that better use should be made of the skills of the midwife. The Short report (House of Commons 1980) also identified a need for the maternity services to become more humanised at a time when it appeared that technology was rapidly taking over the care of the childbearing woman, and midwives were becoming little more than technicians in the process. Walters and Kirkham (1997) have stated that the increasing medical powers of control over pain and progress in labour have meant that enabling the woman to cope with her labour was no longer the key midwifery skill. As maternity care became more fragmented, Kirkham (2000) also relates that it became more difficult for the midwife and woman to develop a trusting relationship.

Comaroff (1977) claimed that at this time the majority of labours appeared to be managed and conducted, as women tended to experience labour as patients in a hospital setting which, for the majority, was probably their first experience of hospitalisation. It was suggested by Graham (1977) that antenatal care could be the means of actually preparing women for this patient role through attending antenatal outpatients clinics and preparation for parenthood classes. However, it is further argued by Leap (1992) that experiencing labour as patients has connotations of sickness and dependency, implying the woman adopts a passive role as she becomes unnoticed in the pursuit of the visibility and importance of the fetus: her wishes and choice having little significance. If professionals fail to respect the woman's autonomy and choices regarding childbirth, Kirkham (1983) claimed they would be stripping the woman of her identity and reducing her to being a patient who is easy to manage. Walton and Hamilton (1995: vi) later reflect:

"Midwifery in the 21st century was visualized in a highly sophisticated, controlled environment where the women were merely recipients of care. In the search for the perfect human being the specialists would have control of the entire process".

What was not being taken into consideration was the opinion of women both as mothers and midwives. Apprehension about this vision of the future led to voices of dissent from individuals and then from representative groups. The Short Report (House of Commons 1980), had for the first time set the scene for the professionals within the maternity services to look at ways in which the mother and her family could be treated with more warmth and compassion than previously.

Following the Short Report, the Government set up the Maternity Services Advisory Committee which produced three reports that were to be very influential in the planning of maternity care: Maternity Care in Action Part 1: Ante natal Care, Maternity Care in Action Part 2: Care during Childbirth and Maternity Care in Action Part 3: Care of the Mother and Baby (Maternity Services Advisory Committee 1982, 1984, and 1985). It was intended that Maternity Services Liaison Committees, Heads of Midwifery Services, Obstetricians and Health Authorities used these reports as guidelines in order to improve the standards of maternity care. However, these reports also reinforced hospital birth as being the safest and best type of care for the childbearing woman and

her baby. Although obstetricians generally agreed with these facts at the time, there were others who were not in agreement. A number of studies, such as those by Ashford (1978) Barron et al (1977) and Chalmers et al (1976), suggested that the relationship between the increase in the hospital birth rate and decline in perinatal mortality was spurious. Tew (1985) had also highlighted the fact that statistically a causal relationship could not be found between the fall in perinatal mortality figures and hospital births. She suggested that it was probably multifactorial and possibly due to the raised standards of living generally, than to changes in the place of birth. Whilst these findings continued to be largely ignored by the policy-makers until the beginning of the 1990s, there were other people, such as Kitzinger (1991) who also emphasised that there was more to consider than solely the perinatal mortality rate. As Kitzinger (1991: 9) states:

“a good birth is not just a matter of safety, or of achieving the goal of a live and physically healthy mother and baby. We want birth to be as safe as possible, but should not take it for granted that delivery in an operating theatre is the best way to achieve this”.

These views were endorsed by both consumer and professional organisations, such as the Association for the Improvements in Maternity Services (AIMS), the NCT and the Royal College of Midwives (RCM). As one of the leading professional groups, the RCM emphasised not only the need for the maternity services to respond to the social, emotional and educational needs of the mother in addition to her physical health, but also for women to have a right to be partners in their care. Furthermore, they affirmed the right for midwives to practise their profession in a system that makes full use of their skills (RCM 1987).

In 1986, the Association of Radical Midwives (ARM) had published their report on the maternity services: *The Vision: Proposals for the Future of the Maternity Services*: which highlighted the frustration felt by many midwives and mothers with the fragmented pattern of care and lack of support for midwives as autonomous, accountable practitioners. The ARM (1986) identified that the medical model was the main impediment to the delivery of team midwifery and a midwifery led service in the 1980s and consequently the report set out the basic principles for the future of the maternity services. Such principles were eventually incorporated into the recommendations of both the Select Health Committee's Report under Nicholas

Winterton's direction (House of Commons Health Committee 1992), and the Expert Maternity Group's Changing Childbirth Report, (DoH 1993) under the Chairmanship of Baroness Cumberlege.

2.5. RECENT DEVELOPMENTS.

Throughout the last couple of decades the NHS has undergone many reforms culminating in the internal market as enshrined in The NHS and Community Care Act 1990 (DoH 1990), in which the commitment to quality and consumer choice and participation was evident throughout. Directives such as, Patients First (DoH 1982), The Patients' Charter (DoH 1991), The Health of the Nation (DoH 1992a), The Patients' Charter and the Maternity Services (DoH 1994), A First Class Service: Quality in the new NHS (DoH 1998), Making a Difference: Strengthening the nursing, midwifery and health visiting contribution to health and health care (DoH 1999), The NHS Plan (DH 2000), Your Guide to the NHS (DH 2001b) to the most recent, Building on the Best: Choice, Responsiveness and Equity in the NHS (DH 2003b) have further emphasised this commitment.

Both the Winterton Committee (House of Commons Health Committee 1992) and the Expert Maternity Group (DoH 1993) collected information from individuals and organisations, professionals and consumers, in order to analyse and make recommendations for improvements in the maternity services. However as the evidence was collected from certain individuals and organisations predominantly of the well educated, middle class type, the true representativeness of the needs and expectations of the whole childbearing population could therefore be questioned. Consumer groups informed the Winterton Committee that the choice of treatment and place of birth was often more illusory than real. These groups claimed that there was little in the way of real choice because of institutional factors and the move towards a 100% hospital birth rate, frustrating, rather than facilitating, those women who wish to have a choice. In examining the data collected from professionals and consumers, including the studies by Tew (1990, 1985), the Winterton Committee also concluded that encouraging women to give birth in hospital could not be justified on the grounds of safety. Furthermore, they also affirmed that the pattern of maternity services / care should not

be driven on a medical model of care based on unproven assertions (House of Commons Health Committee 1992).

A constant feature according to the Winterton Committee (House of Commons Health Committee 1992) was the need for sufficient, balanced, non-judgemental and appropriate information throughout the whole childbirth experience in order for the woman to make informed choices, thus shifting the elements of control and participation towards the woman, as opposed to the professionals. When a woman is offered choice in labour, for example, it is the doctor, or the midwife, who holds that esoteric body of knowledge and who defines the options available. This can easily lead to a massive scope for preferences in care and differences of opinion from one professional to the next. Overall, the information gathered from consumer groups such as the NCT and AIMS, suggested that women were unanimous in wanting emotional support, continuity of care, a competent and confident inspiring birth attendant, and choice and control over their own bodies (House of Commons Health Committee 1992). However, it must again be stressed that such information could be viewed as biased and not fully representative of the views and experiences of women across the whole social class spectrum, as most women attending consumer groups tend to be mainly from the middle classes.

In respect of the professional organisations' recommendations to improve the maternity services, the Winterton Committee (House of Commons Health Committee 1992) found that the opinion of the RCM, the RCOG and the Royal College of General Practitioners (RCGP), was not as clear and unanimous as it had been from the women. This was due to the fact that the professionals appeared more concerned with which group should have control over the maternity services.

Although the Winterton Report (House of Commons Health Committee 1992) greatly criticised the current maternity services and blamed medical, midwifery and management professionals as well as politicians and civil servants, it did find great resources of good will, skill and commitment to draw upon, particularly acknowledging the skill of the midwife, the obstetrician and the paediatrician. Furthermore, it emphasised the need for a dialogue between those resourcing and those providing the service with those using it. It affirmed that the needs of mothers and babies be at the

centre with the maternity services being fashioned around them, not the other way round (House of Commons Health Committee 1992).

Because many of the problems in the history of organisation were due to a rigid and inflexible approach, the Report made it clear that it was not a blueprint for the future. The Winterton Committee (House of Commons Health Committee 1992) considered that the time had come to turn vague promises of a reappraisal of the maternity services into a programme for action at national level. However, such a programme would inevitably prove very costly and therefore the viability of the Winterton Report's recommendations was questioned from the beginning. The Government in its reply to the Winterton Report was generally supportive of the many recommendations made, although it did not agree with them all: particularly in the area of financing them (DoH 1992b). It did nevertheless, decide to establish an Expert Committee to review policy on care during childbirth and make recommendations.

In addition, the three Royal Colleges (RCOG, RCM. and RCGP) published their report in 1992: *Maternity Care in the New NHS: A Joint Approach* (RCOG. 1992). It produced a framework for maternity care that emphasised:

" the three colleges exist to promote excellence in the interests of those we serve, in pursuit of this objective we know that working together and addressing problems together the only way is forward..... care is best structured as an equilateral triangle with the pregnant woman at the centre".

(RCOG 1992: 4)

Such a statement confirmed the sentiments of the Winterton Report (House of Commons Health Committee 1992), and the Government's response (DoH 1992b).

The development that subsequently followed was the creation of the Expert Maternity Group detailing the way forward for the maternity services in its *Changing Childbirth Report* (DoH 1993). This Group also commissioned a MORI Health Research Study of women who had given birth in England from 1989, as well as canvassed Asian and African / Caribbean women for their particular perception of the maternity services.

This report identified that each woman should have choice, control and continuity of care during childbirth, that the delivery of care be woman-centred, appropriate and accessible, and the service should be both effective and efficient. Such factors were to be achieved over a five year period and were further specified as Ten Indicators of Success (DoH 1993). However, the extent to which these recommendations were fulfilled within the maternity services throughout the UK was variable, mainly due to a lack of central funding to support such an initiative. As a consequence, the House of Commons Health Committee for the second time has taken evidence from professionals and consumers on maternity services and published their report: Choice in Maternity Services (House of Commons Health Committee 2003). The report calls for a shift towards midwife bookings, more midwifery units, greater autonomy for the midwife and a larger proportion of Trusts to reverse the medicalisation of childbirth that continues to exist within some areas of the maternity services.

2.5.1 Consumer Response to Choice and Stereotypes.

The factors associated with consumer responses to health care are varied and complex. What pleases one person may in fact be irritating, or even intolerable, to another and therefore it would be misleading to state that all women wish to oppose the advice and control of professionals in the provision of maternity care. Although a number of studies have been conducted over recent years that examine women's perception of childbirth, few actually appear to compare the attitudes or expectations of women from different social backgrounds. Rather they examine the views of women from a particular geographic and demographic population and assess how far they diverge from some hypothetical position: often that of the natural childbirth school. Ounstead and Simons (1979), in their study, suggested that there is a group of women who favour active obstetric management as opposed to another group who insist on natural childbirth at all costs. However, this study neither provided the evidence of such a dogmatic group nor stated the social class background of their informants. Similarly, McIntosh (1986) concluded that the desire for natural childbirth is likely to be a middle class one, but provided no evidence for such a statement, merely that it was not a goal of the working class women he interviewed. In an earlier study, Nelson (1983), found that middle class women suffered a greater discrepancy between what they wished

(little / no intervention) and their subsequent experience, but were more likely than working class women to be able to articulate and have their wishes respected by care providers.

As Green et al (1998) claim, these studies reflect a number of stereotypes of women commonly encountered by professionals providing maternity care for example as in Figure 2.1:

Figure 2.1: Stereotypes of Women (Green et al 1998 pp 22-24).

- The well educated, middle class NCT type,
- the emotional and irrational woman incapable of making sensible decisions *and*
- the working class, uneducated woman: a woman out of control of her fertility.

It is further argued by Green et al (1998) that in this context, stereotypes of women may give a particular cause for concern, because the way in which a midwife or doctor categorises a woman is likely to influence the way in which that woman is ultimately treated and given power to exercise control in childbirth.

2.5.2. Power, Control and Choice.

Mutual processes of empowering and being empowered are facilitated by the existence of a trusting relationship between the individuals and organisations concerned and as Yearly (1997) believes that childbearing should also empower women and not diminish them. In Levy's (1999) informed choice study, she found that one of the central issues to emerge was that of power: who held it and how it was used. The conceptualisation of power, as documented by Lukes (1974) also relates to the effects that one dominant party can exert over a more vulnerable party, which could also be applied to the intrapartum experiences of some women.

When Adams undertook an observation study in 1989 to examine the interactions between midwives and women during the second stage of labour, she discovered that two distinct styles of midwives' communication emerged: the Educational / Encouraging midwife and the Direction midwife. Furthermore, when undertaking follow-up interviews, Adams (1989) found that the women preferred the communication style of the Educational / Encouraging midwife. This particular concept of the midwife kept the women informed of their progress and encouraged them whilst leading them to believe that they were the ones in control of giving birth to their babies. However, in direct contrast was the Direction midwife whose style of communication reflected that she was in control by her constant instruction to the woman throughout the birthing process.

However, as Jamieson (1994) states, where midwives feel disempowered in their work they subsequently are unable to empower women to exercise choice and control in childbirth and consequently give informed consent. It is worth being reminded that the majority of midwives who were educated and trained in the last century had also undertaken nurse training where, according to Siddiqui (1996), compliance and obedience to the doctor was the norm. Much has been written about the doctor-nurse power relations that have manifested over time within the hospital setting by Stein (1967), and more recently by Stein et al (1990) and Porter (1991). The sexual identity was also seen as perpetuating the power relations as doctors were predominantly men and nurses mainly women, that further reinforced male dominance and female passivity. What developed was the doctor-nurse game as first described by Stein (1967) where open disagreement between the two players in decision making had to be avoided at all costs. Traditionally it has been the doctor who has had total responsibility for making decisions regarding the management of his patients, and should he request a recommendation from a nurse, it had to be done without him appearing to be asking for it. Similarly nurses had to communicate their recommendations without appearing to be making them and thus make the doctor believe the decision was his idea. Consequently, it is possible that this power relation between the two groups of health professionals has affected decision-making in midwifery practice.

Whilst examining the literature concerning choice and control in childbirth within the institutionalised setting, Green et al (1998) have also found that the exercise of maternal

control can be often detrimentally influenced by professional domination and inter-professional issues and tensions and that a woman's desire to be in control may conflict with midwives and medical staff who also want to be in control. Edwards (2000) in her home birth study, found that women considered it important to ensure they did not cause any conflict in developing a good relationship with their midwife. As a result, according to Kirkham (1989), some women have to be especially subtle in expressing their wishes if they are to avoid antagonizing their caregivers and thus the least articulate of women would experience difficulty in doing so.

Bluff and Holloway (1994) also found similar results to those of Kirkham's (1989) in their small study into women's perceptions of midwifery care during labour and childbirth. They found that although many women wanted a say in the type of care they received in labour, they did not always know how to communicate their needs. Although it is recognised that this sample size was small (11), it may be considered that this study has a collective value as the findings were similar to other intrapartum studies. Furthermore, both McKay and Smith (1993) and Kirkham (1987) had discovered in their studies that if a woman had a silent fear of the midwife, or perceived the midwife to be too busy or unwelcoming of questions, the woman was less likely to initiate any conversation or ask questions.

As informed choice involves weighing up options that some women do not exercise in the rest of their lives, Kirkham (2000) believes that it may therefore be inappropriate for health professionals to expect these women to be able to freely express their wishes and exercise choice during childbirth. It has also been argued that the concepts of choice and control are essentially middle class notions that may not have any relevance to the vast majority of working class and less-educated women (Green et al 1998). However, Hunt (2004) found when exploring the insights and experiences of childbearing women living in poverty, that some midwives exerted power over the women by failing to provide information or discuss options of care with them.

Whilst Kirkham (2000) and Leap (2000) both stress the importance of midwives recognising the overt and covert clues from women in order to relate appropriately to them, they also emphasise that all health professionals working in the maternity services should continually evaluate their communication skills and ensure they are collectively

working with the woman to achieve the optimum standard of care. However, when Fraser (2002) explored the effectiveness of the labour ward as a learning environment for students, she discovered little correlation between midwives recognising the clues from women and demonstrating appropriate communication skills. Instead, it was found that there were three distinct ways that midwives enabled women to make choices in labour (Fraser 2002). These are illustrated in Figure 2.2.

Figure 2.2: Midwives' Interpretation of Enabling Women to make Informed Choices. (Devised from Fraser 2002: 556).

- **Explained the options: would not give an opinion / advice when requested.**
- **Explained the options and gave advice.**
- **Explained the options in such a way the woman would choose the midwife's preferred option.**

Although it would appear that women are actually offered more choice than a decade ago, it has been argued that they are not always offered a full range of birth choices, including home birth. Newburn (2003) argues that the range of options still tend to be dominated by a medical model of care in many instances, being concerned with consent to medically defined procedures and treatment.

In addition, Singh and Newburn's (2000) nation-wide study of 1,944 women who had recently accessed the maternity services, found that women did not always receive adequate information on the significance of alternatives, as good quality evidenced based information was not consistently available, nor were they given the support to choose freely from the full range of options.

2.5.3. Birth Plans, Choice and Consent.

One means for a woman to articulate her wishes as well as the midwife be in a better position to explore the full extent of the woman's knowledge and understanding of childbirth, may be via the use of a written birth plan. However, there has been little research conducted in terms of evaluating the effectiveness of birth plans as an

intrapartum communication tool. Studies have found that very few women (mainly primigravidae) actually formulate a birth plan prior to the onset of labour with their decision being based on the attitude they have towards such a plan (Jones et al 1998, Green et al 1998).

In Jones et al's research in 1998, only 42 (3%) of the 1172 women studied presented with a birth plan in labour, of whom 40% had spontaneous vaginal births compared to 60% without birth plans. There were more interventions by obstetricians in the group with birth plans. However, there were no data pertaining to whether the original birth plan contained any details about such interventions or the extent that women were happy to accept them. In addition, Green et al (1998) in their postnatal study of 710 women, found that of the 117 women who intended to write a birth plan, only 84 (12%) had written one by the time they went into labour. Of the 47 who stated that their plan had been unhelpful, 10 felt their birth plans had been totally ignored by the staff and were therefore deemed to be pointless, and a further nine felt the plan was made redundant by the turn of events: for example: rapid labour, complications arising etc. As a result, if a woman's birth plan was either ignored or not fulfilled due to a complication developing, she was less likely to formulate another in a subsequent pregnancy.

The results from a postal survey study conducted in Dundee by Whitford and Hillan (1998) that examined the perceptions of 101 primiparous women regarding the use of their birth plans, found that 78 women (77%) had completed a birth plan prior to labour starting: a much higher proportion of respondents than in other studies. However, Whitford and Hillan (1998) were critical that their study sample consisted mainly of older women who lived in more affluent areas of the city and who were more inclined towards planning their labour and baby's birth. Consequently their results could not be generalised to the whole population. As the completion of a birth plan had become an established part of antenatal care in the locality, this was also thought to have influenced the results. Furthermore, Whitford and Hillan (1998) suggest that another explanation for the high completion rate of birth plans is that many midwives use it as a tool for discussing and obtaining consent to procedures, such as the administration of syntometrine, in a response to increasing litigation.

The reasons women gave for not completing a birth plan prior to labour were either because of their uncertainty about what labour would be like or that they wanted to experience it first before making any decisions. As a result, Whitford and Hillan (1998) found that a small number of birth plans were completed during labour. According to the findings of Too's (1996) study of midwives' opinion of birth plans, midwives believe that the labour ward environment is not the ideal place to be discussing labour options and formulating a birth plan with women as there is limited time to discuss issues fully. Jackson (1986) and Carty and Tier (1989) suggest that a home visit by a community midwife during the latter weeks of pregnancy is a more ideal time for such a purpose. Whitford and Hillan (1998) also found that most woman in their study considered completing a birth plan in advance of labour to have been of benefit as it had helped to improve their understanding of what could happen during labour and the choices available to them.

Similar to Green et al (1998), Whitford and Hillan (1998) discovered that the extent of attention given to the birth plan by midwives during labour was less than what the women had expected, with a substantial number (34) of birth plans having not even been read. Although there have been few studies about midwives' attitudes to birth plans, some authors suggest that a number of midwives and doctors are cynical about them and indulge in stereotyping of women who make detailed plans (Green et al 1998, Too 1996).

A number of studies have reported that birth plans improve communication during labour (Green et al 1998, Whitford and Hillan 1998, Jackson 1986) and enhance choice and control during labour (Kitzinger 1987). However, the style or presentation of the birth plan is crucial. A major criticism of pre-set formatted birth plans is that they deny women the opportunity to make informed choices as they simply present a menu of current hospital practices for women to opt in or out of. Furthermore, this type of birth plan can be viewed as another form of coercion in the guise of choice. However, Price (1998) suggests that if in reality, hospital policy and inadequate facilities mean that choice is not truly available to women, then using a pre-set format may offer a more realistic approach to birth planning.

In Whitford and Hillan's (1998) study half of the women who completed a birth plan stated that it made no difference to the amount of control they felt they had during labour, but it merely offered them casual superficial choices. Nevertheless, even when labour did not progress according to the birth plan (61) most women did not consider this to be upsetting or that they had failed, as they perceived the reasons given for any deviation to be important. As Whitford and Hillan (1998) indicate, a good process of intrapartum communication with full explanations can assist in preventing feelings of failure. Consequently, a high proportion of women (68) in their study stated they would make another birth plan in a subsequent pregnancy. However, this was in complete contrast to the findings of Green et al's (1998) study.

Green et al (1998) found in their study that of the 84 women who had written a birth plan in advance of labour, only 35 had actually considered them to be beneficial. These were in situations where there was fragmentation of care due to midwives working shifts, or when the woman could not effectively articulate her wishes, either because of being in advanced labour or the effects of pain / analgesia. The birth plan therefore can ensure the woman's wishes continue to be accommodated as far as possible. Furthermore, not only may the birth plan be a means of reflecting which procedures have already been discussed with the woman, but also to which procedures consent has been obtained by her colleagues. Such benefits have also been recognised by Nolan (2001) and the RCM (1997). However, some authors consider birth plans to be unnecessary where women already know their midwife prior to labour or where hospital policies are more flexible (Bostock 1993, Inch 1988). It would appear nevertheless, that due to the limited amount of data currently available, more research should be undertaken to explore the impact of birth plans on midwifery care and on the women who make them, in order to evaluate their potential value in exercising woman's choice during the intrapartum period.

In December 2003, the DH published: *Building on the Best: Choice, Responsiveness and Equity in the NHS* (DH 2003b). This report specifically refers to the provision of greater choice in maternity services by requesting that local services promote direct access to midwives and for all women to be given the option of having a birth plan. In addition, it is expected that local maternity guides will be published from the DH in a readable magazine format for each woman to consider the options available to her to

then choose what services she would like to access. However, in areas where the numbers of midwives limit the choices that can be offered to women, the report further highlights the government's commitment to addressing the issue concerning the recruitment and retention of midwives (DH 2003b).

2.5.4. The Birthing Environment.

Women particularly primigravidae, often know little about how the culture of hospitals varies, or the quality of facilities and opportunities for control and one-to-one support that are more readily available at home or in a midwife-led unit. In the study conducted by Proctor in 1998, it was found that women considered it important for the surroundings in which they laboured and gave birth to be homelike as this conveyed that their experience was normal and they were not ill. Furthermore, the birthing environment can have a great effect on the amount of fear and anxiety a woman experiences. As Steele (1995) purports, hospital can be a frightening environment for most women where institutionalised routines, such as, the staff wearing uniforms, the woman having an identity bracelet placed on her wrist and undressing into a hospital gown upon admission, combined with a lack of privacy, can contribute to a loss of control. As a consequence, increased anxiety brought on by this lack of control, can interfere with the normal physiological processes of labour, with the use of cardiotocography (CTG) monitoring upon admission as being a prime example (Steele 1995). In addition, studies by Simkin (1992, 1991) into women's birth experiences found that the control, or lack of it, was very important in the long-term memory of birth as a positive or negative experience.

A small-scale ethnographic study was undertaken by Machin and Scamell (1997) to investigate the way that primigravidae recruited from either the NHS or the NCT, gathered understandings of pregnancy and childbirth through their own cultural beliefs, medical advice and personal experience. When comparing the antenatal data, it was found that the two groups of women were distinctly different during pregnancy. The NCT group wanted to exercise control and remain autonomous and commonly wanted a drug-free birth, whilst the NHS group were happy to hand control over to the professionals and wanted a pain-free birth and a healthy baby. However, in labour, this

division disappeared as all women became vulnerable and consequently turned to the culture of the hospital birth environment and its rituals of the medical model as these were the only cultural tools offered to them by their attendants. The NCT group had not anticipated this would happen and became highly influenced by the metaphor of science and safety, just as their NHS counterparts. The findings of Machin and Scamell's 1997 study highlighted the importance of health professionals being sensitive to existing cultural values and beliefs when advocating the notion of informed choice as it may not be applicable to all groups of women within a diverse society. Despite there being an emphasis on informed choice throughout childbirth, Machin and Scamell (1997) found that midwifery practice continued to offer the bio-medical metaphor as the dominant cultural support during labour.

As there now would appear to be more evidence to support the case for normal birth, Robinson (2003) questions how the providers of institutionalised maternity care who continue to dominate the birthing experience for the majority of mothers, babies and midwives can also be convinced of such a feasible option. In order for midwives to rise to these challenges and be confident in their abilities to provide care for low-risk women, consideration should be made as to how this confidence can be nurtured.

Policy documents such as, *The New NHS: Modern Dependable* (DoH 1997), *First Class Service: Quality in the new NHS* (DoH 1998) and *Making a Difference* (DoH 1999) have all provided midwives with further opportunities to demonstrate their autonomous practice. Innovative developments such as team midwifery, midwife-led clinics, midwife-led units to the more recent re-introduction of birth centres, have not only led midwives to regain some of the territory of normal midwifery lost to the medical profession in the 20th century by reasserting their autonomy, but also to increase the choices available to women (Kirkham 2003, Saunders et al 2000, Flint et al 1989). Furthermore, it is claimed by Kirkham (2003) that the small-scale of a birth centre is known to have a positive influence on the relationship between midwife and woman, such that it allows a shift in power from the professional to the woman.

Although there has been much work written regarding student midwives emulating some of the attributes of their midwife mentors (Bluff 2003, Chartres 2000, Spouse 1998, McLeod et al 1997), it must also be recognised that the type of clinical

environment to which student midwives have been mostly exposed during their education and training can play a substantial role in developing confidence and autonomous decision-makers. Although some students are confident to take up work in birth centres and have their own caseload upon qualification, others who may not have had such experience can easily become socialised in the medicalisation of childbirth embracing technology and intervention. In order to address this imbalance of clinical experience, the RCM (2003) launched its strategy for midwifery education: *Valuing Practice: A Springboard for Midwifery Education*: which they expect to become a reality in 5 years time. Their vision recommends that students should gain more experience of maternity care provision in the primary sector, such as the home, in birth centres and group practice midwifery in order to encourage their development as autonomous practitioners and consequently be in a better position to offer women real choice and empower them into making appropriate childbirth decisions. Although there may be resource implications to provide such midwifery-based practices throughout all areas of the UK, the RCM recommendations are expected to serve as a challenge for midwives to take control of their education in order to make such a vision a reality.

Whilst women should be supported to make appropriate childbirth decisions, from an ethical, medico-legal and professional perspective of the health professional providing maternity care, there are also sociological issues surrounding a woman's choice to either accept, or refuse a proposed procedure or treatment, that require consideration. Such a decision concerns informed consent and is discussed in the next section of the literature review.

2.6. INFORMED CONSENT IN THE CONTEXT OF HEALTH CARE PROVISION.

The complex issue of informed consent, historically is founded on a number of disciplines and social contexts, such as the health professions, law, social and behavioural sciences and moral philosophy. Its purpose is to provide protection of the client's autonomy and integrity. The process of informed consent involves mutual communication of information and a shared and reasoned decision by client and practitioner that has been shaped by social, health, ethical and legal considerations. The philosophy underlying informed consent from a social context is a recognition of the

unequal balance in knowledge and power between a health professional and client. The International Childbirth Education Association [ICEA] (1991) suggest that theoretically, informed consent should equalise this balance and recognise the need for the client to be treated as a person who can take responsibility for important health care decisions.

However, Faden and Beauchamp (1986) believe that the most influential disciplines are law and moral philosophy. The Law's approach to consent to treatment has developed from a pragmatic theory that has tended to centre more on the legal process concerned with the laws of negligence and battery and the consequential financial compensation for unfortunate medical outcomes than on either the disclosure of information or the consent of the client in general. In comparison, the American College of Obstetricians and Gynaecologists (1992), assert that informed consent is essentially an ethical imperative evolving from the ethical principle of respect for autonomy that focuses on the individuality of the client who has a right to make an autonomous choice.

In current literature and practices, Beauchamp and Childress (2001) consider there to be two different senses of informed consent. The first they believe to be an individual's autonomous authorisation of a medical intervention or to participate in research. In this sense the person must do more than express their agreement or comply with a proposal. The individual must authorise something through an act of informed and voluntary consent in the absence of controlling influences of others: this involves substantial understanding on behalf of the individual. In the second sense, informed consent is analysed in terms of the social rules of consent in institutions that must obtain legally or institutionally valid consent from individuals before proceeding with diagnostic, therapeutic or research procedures. Beauchamp and Childress (2001) further add that informed consents are not necessarily autonomous acts under these social rules and sometimes are not even meaningful authorisations. Informed consent refers here only to an institutionally or legally effective authorisation, as determined by existing rules.

The following section will discuss informed consent from a sociological perspective before exploring the ethical and medico-legal implications in health care practice with reference to particular case law and aspects of maternity care.

2.6.1. Informed Consent from a Sociological Perspective.

It has been claimed by Symonds and Hunt (1996) that the existence of power relations is accepted by all sociological theories, recognising that all societies have had structures and hierarchies of power. Sociological theories not only seek to examine which groups in society hold this power and how it is used but also the nature of the power and the way in which it is transmitted and reproduced in society. When considering informed consent from a sociological perspective, it is important that the difference between the concepts of power and authority are clearly understood.

Weber (1948) cited in Gerth and Mills (1970), argued that power can be simply coercive, as exercised by physical threat or social and emotional blackmail, whereas authority is based upon true and freely given consent. Individuals may obey others not because of fear, but because of genuine and unquestioning respect to and acceptance of a greater authority. In addition, Jordan and Irwin (1989) recognise that authoritative knowledge can be very persuasive as it seems natural, reasonable and consensually constructed. For the same reason it also carries the possibility of powerful sanctions, ranging from exclusions from social groups to physical coerciveness. In general, people not only accept authoritative knowledge, and in so doing, validate and reinforce it, but are also actively and unselfconsciously engaged in its routine production and reproduction.

Historically, the relationship between the professional and the client has been based upon the claim to legitimate authority. As a consequence, individuals are known to obey doctor's orders or take professional advice simply because of this acceptance of authority based upon expertise, experience and superior knowledge. More recently and in the childbirth context, Davis-Floyd and Sargent (1997) refer to the concept of authoritative knowledge and how this is perceived cross-culturally. In cultures where a holistic birthing model is apparent, they acknowledge that such a model gives the authority of knowing to the woman in comparison to that of a medico-technocratic model where knowledge is invested in its experts and machines. The latter model being more common among western cultures.

Kniveton and Howitt (1989) question the assumption that when individuals adopt the behaviour around them, they are under the influence of, or are being manipulated by others against their will. People who conform or consent to something they have no strong feelings about may be saving themselves effort by adopting strategies that others have probably given much thought to. They may also, or alternatively, be ingratiating themselves to others through the flattery of imitation. This can be done extremely effectively by complying with others' orders, conforming to their behaviour, or functioning within the confines of the role they have adopted. Kniveton and Howitt (1989) further state that when an individual allows others to influence them it should not necessarily be assumed to be a negative thing. However, the question to consider may be who is manipulating whom.

In many instances it is the situation rather than people that determine conforming behaviour. For example, being in a hospital inspires a very different behavioural response from an individual than them being in their own home. The change of the cultural placing of childbirth from the private home to the public hospital setting has medicalised what was originally considered to be a natural event. It is therefore expected that the woman and her partner, regardless of their own cultural and ethnic norms, comply with, and conform to, the hospital rules and standards of behaviour, communicate using the same codes and language and also respect and value the technology surrounding them. In such a way the hospital is seen as a socialising agent (Machin and Scamell 1997, Davis-Floyd 1990) with its medical model of pregnancy and childbirth promoting conformity. As Sookhou (2003) states, when conformity is not perceived, such as the woman wanting to give birth at home, then the pattern of behaviours or attitudes is interpreted as deviation from the accepted norms.

Rituals serve a variety of communicative functions and reflect cultural messages about the underlying values of society. The participants generally do not invent the structure of the ritual but rather perform the structure as it has been taught to them and it then becomes part of a routine. In health care practice, a ritual can be seen as a device used to transform procedures into socially acceptable acts. It could therefore be argued that many of the routine intrapartum procedures a woman experiences in labour serve as a ritual rather than a substantive function and consequently it is taken for granted that the woman will allow them to proceed: further reinforcing the powerlessness of women.

It has also been suggested that the routine interventions undertaken by midwives and doctors during labour simply reflect their societal imperative to do something (Anderson 2002, Enkin 1992) and as a result, such interventions may alter the physiological process of how a woman labours and gives birth. Whilst it could be considered easier to adopt Leap's (2000) approach of: 'the less we do, the more we give' to the home situation where routine hospital policies do not exist, it may also be applied to the hospital setting. Such an approach therefore provides a challenge for hospital midwives to be able to articulate how they make judgments as to when each intervention is appropriate in order to learn how to make timely interventions in the physiological process: but only when necessary.

In the case of vaginal examinations, Bergstrom et al (1992) recognises that touching the sexual organs of another is a social situation that must be performed with great care to avoid any misunderstanding. When such an examination that can also inflict pain, is undertaken as a ritual without explicit consent, the intimate aspects are completely ignored and a barrier is created between the health professional and the woman such that they become role players rather than authentic persons. Ignoring a woman's expression of pain may be a manifestation of the denial or disembodiment that the health professionals are indeed contributing to, if not causing, her pain and reinforces the ritualistic aspects of this social situation.

Bergstrom et al (1992) further discuss that the verbal and non-verbal aspects of the caregiver – woman interaction in respect of undertaking vaginal examinations, also reflect the power and authority invested in the caregiver compared to the labouring woman's general passivity. The gestures of deliberate gloving, (although probably initiated by adhering to the rules to maintain sterility and reduce infection risk), and holding a clenched fist within the woman's view, are symbolic of authority and communicate an implicit social message by the manner in which they are carried out, making it difficult for the woman to express her refusal to the procedure.

In addition, Henley-Einion (2003) refers to the advances in media and information technologies as having contributed to reinforcing birth as a medical event, dramatising and popularising hospital births and conditioning women into expecting similar interventions during their own labour. In direct contrast, the low impact that home birth

has within the media reinforces it as a rare, unsafe alternative. This has led to a greater dependence on science and medicine to support women through childbirth and perhaps a desire for them to consent to all the available medical interventions. Davis-Floyd (1992) suggests that as a consequence of fear and as a reflection of a technological society, some women perceive a medical birth to be the norm and request epidural analgesia and to give birth by elective caesarean section not fully understanding the interventions and procedures or their implications. If women are to be educated about the normal processes of birth and offered a true choice, it is necessary to explore their reasons for choosing a medical birth and the underlying fears that motivate them to make such choices, while at the same time accepting their autonomous right to choose.

2.6.2. Ethical Considerations of Informed Consent.

The primary values that guide decision-making in the client-practitioner relationship according to the President's Commission (1982) are the promotion of a client's well-being and respect for a client's self-determination (autonomy). Adopting this approach would reassert the four ethical principles (Beauchamp and Childress 2001, Richards 1997) that are considered to underpin health care practices as shown in Figure 2.3:

Figure 2.3: The Four Ethical Principles (Beauchamp and Childress 2001: 12, Richards 1997: 164).

- **Respect for autonomy.**
- **Non-maleficence (primum non nocere: above all, do no harm to others).**
- **Beneficence (to do good for others).**
- **Justice (the demand for universal fairness).**

The principle of respect for autonomy is probably the most commonly accepted foundation of informed consent. Historically, the word, "autonomy" has derived from Ancient Greece, where "autos" (self) and "nomos" (rule / law) were combined to refer to political self-governance in the city-state. Jones (2000) supports the claim by the American College of Obstetricians and Gynaecologists (1992) that in moral philosophy, personal autonomy has come to refer to personal self-governance, self-rule and being in

control of one's life. In contrast, Appelbaum et al (1987) state that the principle of autonomy in general ethics, however, refers to the respect for the autonomy of others, whereas in bioethics it primarily relates to the obligation of health professionals to respect the right of clients to make their own decisions about their care and treatment: the basis of the concept of informed consent.

It is one thing to be autonomous and another to be respected as autonomous. Faden and Beauchamp (1986) state that many issues about consent concern failures to respect autonomy, ranging from manipulative under disclosure of pertinent information to non-recognition of a refusal of medical interventions. To respect an autonomous person is to recognise with due appreciation the person's capacities and capabilities, including the right to hold certain views, to make certain choices, and to take certain actions based on personal values and beliefs.

Benjamin and Curtis (1986) believe that such respect for autonomy is an intrinsic value of the ethical theory of Deontology where autonomy is always a priority and follows Kantian philosophy where people are seen as ends in themselves rather than being treated merely as means to the ends of others. The burden of moral justification would therefore rest on those who would restrict or prevent a person's exercise of autonomy. In comparison, autonomy would be seen as an extrinsic value of Utilitarianism, and therefore non-essential if the consequences are that by respecting the principle, less good is achieved than by not respecting it: thus ignoring the principle of beneficence.

There are two basic approaches to autonomy. The first is from a libertarian perspective that according to Jones (2000) assumes anyone older than a toddler is autonomous, unless mentally impaired or possibly emotionally distressed. This is an obvious generalisation with no acknowledgement of the assessment of individual capabilities and understanding, although it is considered that autonomy can be lost with age, as in cases of degenerative senility. This approach would suggest that a person's view must be accepted even in the absence of an acceptable reason or rationality, thus allowing the freedom to make a mistake. Such an approach however, could be considered inappropriate for an accountable health professional to adopt when dealing with the lives of clients, particularly in cases concerning the health and well-being of the fetus, neonate and infant.

Proxy consent may be obtained in cases where the individual client is deemed incompetent to make decisions about their care and treatment, such as minors and the mentally incompetent. Where minors are concerned, it is usual for the parents to act in the best interests of the child, as legally, a competent adult is someone who has reached 18 years of age and has the capacity to make treatment decisions on his or her own behalf. However, in 1985, a legal precedent was set by the Gillick case against West Norfolk and Wisbech Area Health Authority that concerned the supplying of contraception to the under 16s. It ruled that, providing children are capable of understanding the nature and effects of the proposed treatment, they may consent to that treatment, and subject to certain safeguards, doctors may lawfully administer the treatment, even in the face of parental dissent. Although in this respect the doctor would be respecting the autonomy of the child, it cannot be considered a libertarian approach, as understanding has to be demonstrated in the eyes of the law, as well as the ability to rationalise, reflect and make clear judgement. Such elements formulate the second approach to autonomy that is more rigorous than the libertarian perspective.

Autonomy is considered to be a matter of degree, rather than an all or nothing capacity. The more rational and deliberate an individual's actions are, the more choice they are allowed. Jones (2000) questions that if these factors are weak or absent in an individual, their decisions should be overridden. In reviewing some of the cases involving intrapartum consent, Griffith et al (1999) suggest that labour is a condition whereby certain factors such as, fear, pain and sedation may reduce a woman's capacity to the extent they are temporarily incapable of making valid autonomous treatment decisions. However, Jones and Jenkins (2004) argue that it would be unreasonable to suggest that every woman is incapable of making decisions following the administration of pethidine in labour, as most women are found to be easily rousable and able to make competent decisions. Nevertheless, in situations where the woman is sufficiently sedated by drugs to make her incapable of understanding the implications of the situation, any action taken by a health professional would be judged according to the Bolam principle (as discussed on page 40). Should the woman subsequently challenge the action taken, the court would expect to see evidence that the woman's mental capacity had been assessed rather than the health professional automatically making a paternalistic decision. It is widely endorsed that good record keeping is essential to this avail (NMC 2005, Jones

and Jenkins 2004, NMC 2004b, Dimond 2002, MDU 1996). Consequently, health professionals may make decisions for that individual or refer the case to court.

Health professionals have dual autonomy; as people in their everyday life, and as practitioners in their working life. The NMC (2004c) specifies that pre-registration midwifery programmes should be designed to enable the student to achieve competence under the direction of a practising midwife and so to assume on registration the responsibilities and accountability for her practise as a midwife. However, unlike the guidelines issued by the National Boards for Nursing, Midwifery and Health Visiting (ENB 1991), these revised standards of proficiency no longer refer explicitly to the midwife's autonomy. In practice, as Jones (2000) suggests, it may be difficult to utilise professional autonomy, partly as a result of restrictive maternity unit policies and procedures: many of which can affect the woman's freedom of apparent choice or movement, and the midwife's practice.

Richards (1997) relates the dilemma of two East Hertfordshire community midwives that opened up the debate on how far midwives should go in seeing their clients' aspirations fulfilled. The two midwives had recently attended a successful waterbirth at home and despite careful preparation under the aegis of the supervising midwife, the midwives were disciplined for failing to adhere to Trust policy because the woman had refused to get out of the water for the birth. Although the birth took place in the woman's home and the midwives had taken responsibility to develop their knowledge and skills in order to support the woman to give birth in water (NMC 2004b), the case highlights the incongruities in professional practice that exist as much between different areas as between midwives themselves. Client autonomy, it appears, can also be affected by distinctions as ambiguous as location. However, whilst it has been recognized that few professionals would argue against the formulation of policies and procedures for the safety of those receiving and providing care, it is acknowledged that the policies should be flexible, based on current research and formulated by a representative group of professionals (Marshall and Kirkwood 2000). Furthermore, inflexible, obstetric-oriented and litigation-fearing policies may create a conflict of interests between the obstetricians, the midwives and the women.

Doctors also have a dual autonomy. In their professional lives they are in a position of great authority to make decisions regarding the management of their clients' conditions and treatments. However, in midwifery and obstetrics, this situation may only occur when a deviation from normal is detected as midwives are expert practitioners of normal midwifery, or in situations where a woman chooses to see a doctor instead of the midwife. The BMA (1986) acknowledge that doctors are legally protected to accept midwifery decisions in the absence of actual complications, as the midwife will be accountable for her own decisions and actions.

As discussed elsewhere, it is also important to consider that the formation of a good working partnership in which the autonomy of each individual is respected, should lead to a more positive experience for both client and professional (Marshall and Kirkwood 2000). Accepting the rights of any one profession may take precedence over the needs of the woman as there may be some instances where the woman's choice could be considered inappropriate. For example, the woman who refuses a caesarean section following advice from the health professionals, as a consequence, could not only be putting her own well-being at risk, but also that of her fetus. Griffith et al (1999) discuss how such a situation challenges the health professional in terms of both the legal and ethical implications of their professional responsibility to the woman and the fetus, by conflicting with their respect for the autonomy of the woman to make such choices. It would therefore be difficult for the midwife's autonomy to supersede that of the woman in such an instance as doing so would be seen as going against the woman's wishes.

2.6.3. Medico - Legal Obligations of Informed Consent.

The medical view of birth as potential pathology, in which something could go wrong at any time, is both a powerful and dominant model (Lazarus (1997)). Doctors have increasingly become more cautious and use all birth technology available for fear of becoming involved in malpractice suits. As a result, this dominant ideology that perceives medical controlled birth as the norm, envelops women's thoughts about their own birth and the use of technology and interventions. However, regardless of the model of childbirth practised, all health professionals should be aware of their legal obligations and ensure they obtain informed consent before undertaking any procedure / use any technology with women.

Recent developments in the law relating to consent are leaning towards the foundation of moral philosophy, and demand that physicians respect a client's autonomy, even if the physician may not always feel that this is consistent with the best medical practice, or indeed, the client's best interest. Whilst Gillon (1986: 113) recognised that;

“consent is a voluntary, uncoerced decision, made by a sufficiently competent or autonomous person on the basis of adequate information and deliberation, to accept rather than reject some proposed course of action that will affect him or her,”

it is further suggested by Annas (1989) that the aim of informed consent is to enhance and encourage a responsible client-practitioner partnership in respect of decisions regarding medical treatments. This has been emphasised by Gilberthorpe (1996) who stressed that no longer should a health professional make paternalistic decisions about a client's treatment and expect the client to accept without question. As a result of these developments, including the introduction of the Human Rights Act 1998 (Her Majesty's Stationary Office [HMSO] 2000), in order to help clarify the position of health professionals in respect of the law, moral philosophy and the health care professions, there has been a wealth of guidance published over recent years regarding consent to treatment and the involvement of clients in making decisions about their care (NMC 2004a, BMA 2001, DH 2001b, DH 2001c, DH 2001d, RCOG 1997, MDU 1996). However, it would seem from the work undertaken by Coldicott et al (2003) that there is still a general lack of awareness of the legal and ethical responsibilities among medical students when undertaking intimate examinations, such as vaginal examinations. Regardless of the RCOG (1997) guidelines concerning obtaining consent for such procedures, in practice the extent to which they were respected varied considerably. Nevertheless, Hennigan et al (1991) argues that although the need for students to learn skills in undertaking clinical examinations is well recognised, it does raise legal and ethical dilemmas as far as the vulnerability of the individual, for example, the labouring woman, is concerned.

The importance of consent and information disclosure is further endorsed in the DH's consultative paper: Making Amends: that sets out proposals for reforming the approach to clinical negligence cases in the NHS (DH 2003a). As Algire (1994) purports the lack

of informed consent can create a health care environment where abuses can, and will, occur.

Informed consent is not an event: it is considered to be an ongoing process that should continue throughout the procedure and even afterwards. The NMC (2004a), DH (2001c), MDU (1996) and the ICEA (1991), state that informed consent imposes on the health professional two duties: the first is to disclose to the client the nature, purpose, benefits and material risks of any proposed procedure, and of any alternatives, including non-treatment, in language that the client can understand, and the second is to obtain their consent before proceeding with the procedure or treatment.

2.6.3.1. Information Disclosure and Informed Consent.

Of increasing importance in the field of consent is what information should be given to the client before they decide to go ahead with certain procedures. Dimond (2002) states that if insufficient information has been given to a client by a health professional, an action in negligence may be proven. Until recently, the extent of information clients should receive depended entirely on medical evidence: the leading case being, *Bolam v. Friern Hospital Management Committee* (1957). This stated that as to warnings and advice, just as to acts and omissions, the standard was that of the ordinary skilled man professing the special skill of the relevant defendant. It also stated that if a responsible minority of practitioners would support the defendants' actions, then these actions were not negligent.

There is a requirement that a doctor seeking consent must disclose what a reasonable person (in what the doctor knows to be the client's position), would be likely to attach significance to in deciding whether to consent. Heneghan (1996) refers to this as "the reasonable patient test". One effect of this has been that some doctors feel unable to predict what lawyers will see as reasonable, and the doctors therefore try to tell their clients everything. There is then the risk of putting clients off essential surgery, so there may be a duty not to disclose risks in this circumstance; referred to as the "therapeutic privilege". As the ICEA (1991: 24) state:

“critics point out that the danger with this exception (therapeutic privilege) is the ease with which it can be abused by a practitioner who uses it as an excuse for not telling patients the facts they are entitled to know.”

However when analysing the literature in this field, there is little evidence to show that informing clients is more dangerous to their health than not informing clients (President’s Commission 1982).

According to the MDU (1996), for many of the physical contacts between practitioner and client, consent is implied. It can be assumed that a client has consented by their non-verbal behaviour, for example to abdominal examination, when he or she voluntarily undresses and lies on a couch, or when they raise their sleeve for blood pressure readings, or venepuncture. Dimond (2002) warns that it is also important in such instances of implied consent, to ensure that the action carried out is that to which the implied consent refers. This shows the weakness of relying upon the client’s implied consent and the problems of misinterpretation. Where any risky procedure is contemplated, express consent (either oral or written) should be obtained: the client’s specific agreement must be obtained before the procedure is contemplated. Oral consent is valid, in medico-legal terms, but it is usual to obtain written consent for major procedures. If for any reason, a health professional is only able to obtain oral consent, it would be appropriate to make an entry in the client’s clinical records confirming that advice was given and that the client freely consented and without duress (NMC 2005, NMC 2004b, MDU 1996). However, according to the MDU (1996) the signing of a consent form is of secondary significance, although it may provide invaluable evidence that consent had been obtained in cases where an assault and / or battery is being defended.

Dimond (2003) emphasises that failure to provide sufficient information may constitute a breach of a health professional’s duty of care to the client, and if any harm results, the client may be entitled to compensation and the health professional face the potential legal and ethical consequences of such actions / omissions. Health professionals can sometimes assume that they have consent when all they have is acquiescence and as Patterson (1994) found in her study, the majority of midwives did not seek consent from women when carrying out midwifery procedures during labour. Similarly, Bergstrom et al (1992) discovered that only rarely did the caregivers explicitly ask women for their

consent when undertaking a vaginal examination during the second stage of labour. In most cases, the examination was simply announced and then carried out. Vaginal examination cannot be assumed to be a benign procedure as all internal examinations not only carry some degree of infection risk, for some women, as Clement (1994) and Menage (1993) suggest, they may also carry a substantial psychological risk.

Client waiver may apply if a person does not wish to be informed fully about the care or treatment or to make a decision about it, and, instead, have the practitioner decide. The legal position on whether or not a health professional is negligent in failing to mention a risk to a surgical client was determined in Sidaway against Bethlem Royal Hospital (1985). In this case, a middle aged woman suffered paralysis after neck surgery for pain. The surgeon had not mentioned the possibility of the small risk of spinal cord damage (as it was less than a 1% risk), and as a result the woman sued him for breach of his duty of care to warn her of all the possible risks inherent in the operation. Applying the Bolam test, the House of Lords accepted that the woman need not have been warned of the small risk of paralysis, and therefore the doctor was not negligent. The Law Lords emphasised, however, that in certain circumstances, should the procedure involve a substantial risk of grave adverse consequences, the judge might come to the conclusion that the disclosure of a particular risk was so obviously necessary to an informed choice on the part of the client, that no reasonably prudent doctor would fail to make it.

To determine what a reasonable client would find material to making a decision, health professionals are compelled to engage in discussion with each client. In doing so, they act to implement one of the fundamental goals of the idea of informed consent: to involve clients in decision-making about their own care. Notwithstanding the legal principle, emphasised by the BMA (2001), DH (2001c) and the MDU (1996), health professionals should be aware that there is an increasing opinion among colleagues, lawyers and the public, that clients should be informed of all possible risks, in non-technical language. However, despite research-based evidence that highlights maternal risks of amniotomy (Henderson 1991, 1984, NCT 1989) and episiotomy (Thorp 1995, Greenshields and Hulme 1993, Sleep and Grant 1987, Kitzinger 1986, Kitzinger and Walters 1981), health professionals do not always inform women of these facts. The current series of Informed Choice leaflets (MIDIRS 2003) are based on best available evidence and are an ideal information source for the woman to read, understand and

clarify any issues concerning intrapartum care and management with the midwife in advance of labour, however, not all maternity units have adopted them.

The Expert Maternity Group (DoH 1993) also stressed the importance of health professionals providing unbiased information to childbearing women so that the woman can make an informed decision about her care. However, Jackson (1993) emphasised that it cannot be underestimated how difficult it may be to present an unbiased opinion. It had also been found in studies by Fraser (2002), Kirkham and Stapleton (2001), Edwards (2000) and Levy (1998) that information was often disclosed in such a way to the women so as to direct them into making decisions that were more in line with the midwives' views. However, Jackson (1993) warns that on seeking professional advice, it is hard to believe any woman would not also want to know the professional's personal views on a given method of treatment. In such circumstances, Jackson (1993) continues by recommending that the health professional should state clearly the facts that are available and then give his or her view on the reliability of those facts. The woman must then be encouraged to make her own decision after full discussion of all the issues, secure in the knowledge that those health professionals will also respect her right to choose her care. In addition to the content of information disclosed, informed consent also involves the key elements of how, where, and by whom, the information is to be given if disclosure of information is not itself to be used as a coercive tool.

2.6.3.2. Timing of Information Disclosure and Informed Consent.

According to DH (2001c) and BMA (2001) the seeking and giving of consent should be a process rather than a one-off event and that for major interventions, it is good practice to seek consent to the proposed procedure well in advance. A short interval between obtaining consent and an elective procedure is advisable to enable the client time to consider the matter further and / or take advice. This would however, be totally inappropriate in emergency cases. It is further endorsed that where there has been a significant interval between consent being given to the treatment or procedure being carried out, it is good practice to reaffirm that the client's consent still stands (DH 2001c, BMA 2001).

Griffith et al (1999) debate certain intrapartum cases that have been referred to the High Court where the judiciary have viewed the effects of labour to reduce a woman's mental capacity to the extent that she is incapable of giving consent. Bearing this in mind, the suggestion made by the MDU (1996) that consent to obstetric procedures should be discussed during the antenatal period, would seem appropriate. If a pregnant woman's wishes be unusual, they should be noted carefully in the antenatal records, since the health professional who discusses the woman's expectations may not be on duty when she is admitted in labour (MDU 1996). Although birth plans may also be used to this purpose, Dimond (2002) claims that it would be wrong to see birth plans as written consent to treatment as they are a result of discussions between midwife and woman over the options available, reflecting the woman's wishes at a given moment in time. Jones and Jenkins (2004) also support the fact that birth plans should not be seen as the final consent to treatment, believing it unwise to rely upon consent given some time in advance of the birth. They stress the importance of obtaining consent as close to the procedure as possible in order to give the woman the opportunity to reaffirm her consent or refusal to the procedure, or even change her mind (Jones and Jenkins 2004).

If a birth plan is constructed, Dimond (2002) further endorses that it should always be impressed upon the woman that the plan is subject to the clinical situation and may need to be modified. If problems arise, the midwife should have the freedom to act in the woman's best interests at the time, as she cannot agree to place a restraint on her professional judgment. Riley's (1977) study revealed that women generally felt relieved, grateful and positive after the safe delivery of a healthy baby regardless of their original expectations being abandoned due to the development of intrapartum complications. A further study conducted by Fleissig in 1993 also found that women were less critical of the overall care they received if the baby's health was not affected.

Should the woman refuse to accept the possibility of variations from the birth plan, difficulties can arise, and either the midwife must accept the wishes of the woman or refer the matter to court as in the exceptional case in 1992. In this particular case, the President of the Family Division granted a declaration authorising an obstetrician permission to perform a Caesarean Section on a woman who was in labour with complications. As Brahams (1992) reports, the woman had expressed her refusal to the Caesarean Section because of her religious beliefs, regardless of her own life and that of

her baby being at risk. The concern in this case was that the woman was not represented: the hearing was “ex parte”. As there was no appeal, the Caesarean Section went ahead: the mother survived, but the baby died. This declaration does not under any circumstances provide doctors with the authorisation to proceed without a client’s consent and should not be relied upon to secure maternal compliance.

The RCM published guidelines for midwives faced with (what are still extremely rare) cases of court authorised Caesarean Sections (RCM 1998a, RCM 1998b). Although such guidelines affirm there are no easy answers to such complex a situation, they state that should a woman choose an option that the midwife and the obstetrician disagree with, if the midwife is to be the woman’s advocate then she must represent the woman’s choice. The only challenge to this is that the woman is not competent to make such a choice. In the case of *Re MB*, who refused to have an injection preceding a caesarean section because she had a needle phobia, referral was made to court. Consequently, the judge held that the woman’s fear of needles rendered her mentally incapable of making a decision about her treatment. She was therefore treated as mentally incapacitated and the caesarean section was authorised to proceed in her best interests (*Re MB* 1997).

The RCM (1998b) argues that although in theory a midwife may accept a woman’s right to make decisions on the planning and delivery of care, in practice, the midwife may fear litigation if the birth outcome is not good. As the RCM (1998b) further state it is equally difficult to imagine that any midwife would not be psychologically affected by a woman choosing an option resulting in the death of the mother and / or her baby. Each case must therefore be assessed on its own merits.

In some instances, it may not be possible for the doctor to ask a woman for her written consent to operative or manipulative procedures associated with childbirth, as decisions sometimes have to be taken quickly and at a time when the woman’s ability to give fully-informed consent may be impaired because of sedation. For this reason the BMA (2001) and MDU (1996) do advise their members to obtain written consent for operative procedures that require a general or regional anaesthetic whenever possible. However it may be argued that more appropriate management would be to follow the DH (2001c) and NHS Executive (1997) recommendations as stated in Principle 3 of *Surgical Interventions in Pregnancy*, that those in charge of providing maternity care

should identify a potential problem as early as possible so that both the hospital and the client can obtain legal advice. This would then attempt to prevent any conflict of interests between the health professionals and the woman from occurring, as well as any last minute application to the High Court where the woman's wishes may not be fully represented.

It is important that the person who discusses the procedure with the client should, wherever possible, be the person who will carry out the procedure (BMA 2001, MDU 1996). If that is not possible, the law accepts consent being obtained by someone who is appropriately qualified and familiar with all the details and risks of the proposed procedure and any alternatives: this therefore rules out medical students.

2.6.3.3. Understanding of Information and Voluntariness to Consent.

There are two essential features of a legally valid decision besides consent to or refusal of treatment: one is understanding and the other is voluntariness. People are often told things they do not fully understand, and Appelbaum et al (1987) state that this is also true in conversations between doctors and clients. If the argument that information about health is difficult to understand because of its technicalities were to be pursued to its logical conclusion, then only those who could understand the technical impact of treatment or the procedure are able to give true informed consent. No one, therefore, except a doctor in the same specialism and at an equal or superior level of skill could legally offer a meaningful consent.

Assessing understanding and mental capacity is difficult and very subjective, however, guidance has been published by the DH (2001c) as well as the BMA and the Law Society (1995). The average client cannot fully understand the information which is in fact relevant to him or her: e.g. informing the client that they may or will recover, that the best that will be done is to relieve discomfort, or that there will be some harmful side effects of treatment. In other words, according to McLean (1989), what renders the client competent to make decisions is the fact that he or she can understand (given the information) the likely personal impact of his or her choice. In some instances, it may be helpful for practitioners to supplement the verbal explanation with drawings, diagrams or models, and if necessary, an interpreter should be present to ensure the

explanation is given in a language the client understands. However, in a national survey conducted by Garcia et al (1998) into women's views of maternity care, it had been suggested that in situations where health professionals had assumed women had difficulty in understanding, e.g. women from non-English speaking backgrounds, they were consequently given limited explanations concerning their intrapartum care.

There have been a number of studies undertaken that suggest clients frequently fail to understand the information they are told or are expected to read (Kirkham and Stapleton 2001, Swan and Borshoff 1994, and Lavelle-Jones et al 1993). Disclosure of information is an area where much work needs to be done to ensure clients do comprehend and can retain the information in order for them to make informed choices in respect of their care. Attending antenatal preparation for parenthood classes in the case of maternity clients may improve understanding and recall of information as recognised in Swan and Borshoff's (1994) study assessing the recall of risk information following epidural analgesia in labour. Despite overall recall of information being poor, it was significantly better in women who had attended antenatal epidural education classes and consequently it was recommended that informed consent for epidural analgesia in labour be obtained antenatally (Swan and Borshoff 1994).

There is no doubt that a client's decision about treatment or a procedure is not legally effective if the client has not given it voluntarily, however, although voluntariness is critical, it is an ill-defined concept. While courts have enthusiastically endorsed the dictum that to be effective, informed consent must be freely given, Appelbaum et al (1987) argue that they have shied away from the onerous task of giving content and meaning to this concept. Appelbaum et al (1987) continue by affirming that a decision obtained under any form of duress by the use of physical force, or the threatened or attempted use of force, certain to be highly suspect in both its legal and ethical validity. It is therefore up to health professionals to ensure they obtain consent from clients without duress, thus practising within the legal doctrine.

It is clearly stated by Dimond (2003, 2002), DH (2001c), BMA (2001) and the MDU (1996), that should the mentally competent patient withdraw their consent or refuse life-saving treatment, the doctor or health professional cannot proceed. This also extends to the maternity client where it is acknowledged that a midwife or doctor cannot undertake

any procedure even it is considered in the interests of the unborn child, without the woman's consent. However, if a woman is incapable of making a decision, the position should be discussed with her husband or partner, but while he cannot give consent on her behalf, he should nevertheless be informed. If this is not possible, and the safety of the woman and baby are at stake, the obstetrician should act in the best interests of the woman: adopting the ethical principles of beneficence and non-maleficence.

In the light of the many recent developments in the NHS, it is expected an enhanced client-practitioner partnership be developed in health care / maternity care, central to which is the concept of informed choice / consent. While this section has attempted to explore issues of informed consent in sociological, ethical and medico-legal terms, it still remains a very complex concept. Each health professional has a responsibility to be aware of their limitations in enabling clients to exercise informed consent, taking into consideration the constraints of sociological, ethical and medico-legal theories. It must be acknowledged that central to midwifery practice is the idea of accountability and the sharing or disclosing of information with clients does not displace this accountability. Autonomy and respect for persons dictate that health professionals cannot tell a pregnant woman what and what not to do.

It is difficult to argue with Richards (1997) claim that professional knowledge should be used to help women exercise choice, not to frighten them, for as a rule women are equally guided by beneficence and non-maleficence. There may, however, be a fine balance between the professional judgement and the views or wishes of the client. While shared decision-making means shared problem solving, a certain proportion of clients may not wish to have an insight into those problems, and their wishes must be respected. Therefore the amount of information given remains for each individual to decide upon.

Remembering that informed consent imposes on the health professional two duties: to disclose to the client the nature, purpose, benefits and material risks of any proposed procedure and of any alternatives, including non-treatment, in language that the client can understand; and to obtain their consent before proceeding with the treatment or procedure; should the individual health professional acknowledge these facts in the client-practitioner relationship, they would be fulfilling both medico-legal and ethical

dimensions of informed consent. This is a particularly challenging task for health professionals to accomplish with the endless advancements in technology and the need for continuing up-to-date professional knowledge and understanding.

2.7. SUMMARY AND AIMS OF THE STUDY.

By examining the literature pertaining to the focus of the study, this chapter has explored the many political, organisational and social factors that have influenced childbirth culture over the past century and contributed to the emergence of choice in maternity care over more recent years. There has been continuing emphasis placed on providing a maternity service where the woman is at the centre: not only as the recipient of care, but also as a key figure in the decision-making process. Furthermore, the literature is explicit in recognising the importance of all health professionals possessing effective communication skills. This is especially evident in respect of continuing government social policy and the recommendations for the practice of obtaining informed consent to procedures and treatment. Consequently, this chapter has also examined the complexities of obtaining informed consent with reference made to case law and legal precedents arising from health care, including obstetric practice. This included an examination of the pertinent sociological, ethical and medico-legal principles that health professionals should always consider before undertaking any procedure or treatment with pregnant women in order to avoid litigation.

Drawing upon the evidence from the literature examined, three aims to the research study were finally identified.

- ❖ To determine the factors that influence midwives' and doctors' communication with women about procedures during the intrapartum period.
- ❖ To explore how consent to intrapartum procedures is obtained from women.
- ❖ To investigate midwives' and doctors' knowledge and understanding of informed consent from an ethical, medico-legal and professional perspective.

In the following Chapter 3, the decision to choose qualitative research methods to fulfil these four aims will be debated and supported by reference made to other studies undertaken in this particular area.

CHAPTER 3: RESEARCH DESIGN AND METHODOLOGY.

3.1. METHODOLOGICAL CONSIDERATIONS.

There are various styles, traditions and approaches to research that use different methods of collecting data, but no one approach either prescribes nor automatically rejects any particular method. Quantitative researchers collect facts and study the relationship of one set of facts with another, which are then measured by using scientific techniques to produce objective, verifiable, quantifiable, and generalised conclusions. In comparison, researchers adopting a qualitative approach are more concerned in understanding an individual's perception of the world. According to Bell (1991), they seek insight rather than a statistical analysis, doubting whether such social facts exist and question whether a scientific approach can be used when dealing with human beings.

Traditional links with medicine have led to the use of a scientific approach in nursing and midwifery research, with a preoccupation on experimental methodology in which variables can be closely controlled. Such an approach may be appropriate for the trial of new treatments and drugs, but in the complex and diversified professional domain of midwifery practice, this approach cannot be fully applied without distorting or altering the fundamental nature of situations. Consequently, Bluff (1997) claims that the majority of research undertaken in midwifery practice tends to be of the qualitative kind rather than quantitative.

Classifying an approach as quantitative or qualitative, survey, ethnographic, action research, etc., does not mean that once an approach has been selected, the researcher may not move from the methods normally associated with that style, or even utilise both quantitative or qualitative methodology. Each approach has its strengths and weaknesses and each is particularly suitable for a specific context and dependent on the nature of inquiry and type of information required.

This chapter debates the case for adopting a qualitative approach and more specifically, ethnography, to study the nature of informed consent in respect of intrapartum care

practices. In addition, the classic typology of field roles developed by Gold (1958) and Junker (1960) to carry out data collection in ethnographic studies, will be examined in order to justify the choice of role adopted and clarify the parameters and extent of the participation undertaken in the study. Further discussion regarding reflexivity and the possible effects of the familiarity of the person conducting the research being known to the staff in the study, will also be included in this chapter. The final section intends to provide debate on the data analysis of qualitative research and the decision to use some elements of grounded theory (Strauss and Corbin 1998, Glaser and Strauss 1967) and Computer Assisted Qualitative Data Analysis Software (CAQDAS) to assist in such a process.

3.1.1. Influence of Previous Studies on Methodology.

In examining informed consent in labour, the purpose of this study is to examine the communication, conversation and the interactive processes that take place between the woman and health professional, and the extent that women actually contribute to the decisions made about their care during labour. It is therefore essential that an appropriate method of data collection be selected at the outset and that this method is supported by the evidence of previous studies conducted in this area. Various strategies were adopted to search the literature. This initially included manual searching through journals and text for possible papers before extending it to databases such as Medline, the cumulative index for nursing and allied health literature (CINAHL), applied social sciences index and abstracts (ASSIA) and profession specific resources such as MIDIRS and the RCM. Key words used in this literature search on methodology included: qualitative research, ethnography, observation / participant observation, interviews, childbirth, labour, labour ward and informed consent. Certain issues that assisted in informing the methodology finally chosen to undertake the study into intrapartum informed consent are considered in the following sections.

3.1.1.1. Freedom or Control of Responses.

It is acknowledged that scientists try to find solutions in more controlled research, by experiment. However, as Rosenthal (1966) suggests the experimenter's knowledge of

the hypothesis being tested and of the expected outcomes, can also affect the participants of social psychological experiments. Such an approach would therefore be inappropriate to adopt in this study exploring intrapartum informed consent from both an ethical and legal perspective. Furthermore, large-scale surveys, clinical trials or experimental research only seek answers that can be generalised to populations and consequently the experiences of individuals tend to be lost and their needs overlooked.

Should the questionnaire survey and interview methods be considered to collect the data, as in the survey conducted by the NCT on women's views of amniotomy or Coldicott et al's (2003) survey of intimate examinations by medical students, Rees (2003) warns that one of the major shortcomings of these methods is that it has to be assumed that what people say they do, is what they actually do in practice. Furthermore, it is generally acknowledged that the characteristics and biases of survey interviewers can considerably affect the responses they get from those they interview.

In contrast, an ethnographic approach using observation differs in that it collects data first hand, based on what people are seen to do by the researcher. Such differences are highlighted by Garcia et al's (1998) personal criticism of their national survey into women's views of maternity care, that had they used interviews or observational methods, they would have gained a better understanding of women's real involvement in decision-making, including their choice to be involved.

When deciding upon her methodology to explore the interactions between midwives and women and information giving during labour, Kirkham (1987) stated that she did not want to control the responses of those she studied by using preconceived and pre-coded categories of the survey and questionnaire. Consequently she adopted an ethnographic approach that was claimed by Kirkham (1987) to give her the freedom to discover what aspects of interaction in labour were important to those involved and the meanings for them of those actions and concepts within the different birth settings. Her findings discovered that midwives and women lacked appropriate language to explain the intricacies of the birth process. It would therefore seem appropriate to adopt a similar approach to explore the factors that influence midwives' and doctors' communication with women about intrapartum procedures and how consent is obtained in practice.

3.1.1.2. Choosing the Tools to Collect the Data.

Although, Henderson (1984) had initially considered that observation was the most appropriate method of enquiry to study consent to intrapartum amniotomy, she did find that using this method alone was insufficient to gain an insight into the thoughts of those being observed. She therefore undertook interviews with the women immediately following each vaginal examination and then with the midwife using a questionnaire. The incongruence between what the midwives thought they did in practice to what had been witnessed by Henderson (1984) (which is also a major criticism of using survey and questionnaire method alone [Rees 2003]), supported the study design to also use observation. This was an important issue to consider in respect of collecting data relevant to intrapartum informed consent. Furthermore, Kirkham (1987) had used both observation and interviews in her ethnographic study of interactions during labour.

Hunt (1989) also found that ethnography was appropriate for studying the effect of shift handover on the quality of intrapartum care within the complex environment of a hospital labour ward. This study involved a total of 24 visits to the labour ward to observe shift handover and interview the staff who participated. When contemplating the methodology to explore the insights and experiences of childbearing women living in poverty, Hunt (2004) also chose an ethnographic approach using empirical observation and tape-recorded interviews. However, her decision against using the questionnaire / survey method to collect such data was based on a rather biased view that such women traditionally do not contribute to postal surveys or telephone polls.

Ethnographic techniques were also used by Machin and Scamell (1997) to collect comparative data from women recruited from the NHS and NCT. Such data were collected using a variety of methods and included an initial tape-recorded semi-structured interview with each woman, followed by a period of intensive participant observation where the researchers accompanied the woman to antenatal appointments, the labour ward and postnatal ward. It was claimed by Machin and Scamell (1997) that using an ethnographic approach in their particular study was appropriate. They believed that if other methods had been adopted, such as a questionnaire / survey, the power that certain childbirth cultures portray to women may not have been as vivid.

Due to a limited time-scale, Patterson (1994) chose only to interview women and midwives about their experiences of giving / obtaining consent to procedures in labour. However, the interview data may not necessarily have been a true reflection of what actually happened in practice as it could be argued that the participants may have responded according to how they perceived the researcher wanted them to and also in such a way as to please the researcher. Consequently Patterson (1994) did state that had she had more time, she would have preferred to have undertaken in depth interviews with women at 36 weeks gestation and also observe their labours.

3.1.1.3. Recording the Data.

Although it is common to make hand written field notes during the observation stages, (Hunt 2004, Hunt 1989, Kirkham 1987, Henderson 1984), some studies also used a video camera to record the details of events that occurred. However, the studies that were reviewed only involved observation of part of the woman's labour: the second stage rather than the entire labour as was the intention of the study into intrapartum informed consent. Hence, it was considered impractical to adopt such a method to record the data. One such study was that of Adams (1989) who adopted an ethnographic approach in order to examine communication during the second stage of labour. This included a video camera to collect data from the labours of primigravidae followed by interviews with the women 3-4 days after their baby's birth. Adams (1989) acknowledges the work of Bouchard (1976) that maintains the presence of a video camera can distort and lie and consequently she argued that such a data collection tool could have altered the midwives' and women's behaviour in her study.

When collecting data to investigate the practice of undertaking vaginal examinations during the second stage of labour, Bergstrom et al (1992) used an ethnographic approach that included videotaping. This involved two researchers taking turns to operate the camera and back-up audio tape recording. It is claimed that the camera operator stood in a corner as far away as possible from the bed where the woman was situated and the second researcher sat in another corner of the room writing notes. A wide-angled lens, an omni-directional microphone and the use of the zoom feature was expected to capture most of the action within the room without being physically close to the participants. Although written informed consent to participate in the study was

obtained from women during the first stage of labour, in only two labours did the videoing stop at the request of one or more participant before the actual birth of the baby. Despite Bergstrom et al (1992) stating that all participants soon became used to the presence of the camera and subsequently ignored the researchers there is no discussion in their report as to whether the video camera affected the behaviour of those under study.

Although some studies have used audio-recorders to record the data from the interviews (Hunt 2004, Machin and Scamell 1997), others such as Patterson (1994), Adams (1989), Hunt (1989), Kirkham (1987) and Henderson (1984) all made hand written records. The reason that Patterson (1994) chose to make hand written notes during the interviews with the participants in her study was that she believed using a tape-recorder could be obtrusive and generate data that would be time-consuming to transcribe. As interviews were the primary source of data collection compared to the other studies where they were secondary to observational methods and used to confirm or refute earlier data, Patterson's (1994) study could nevertheless be criticised for not using an audio-recorder to ensure that the content of the participants' interviews was accurate. However, in addition to the amount of time taken when transcribing interview data from audio tapes Hunt (2004) stated that she experienced difficulty in always achieving a quality recording as in some instances the noise from the television and from other children present drowned out the recordings. As interviews were to be a secondary means of data collection regarding intrapartum informed consent, a decision to hand record the data was made supported by other studies that had also adopted this method.

3.1.1.4. The Effect of the Researcher's Presence and Being Known as a Midwife.

A number of the studies make reference to the effect that the researcher may have on the data collection, which was important to consider as the study into intrapartum informed consent was to be undertaken by a researcher who was also a midwife and familiar to both the staff (as an experienced midwife teacher) and to the clinical setting. Although Henderson (1984) considered that observation was the most appropriate method of enquiry to study consent to intrapartum amniotomy, she realised that such a research approach could not only influence the behaviour of those observed, but also the data collection may be further complicated by her being known to the midwives in the area

under study. Nevertheless, she claimed that as the study progressed and she became accepted as part of the scene, the influence of her presence became minimal. Hunt (1989) also found similar issues and expressed that she encountered difficulties when collecting the data during shift handover on labour ward such that data analysis became a major challenge. Treating the familiar as strange and developing the reflexivity that is essential for the correct use of ethnography was sometimes problematic, for outside of her role of researcher, Hunt (1989) was also a midwife and teacher. Consequently she was acutely aware that by contributing to the labour ward scene, she was also fundamentally changing it. However, there was no detail as to whether Hunt's presence became less obtrusive as the study progressed.

It would appear that on a couple of occasions Hunt (1989) decided to intervene in the best interests of the woman and fetus and thus step out of her role of researcher. This supported the work of Estroff and Churchill (1984) who note that two of the most problematic situations for the researcher in the clinical setting are getting caught between the patients and staff and being privy to unethical / illegal conduct by staff. Refusing to intervene in a situation would place the value of the research as such above the quality of the life of the woman and fetus. There is no mention in Hunt's (1989) study as to whether her interventions had any effect either in the specific situations in which she intervened or in the subsequent relationships she had with the staff she was observing and interviewing. She did however, acknowledge that one of the main difficulties of her study was the task of separating professional judgment from ethnographic analysis. The issues raised by Hunt's (1989) difficulties of undertaking ethnography in the labour ward setting were also important to consider should similar experiences become apparent when undertaking the study into intrapartum informed consent. Nevertheless, it could also be viewed as a positive element of the data collection for a midwife who already has some appreciation of the labour ward culture, to undertake the study into intrapartum informed consent rather than a non midwife.

3.1.1.5. Sample Size.

Overall, the ethnographic studies reviewed revealed some variation in sample size. These ranged from Kirkham's (1989) study involving a total of 113 labours in a variety of settings, (90 within a consultant led unit in a teaching hospital, 18 labours within two

rural GP units and five in the woman's home), to Adams (1989) second stage of labour study that involved a total of 11 labours. Both these studies included observation and interviews of their participants. However, Patterson (1994) decided to only undertake interviews with 10 women and 13 midwives about their consent to intrapartum informed consent due to the constraints of time compared with Henderson (1984) who observed 28 labours followed by interviews with 28 women and 22 midwives regarding the practice of amniotomy.

Whilst it is recognised that qualitative studies involve smaller samples compared to quantitative studies, after some consideration and debate with academic supervisors in respect of the study contributing to a doctorate award, it was encouraged that a similar sample size to that of Kirkham's (1987) study be recruited or until no new data emerged from the data collection: i.e. the saturation point (Strauss and Corbin 1998). After exploring these studies in detail in terms of their methodology, it was therefore decided that adopting an ethnographic approach using both observation and interviews, would be appropriate to study the intrapartum experiences of women and explore the interactions they had with health professionals regarding consent to procedures during labour within the setting of a hospital labour ward.

3.1.2. Key Aspects of Ethnography.

Historically, ethnography has evolved from within cultural anthropology whereby it has been the principal method to study previously unknown and primitive tribes and societies in depth: i.e. "the view from within". Examples of such a research approach include the early works of anthropologists Mead (1929) and Malinowski (1922) who studied the island cultures of the South Pacific. However, as the number of unknown societies has diminished, anthropologists have sought other societies to study. As a result, educationalists, sociologists and health professionals have joined them in an attempt to understand subcultures and groups within society.

Werner and Schoepfle (1987) define that ethnography is any full or partial description of a group of people: "ethno" meaning "folk" and "graphy" meaning "description". Such an approach is founded on the belief that all human beings share sufficient

characteristics to begin to develop social relationships. Ethnography is therefore a means of obtaining a holistic view of people in their natural, physical and socio-cultural environment in order to make some sense of their behaviour and interactions within that setting so as to uncover its rules, values and norms. In many ways ethnography is the most basic form of social research as it bears a close resemblance to the routine ways in which people make sense of the world in their everyday lives. However, Hammersley and Atkinson (1995) express that whilst some regard this as a strength of method, others may see this as a fundamental weakness.

It is true that the simplicity and lack of the use of complex statistical methods has resulted in ethnography being seriously underestimated by other social researchers and scientists. As a consequence, Edwards (1994) states that researchers have found it difficult to obtain funding for ethnographic studies from some of the national sources of research funding. Despite this, ethnography implemented correctly should be as rigorous as any other research method, although the level to which one can generalise may differ. In some instances, it could be argued that ethnography may be the best or the only method to be used, particularly when dealing with sensitive and difficult issues, such as sexuality and death.

The concept of ethnography is based on the belief that human action is complex, informed by social meanings, influenced by intentions, values, beliefs, rules and aspects of culture, and as such cannot be understood only in terms of scientific laws. Ethnography has also been described as a symbolic interactionist research approach whereby the ethnographer portrays people as constructing the social world, both through their interpretations of it and through their actions based on those interpretations. However Blumer (1969) suggests that those interpretations can sometimes reflect different cultures, so that there is a sense in which people create different social worlds through their actions.

Hammersley and Atkinson (1995:1) state that the work of the ethnographer involves:

".....participating overtly or covertly in people's daily lives for an extended period of time, watching what happens, listening to what is said, asking questions: in fact, collecting whatever data are available to throw light on the issues that are the focus of the research."

In a sense, it could be argued that all social researchers are participant observers and as a result, Hammersley and Atkinson (1995) allege the boundaries around ethnography have subsequently become unclear. Ethnography is an overall term that includes several variations, of which four types have been described by Muecke (1994) and are acknowledged in Figure 3.1.

Figure 3.1: Types of Ethnography. (Muecke 1994).

- Classical Ethnography,
- Systematic Ethnography,
- Interpretive Ethnography *and*
- Critical Ethnography.

According to Melia (1982), traditionally ethnographic research “tells it as it is” and as a result, depends heavily on observation and in some cases, complete or partial integration into the society being studied for an extended period. The concept of *classical ethnography* allows unanticipated data to emerge, the researcher being free to follow up new leads, to explore hunches and to allow new theories to emerge as the research progresses, rather than beginning with a clearly defined hypothesis to be tested in a rigorous controlled trial. A key element in this type of approach is that the researcher adopts an attitude of respect or appreciation of the world being studied: the researcher being there to observe, not to improve, challenge, change, question or criticise what is seen. In this way the researcher is able to experience the world of the participants and describe its culture from their perspective: the “emic” perspective.

In contrast, the aim of *systematic ethnography* is to define and delineate a specific cultural structure within a particular society and as a result, the data collection and analysis tends to be more logical and methodical than in classical ethnography. The researcher seeks to understand the motivational factors that influence the behaviour of individuals within a group and thus an attempt to provide some meaning for the behaviour observed is made: the “etic” perspective. However, whilst it could be argued there is little difference between systematic ethnography and *interpretive ethnography*, as they both seek to understand the behaviour of individuals, the latter approach also

attempts to discover the meaning of social interaction within the culture in which it occurs. It therefore focuses more on analytical and interpretive processes. Furthermore, interpretive ethnography has been recognised by Agar (1986) as being neither objective nor subjective, as it seeks to mediate two worlds through a third: that of the researcher.

When defining *critical ethnography*, Grbich (1999) claims that this approach focuses on power and how it is distributed within a cultural setting. It assumes that society is inequitably structured and dominated by powerful hegemonic practice that create and maintain the continuance of a particular view of the world. The aim of critical ethnography therefore is to enhance collective action, improve societies and foster the emancipation and empowerment of individuals and groups. This type of ethnography shares similarities with certain aspects of feminist ethnography (Jordan and Yeomans 1995). *Feminist ethnography* takes into account the needs, interests and experiences of women, assuming that they are oppressed, vulnerable and victims of an imbalance of power and subsequently aims to improve the lives of women in one way or another. As a result, it could be argued that the overall aim of critical ethnography and that of feminist ethnography has little in common with the intended aim of classical ethnography that seeks to observe, not to improve, challenge, change, question or criticise what is seen.

When considering the type of ethnography to adopt for the study into intrapartum informed consent, it was finally decided that the approach would probably possess elements of more than one type. Whilst one of the aims of the study was to develop an understanding of the communication and social interactions involved during labour, an interpretive ethnographic approach was considered appropriate. However, it was also appreciated that as the research would be undertaken within a hospital labour ward there was potential to experience an imbalance of power between the health professional and the woman in labour, such that the ethnographic approach adopted would to some extent also reflect the critical / feminist ethnography type.

3.1.2.1. Objectivity and Bias.

In order for the researcher to imagine themselves in the position of the individuals participating in the study, ethnographic research makes use of human skills such as

sensitivity, compassion, intuition and concern towards these people. This form of understanding social phenomena has been referred to as “*verstehen*” (Truzzi 1974). However, Hobbs and May (1993) express concern with how the ethnographer is able to remain objective whilst attempting to establish closeness and authenticity in social scientific accounts of other peoples’ lives. Seale (1999) believes that objectivity is an attitude of mind on the part of researchers who try and stand back as far as possible in terms of their own values so that any preconceptions they may have do not influence the design, data collection and analysis of the study. In “telling it as it is” the researcher is expected to be both on the inside as a researcher and on the outside as one who communicates the story to the outside world. However, ethnography cannot be undertaken in some autonomous realm that is protected from the wider society and from the particular biography of the researcher. Hunt (2004) recognised that the challenge to set aside all those aspects that make the researcher an individual with individual experiences is virtually impossible. Hammersley and Atkinson (1995) further claim that social processes and personal characteristics will inevitably affect the findings of ethnography, such that there is increased potential for bias.

Miles and Huberman (1994) state that bias can emerge when data are interpreted as having themes or patterns that are insignificant, when more emphasis is placed on responses from reputable participants than others, or when the researcher becomes so involved in the group being studied that a balanced perspective is lost. In ethnographic studies it is to be expected that there will be some degree of subjectivity as the researcher becomes actively and empathetically engaged with people in the setting being studied. Dingwall (1980) however, warns of the tendency for some researchers to champion the underdog and purports that ethnographic studies should always seek to comprehend the perspectives of all subjects regardless of their position. It is therefore suggested by Spencer et al (2003) that steps should be taken to achieve a “reasonable” level of objectivity. However, Hunt (1989) claims this was difficult to do and as a consequence she found the data analysis problematic that could be considered a weakness of her study. Many authors such as Meyer (2001), Cutcliffe and McKenna (1999), Murphy et al (1998) Sandelowski (1986) and Lincoln and Guba (1985) support the call for reflexivity on the part of the researcher to consciously reflect on the values that have guided the research and discuss the impact of their role and presence and how

the research process has affected them. In so doing, it is possible that a reasonable level of objectivity be demonstrated.

3.1.2.2. Reflexivity and the Personal Characteristics of the Researcher.

All social researchers are part of the social world in which they study regardless of the approach they use. The researcher in ethnographic studies is part of the research process and plays a dominant role in the data collection and analysis. It is therefore important that as the study is being carried out, the researcher has the ability to constantly reflect back and forth on the research process and challenge their own perceptions and influence on the process. This is known as reflexivity. The extent that the researcher's participation and relationships with the participants in the study may affect the data that are gathered are questioned by Becker (1958: 652):

"to what degree is the informant's statement the same one he might give, either spontaneously or in answer to a question, in the absence of the observer?"

As a result, this demands a certain degree of introspection, self-awareness and self-analysis by the researcher as data are interpreted through the mind of the researcher as well as the participants. Lipson (1991) stresses the importance of the researcher cultivating self-awareness, constantly reflecting on how they behave, both verbally and non-verbally and how their own emotions and reactions may impact on the collection and analysis of data.

As Stevens et al (1993) state one important aspect that is often neglected in the discussion of research are the characteristics and personality of the researcher. Personal characteristics such as gender, age, race and ethnic identification, may all affect access to information and data collection, as well as trust-building between researcher and the participants in the study. Goffman (1959) recognised that during the course of the fieldwork, participants who associate with the ethnographer will cast him or her into certain identities on the basis of ascribed characteristics as well as aspects of appearance and manner. This must be monitored for its effect on the kinds of data collected. At the same time the ethnographer will generally try and shape the nature of their role, through adaptation of dress and behaviour in order to facilitate obtaining the necessary data.

Hammersley and Atkinson (1995) acknowledge that the researcher cannot escape the implications of gender as no position of genderless neutrality can ever be achieved, though the implications of gender vary according to setting and are intertwined with sexual orientation. Most concern regarding the effects of gender has focused on the role of women field workers in the way in which their gender bars them from some situations and activities, while opening up others that are not accessible to men. However, this tends to be more evident in cultures where there is a strong division between the sexes. Furthermore, where the researcher is also known to be a foreigner such restrictions can also allow some distance to be created. It was therefore expected that being a woman would improve access to the labour ward and its participants for the researcher when undertaking the study into intrapartum informed consent as childbirth is essentially women's work. However, it was also important to be reflexive and constantly assess the impact of one's gender and familiarity with the setting to ensure the account accurately reflected the experiences of all the participants and was not biased to one particular sex or group.

Hammersley and Atkinson (1995) also consider that age and its associated features will have a bearing on the way people react to the researcher and what they are permitted to do. This ultimately will determine the kinds of relationships established between researcher and participants and the extent of data collected. As a result, a junior research student may establish quite different working relationships with the participants than a middle-aged professor (Hammersley and Atkinson 1995). In terms of the researcher's age regarding the study into intrapartum informed consent, this was not really perceived to be a problem as it easily fitted into the wide age range of participants. It was acknowledged that where there may be difficulties in developing a relationship with participants, because of difference in age, for example young pregnant teenagers, others in the study, such as the health professionals providing the intrapartum care, could also experience this. However, it could be argued that such difficulties could also arise with any age of participant in the study. As a professional, middle class woman, the researcher also had to be mindful of how her social status may affect her relationships with the participants and the collection of data, especially as far as the childbearing woman was concerned.

In reality it would be difficult to agree that the presence of a researcher would have no effect on the situation being studied or, equally the situation would not affect the researcher to a certain degree. Often researchers are conscious, indeed oversensitive to the mere presence effect, and may draw attention to themselves unduly and introduce those effects in what almost amounts to a self-fulfilling prophecy. Stoddart (1986) points out that becoming invisible can be facilitated by participating in the ongoing activities of those being studied without calling particular attention to oneself, rather than adopting the posture of a detached observer seeking objectivity. This tendency to over-react to the research environment when undertaking ethnographic studies has been documented by Sanders (1980: 159-160) as follows:

"Participant observation is not an approach with which all researchers are equally comfortable..... A natural and common experience..... is the fear which arises from finding oneself to be a stranger in the home territory of a group of actors bound together by common understandings, strategies and problems..... This fear has its foundation in the salient proscriptions we have learned concerning the illegitimacy of asking people probing questions about their personal lives. In violating these rules, we risk personal rejection.....Not only does the field research appear to violate some deeply held rules of interaction, it also thrusts the researcher into an intensely self-conscious situation.....the result of a critical focusing attention on the self."

There is therefore the danger of being preoccupied with their own at-risk situation, rather than being immersed in the field, the participants being studied and the data being collected, and this can extend beyond the risk of actually creating more presence or observer interference effects. The researcher may become so apprehensive that judgment becomes clouded and the data recorded is inaccurate or unsound.

It must also be acknowledged that in some situations the effects of the researcher's presence could be adverse. Stacey (1988) argues that ethnography is not always beneficial and can sometimes be seen as exploitive. Whilst there is the risk of misunderstanding and misinterpreting the lives of the participants, there is the bigger risk of the ethnographer making their lives worse by the exploring, probing and revealing nature of inquiry. It is therefore expected that the ethnographer possesses a high level of social skill in respect of observing and asking questions (which may be taken as obtrusive), in an inoffensive manner and with tact.

Furthermore, to undertake ethnographic research is more than having the right inquisitive attitude, it is also about being controlled, relaxed and at ease in the environment being studied. Having already had the experience of working as a midwife on the labour ward where the study into intrapartum informed consent was carried out, the researcher was already familiar with many of the staff members and generally felt comfortable in the surroundings. However, it has been recognised that in order to present an authentic and trustworthy account from participants in ethnographic studies, the researcher should be intellectually poised between familiarity and strangeness, while socially being poised between stranger and friend. As Hammersley and Atkinson (1995: 115) state:

"There must always remain some part held back, some social and intellectual 'distance'. For it is in the space created by this distance that the analytic work of the ethnographer gets done. Without that distance, without such analytic space, the ethnography can be little more than the autobiographical account of a personal conversion."

To maintain and control such a balance within the role of researcher rather than that of a midwife would prove a challenge in this particular study. However, Pearsall (1965) recognises that there may also be problems with being accepted by those in the field because they are on home territory and make the ground rules about collaboration. This was found in Adams' (1989) study. Whilst some midwives did not inform her as appropriate as they felt their practice would be under scrutiny, others readily gave her access to women during the second stage of labour. The more willing midwives felt that by participating it would not only help to improve their communication skills, but also benefit them teaching these skills to student midwives. As the researcher was reliant on the midwives to obtain consent from the women to participate in the study into intrapartum informed consent, it was therefore appreciated that some of them could feel threatened that their practice would be assessed, and consequently may not be as eager to recruit women to the study.

Such issues of personality and familiarity with staff were borne in mind for this particular study as to whether they would have either facilitative or hindering influences on the research process and the data collection and analysis to ensure that the findings are authentic and trustworthy. It is therefore important to be reflexive and consider the

significance of these concepts in respect of assessing the standard of quality in qualitative data research and evaluation and consequently the overall quality of this particular study into intrapartum informed consent.

3.1.2.3. Authenticity, Credibility and Trustworthiness.

When Spencer et al (2003) set out to develop a framework to guide the assessment of qualitative research evaluations, they discovered that although concepts traditionally associated with evaluating scientific quantitative studies, such as validity and reliability were used, the meanings attributed to such concepts and how people viewed their applicability or otherwise to qualitative research, varied considerably. Most of the discussion appeared to revolve around the credibility of data and the trustworthiness of the interpretations and conclusions that were made (Spencer et al 2003). Furthermore, Hammersley (1992) associates validity with truthfulness and credibility of a claim (whether the evidence for the claim is convincing) and plausibility (how the claim fits in with what is already known). In an earlier paper, Sandelowski (1986) had argued that the terms authenticity and trustworthiness are preferable to validity and reliability in qualitative studies.

Hammersley and Atkinson (1995) warn that should social research be reliant on a single piece of data, there is the danger that undetected error in the findings may render the analysis incorrect. Therefore, in order to strengthen a claim, one frequently discussed method that is used is “Triangulation” (Denzin 1978). This term derives from a loose analogy with navigation and surveying whereby an exact position can be pinpointed on a map according to where two or more lines cross (Fielding and Fielding 1986). Although mainly used in quantitative research using two measurements to gain information about a particular variable, it could be questioned as to the appropriateness of triangulation to qualitative research methods, such as ethnography.

Despite a triangulation method that involves collecting data through different methods, data sources, researchers or theoretical perspectives, being considered more likely to

provide confidence in the overall findings should they all lead to the same conclusion, there is much debate in the literature about its value in qualitative research and the extent to which a single definitive account can be achieved. Many authors such as Mason 2002, Patton 2002, Silverman 2000, Seale 1999, Miles and Huberman 1994, and Fielding and Fielding 1986, recognise that such an approach assists in the credibility or validity of a claim by providing a broader, richer account, or even in generating alternative accounts. However, triangulation is not a simple test for even if the findings tally, there can be no guarantee that the inferences involved are authentic. Hammersley and Atkinson (1995) state that it may be that all the inferences are invalid and that as a result of systematic, or even random error they lead to the same incorrect conclusion. They further add that researchers should not adopt a naively optimistic view that the aggregation of data from different sources will produce a more complete and accurate picture. Different sets or types of data may just be as important and illuminating (Hammersley and Atkinson 1995). When analyzing the data obtained from the observation and interviews, it is important to consider these criticisms of triangulation such that, in order to produce a complete and authentic account of intrapartum informed consent, alternative accounts may be generated rather than a single definitive account.

Member checking or respondent validation can improve the credibility of qualitative data. This involves checking the data for authenticity with those subjects who have taken part in the study and provides an opportunity to fill any gaps in the data collected. However, as Spencer et al (2003) highlights, some subjects may agree or disagree with an account for a number of reasons that may be unrelated to its credibility. Alternatively, or sometimes in addition, peer review can be used to establish whether others would come to the same categories or conclusions as the researcher, thus fitting in with Hammersley's (1992) notion of plausibility. It was therefore considered appropriate to undertake member checking following completion of the interviews with the participants and peer review, in order to challenge interpretations and demonstrate whether explanations concerning intrapartum informed consent appeared plausible or suspect.

In Spencer et al's (2003) study, it was also found that providing the reader with some of the original data further supports the credibility of a claim as quotations were seen as

important to convey depth and breadth of the data from the participants in their own words: thus providing essential evidence for the conclusions drawn. Silverman (2000), Seale (1999) and Miles and Huberman (1994) acknowledge that it is also important to demonstrate how examples were chosen and how they relate to the data as a whole to avoid the risk of being anecdotal or deliberately selective to emphasise the view of the researcher. As quotations are predominantly used to present the findings from ethnographic studies, it is therefore important to be aware of the significance they have to the credibility of a claim and subsequently, the overall quality of the research.

3.1.2.4. Consistency.

As the social world and its constructs are not constant and the design of qualitative studies is not only emergent, but also responsive to the social setting, replication is problematic to achieve, mainly for these methodological reasons (LeCompte and Goetz 1982). In addition, Lincoln and Guba (1985) state that the qualitative researcher assumes that the entity being studied will in fact change. Replication is therefore particularly difficult to achieve in ethnographic studies.

The concept of consistency has been suggested by LeCompte and Goetz (1982) to distinguish between external and internal reliability in qualitative studies. They define external reliability as being whether the same phenomena would be discovered, or the same constructs generated in the same or similar settings, by (an) independent researcher(s). In contrast, they consider internal reliability to be the extent to which other researchers would match a set of previously generated constructs with the data in the same way as the original researcher (LeCompte and Goetz 1992). Furthermore, Silverman (2000) discusses the concept of reliability in terms of the consistency with which data are assigned the same categories by the same researcher on different occasions, or different researchers on the same occasion.

According to Lincoln and Guba (1985), and Sandelowski (1986) the concept of reliability can also refer to auditability, dependability or reflexivity. From these perspectives, there is no assumption that another researcher would necessarily apply

concepts consistently in the same way or arise at the same interpretation of the data. However, if there is a marked difference, the value of the interpretation could be questioned. It is therefore expected that the researcher provide a transparent account of how the research was conducted and the findings derived: i.e. an audit trail. This is to enable others to see that the research has been undertaken with rigour in a logical, systematic way with attention paid to factors that may affect the results (Chamberlain 2000).

3.1.2.5. Generalisation, Representativeness and Transferability.

Although there are a number of different ways in which generalisations can be made in qualitative research, there is a common view that it is based on assertional rather than probabilistic logic as in quantitative research (Stake 2000, Kvale 1996). As Mitchell (1983) elaborates, generalisation does not rest on statistical representativeness and sampling theory, but on careful comparison and sound analysis. Whilst Lewis and Ritchie (2003) refer to generalisation in qualitative research as being representational, there is still an issue as to the extent to which the findings, which are selective in terms of participants interviewed or events observed, can be taken as representative of the phenomenon or setting being studied.

In the literature there appears to be various interpretations of empirical or inferential generalisation whereby the findings from one setting are generalised and can be applied to another. Lincoln and Guba (1985) refer to this as “transferability” or case-by-case transfer. However, Hammersley (1992) describes it as a process whereby the findings from one case are judged as relevant to a wider group, or an aggregate, because the case is deemed typical, atypical, extreme or vanguard. In addition, there is also analytical or theoretical generalisation whereby analytical theory, such as formal grounded theory (Strauss and Corbin 1998, Glaser and Strauss 1967), is generated from the data and consequently applied more widely to different contexts. Authors such as Seale (1999) and Mitchell (1983) however, are more hesitant about the idea of theoretical generalisation in the sense of generating theory from a single study. They prefer to think

of generalising from a case to a theory through the application of analytical concepts or theoretical ideas.

As far as the transferability of ethnographic observational studies are concerned, such as this study into intrapartum informed consent, Delamont and Hamilton (1976) argue that this may only be achieved so far as the setting to which the generalisation is sought share the characteristics of the setting being studied. Nevertheless, Schofield (1993) warns that choosing a setting on its typicality is not necessarily appropriate in determining generalisation since the setting may be typical in one dimension or characteristic, but atypical of another.

3.2. QUALITATIVE DATA COLLECTION METHODS.

Qualitative techniques are mainly unstructured and contextual and according to Lincoln (1992), there are two kinds of data collection methods: human - to - human and artefactual. The former refers to such methods as interviewing and observation, whereas the latter refers to the analysis and examination of artefacts, such as written material: biographies, diaries and letters etc., or artistic expressions such as paintings and music, sculptures etc. However, artefactual data collection would seem inappropriate as far as studying communication and interpersonal skills between health professionals and women in the context of informed consent in the study. Stevens et al (1993) and Ragucci (1972) suggest that from an ethnographic context, the main technique of collecting and analysing data is using field notes through undertaking participant observation as well as unstructured interviews.

3.2.1. Participant Observation.

Initially the observation may be unstructured because, while the area of inquiry is known, the specific research question(s) that the researcher will pursue, may only become clear after the researcher enters the field. Studying the interpretation of research participants requires an open-ended approach to observations and as Schwartz and Schwartz (1955) purport, requires sharing the sentiments of people in social situations in face-to-face relationships. Although most researchers have an idea what to observe,

as Millman (1975) argues, they could be attracted to certain phenomena more than others. The value of being a participant observer lies in the opportunity that is available to collect rich detailed data based on observations in natural settings. Furthermore, the researcher can obtain accounts of situations in the participant's own language which gives access to the concepts that are used in everyday life. The researcher can therefore construct an account of a social situation on the basis of the various accounts that are obtained from those being studied. It is also the researcher's aim to compare these accounts with each other and with other observations that they have made in the field of study. It could therefore be argued, that observations may not only be used to support ideas about human behaviour, but also to refute them. In addition, questions could also be generated to use in future research. According to Becker (1958:652):

"the participant observer gathers data by participating in the daily life of the group or organisation he studies. He watches the people he is studying to see what situations they ordinarily meet and how they behave in them. He enters into conversation with some or all of the participants in these situations and discovers their interpretations of the events he has observed".

As the term participant observer implies that the researcher be in the field or present in the natural settings where the phenomenon or participants under study takes place, Berg (1989) and Stoddart (1986) suggests that in addition, the challenge to the researcher of being there is complicated by the task of also becoming invisible as a researcher. Furthermore, Foucault (1977) has argued that the development of certain organisational structures such as prisons and hospitals has been for the purpose of surveillance of large numbers of people in an increasing population. The very design of these institutions constructed open spaces where many people could always be observed by the few. As a consequence, Foucault (1977) found that these people felt permanently under scrutiny and adjusted their behaviour accordingly. The researcher may therefore assume that the participants in the setting to some extent will react to his or her presence, but as Maykut and Morehouse (1994), state, by assuming an unobtrusive presence, the researcher may minimise this reactivity. It has been suggested by Rees (2003) that in observation studies, the challenge to both the reliability and validity of the findings is reduced where the observation is spread over a period of time. Through the process of prolonged engagement the participant observer's researcher status becomes less prominent and people relax more into their usual way of behaving.

The question arising, therefore, is to what extent should the researcher actually participate, or attempt to fit into the setting and with the participants, being studied. This is not a simple decision, nor one that necessarily remains constant throughout the study. As Patton (1990:128) states:

"the challenge is to combine participation and observation so as to become capable of understanding the programme (setting, participants) as an insider, while describing the programme for outsiders".

Maykut and Morehouse (1994) claim that this is often a delicate balance to achieve and that researchers have found becomes easier with experience.

Major distinctions have been made between active and passive roles (Schwartz and Schwartz, 1955), open and closed roles (Burgess, 1993) and known and unknown participant observers (Schwartz and Jacobs, 1979). Whatever distinctions have been made between the various roles the basic typology involved is that devised by Gold (1958) and Junker (1960), in which four ideal typical field roles are distinguished as detailed in Figure 3.2:

**Figure 3.2: Theoretical Social Roles for Fieldwork.
(Gold 1958, Junker 1960).**

- The complete participant,
- the participant-as-observer,
- the observer-as-participant *and*
- the complete observer.

Each of these roles will be examined separately, however, it is apparent from the literature studied that the roles of "participant-as-observer" and "observer-as-participant" tend to be jointly referred to as "the participant observer". It must also be recognised that researchers are all, to some degree, both observers and participants in every situation: these two functions being complementary aspects of all human activity.

3.2.1.1. The Complete Participant.

The complete participant is known to conceal the observer dimension of their role with the result that covert observation is involved. The researcher would join a group or organisation e.g. Alcoholics Anonymous (Lofland and Lejeune, 1960) or a mental hospital (Rosenhan, 1982) as though they were ordinary members, but with the purpose of carrying out research. On the other hand, complete participation may occur where the researcher is already a member of the group or organisation they are studying, as in Holdaway's (1982) research on the police.

Some writers have controversially suggested that complete participation is the ideal to which researchers should aim; for example, Jules-Rosette (1978) has argued for the total immersion in a native culture. This would involve not simply only passing as a member, but actually becoming a member. In Jules-Rosette's case, this was accompanied by personal conversion to the Apostolic Church of John Maranke, an indigenous African Movement: a rather extreme case of complete participation, that not every researcher would be happy to undertake, nor find appropriate to their research study.

However, to the inexperienced, the role of complete participant may seem very attractive, and may be the only strategy by which the data required can be obtained. Although such identification and immersion in the setting may appear to offer safety in being able to travel incognito, obtain inside knowledge and avoid the trouble of access negotiations, it can be argued that the strategy of complete participation, (as well as having ethical implications of studying group members without their knowledge and consent), may prove too limiting. Stevens et al (1993), indicate that in some situations, such as in prisons, or in subcultural settings with racist groups or drug abusers, this approach can also be very dangerous. In addition, passing as a member over a protracted period of time may place great strain on the researcher's acting abilities, and in some instances, they could be handicapped by their assumed role. Should their true identity be discovered, the consequences may be disastrous for the researcher on a personal level and for the completion of the study.

The range and character of the data collected could also prove restrictive in practice as the participant will, by definition, be implicated in existing social practices and expectations in a far more rigid manner than the known researcher. Burgess (1993) actually states that in order to overcome this problem, researchers utilising this role have recommended frequent breaks from the setting in order that they can reflect, record and analyse the data that are collected. On the other hand, however, such absences from the group could also prove detrimental to its functions and the relationship the researcher has with its members. The participants may become increasingly suspicious of the frequent absences the researcher makes, being more inclined to view them as an outsider, different to themselves, and as a result, their behaviour (the very essence of the study) may be changed.

As a complete participant, optimising data collection possibilities around the activities within the group setting can be very difficult. Some potentially fruitful lines of inquiry may be rendered practically impossible insofar as the complete participant has to act in accordance with existing role expectations. Pollert (1981: 6) highlights this fact in relation to her study of female factory workers when discussing the possible strategy of obtaining a factory job herself. She states:

".....had I got a job, the advantages of experiencing for myself what it felt like, and possibly becoming very close to a small work-group around me, would have been heavily outweighed by the disadvantages of restricted movement, abiding by the rules preventing entry into other departments (without permission), and losing the privileges of the outsider, of speaking to other employees in the factory, including charge hands, supervisors and managers."

Similarly, Gregor (1977) has documented the limitations of complete participation in his study of a Brazilian Indian village. The very nature of the activities he and his wife became involved in, not only made it difficult to informally question the participants in the study about their family and culture, but it also affected their health and well-being. As a consequence they stopped assuming the role of Brazilian villagers and adopted more overt research means by collecting data for census material, genealogies, residence patterns and hammock arrangements.

3.2.1.2. The Complete Observer.

In contrast to the complete participant, Burgess (1993) states that the complete observer has no contact at all with those subjects being observed, and does not take part in any of their activities: it is a role associated with eavesdropping. By observing but not participating, the researcher would hope to obtain an accurate and uncontaminated record of what is happening. Such expectations are questionable as the mere presence of an observer may affect what is being observed. However, if the observation takes place via a one-way mirror or screen and the participants are totally unaware of it, or, as Lofland (1973) suggests, if covert approaches are used, such as observation from a window of public behaviour in the street, the participants' behaviour would be unaffected. It could be argued that these methods also raise ethical concerns regarding the lack of informed consent to the research as well as being an invasion of personal privacy of those being studied. Bulmer (1982) is concerned that participants have little opportunity to consider the purposes and content of the research and decide whether or not to participate.

Paradoxically, complete observation shares many of the advantages and disadvantages of complete participation. Both approaches can minimise problems of reactivity; in neither case will the ethnographer interact as the researcher with those being studied. However, there may be severe limits on what can or cannot be observed and the questioning of those being studied may be impossible. It could therefore be considered that adopting either of these roles alone would make it very difficult to generate and test theory in a rigorous manner, though both may be useful strategies to adopt during different phases of the research study, and in some situations may be unavoidable.

3.2.1.3. The Participant-as-Observer.

Most field research involves roles somewhere between these two roles. The participant-as-observer role involves situations where the observation activities are not wholly concealed, but are subordinated to activities as participant and the development of relationships with those being studied. The main distinction between this role and that of the complete participant lies in the research role concealment. As Roy (1970: 217) distinguishes:

"the participant-as-observer not only makes no secret of his investigation; he makes it known that research is his overriding interest. He is there to observe... the participant-as-observer is not tied down, he is free to run around as research interests beckon".

In this role, the freedom to go wherever the action is that is relevant to the investigation is reduced for the participant-as-observer. Furthermore, in her observations on American maternity hospitals, Danzinger (1979: 530) discovered that combining data recording whilst trying to participate as a useful member of the group was problematic. She states:

"... my acceptance in these settings relates to the style of data collection I used. I wrote up most of my data after I left the field, relying on memory and eye to fill in the context of skimpy notes. I found that when I became too absorbed in my own data-recording work during a course of observation, my ability to help others suffered. My rapport in the field was based on being viewed as somewhat useful to all three types of participants: doctors, nurses, and parents / patients."

While it may be considered important for the researcher to be seen to develop relationships with those observed in order to ensure continued access to the situation, Kirkham (1987) heeds caution in the fact that if an observer is viewed as too useful by other staff members, she may be sent on a useful errand away from that which she wishes to observe. It therefore seems that the question of the extent to which a researcher should actually participate and balance it with their observation, could be problematic in this type of participant observation.

3.2.1.4. The Observer-as-Participant.

In comparison, Burgess (1993) suggests that the observer-as-participant role is used to refer to situations where contact with group members tends to be brief, formal, and openly classified as observation. Observation, therefore, takes precedence, and the person conducting the research is seen by those observed, primarily as an observer. Although it may be assumed that this should reduce the risk of over-involvement, or "going native", the participants' view of the observer (or outsider) could make them more likely to change their behaviour in their presence and less likely to provide relevant information for the purposes of the study. Kirkham (1987) comments that the busier the workplace or area being studied, the more inclined the researcher may feel

pressurised into being useful, at the expense of observing. Furthermore, Schatzman and Strauss (1973) argue that the nature of this particular role and the possible brevity of its relationships with those being studied may result in problems of bias arising out of the limited contacts and difficulty in establishing meanings that participants utilise in social situations.

3.2.1.5. Deciding which Role.

Most field research involves roles somewhere between complete participant and complete observer with the distinction between participant-as-observer and observer-as-participant remaining questionable due to the fact that the literature tends to refer to the two roles jointly as the participant observer. Decisions about the role to adopt in a setting will depend on the purposes of the research and the nature of the setting. Hammersley and Atkinson (1995) debate the issue of whether the researcher should take on a role already existing in the setting or negotiate a new role. In studies where the participants are unaware of the research being undertaken, it could be argued that the researcher has little option but to take on an existing role, either as a complete participant, or as a complete observer. However, where more overt methods are adopted, the researcher has some choice over whether or not to take on one of the existing roles. Hargreaves (1967) and Lacey (1976) in their research on schools used participant observation and adopted the role of teacher to collect their data, whereas Corsoro (1981) and Llewellyn (1980) actually took on the role of the pupil.

Anticipation of the likely consequences of adopting different roles can rarely be more than speculative. There are strong arguments in the literature in favour of moving among roles so as to allow one to discount their effects on the data. Corsoro (1981), in studying nursery-school children, not only became a participant in the children's games, but during a later phase of the research, he also used a one-way mirror to observe their behaviour. Similarly, Sevigny (1981) collected data by surreptitiously taking on the role of the student, by acting as tutor, as well as adopting a variety of researcher roles, whilst studying art classes in a college. However, adopting such extremes of movement between roles in the context of this study into *intrapartum* informed consent would seem inappropriate and not possible

It seems that different roles within a setting can be exploited in order to get access to different kinds of data, as well as to acquire some sense of the various kinds of bias characteristic of each. Both Kirkham (1987) in her study of interaction between health professionals and women during labour, and Holdaway (1982) in his study into police practice, particularly among the lower ranks, used participant observation as their data collection means, in settings they were professionally qualified and well experienced in. Although being a professional in the setting enabled access with relative ease, it also highlights areas of concern. The fact that these researchers could never be complete strangers the way that most researchers are, could give rise to issues of familiarity being overlooked in their observations. Kirkham (1987) states that she felt very uncomfortable at first attempting mere observation, as it was difficult to refrain from thinking as a midwife, rather than viewing the situation from the client's perspective. In some instances, when the number of staff on duty was limited, she had a tendency to intervene. It is therefore important in settings that are familiar to be reflexive, adopting a more marginal role and being intellectually poised between familiarity and strangeness in order to minimise subjectivity and bias and aim towards a more objective, critical and analytical perspective:

Another issue to consider is that of ethical decision-making. In Holdaway's (1982) case, he adopted the role of a participant observer using covert means whilst legally employed as a police officer. He found he had to manage situations himself where less experienced officers were involved, or be the witness to inappropriate action of others. This caused tremendous stress and anxiety on the researcher in respect of the delicate and confidential nature of covert inquiry and being unable to confide in others. In comparison, in Kirkham's (1987) study she was more overt and informed all the participants of her research intentions but this also had its problems. Although she generally attempted to concentrate on observation, Kirkham (1987) did find her role at times became more participatory. Her role depended on certain factors, such as, the time available and the actual participants involved. She had decided at the outset not to wear any uniform that would identify her with any group, so she wore ordinary, unobtrusive clothes that would also limit the extent of her participation, particularly participation as a midwife. In contrast, Holdaway (1982) wore the uniform of a police officer in his covert study, and therefore proceeded to participate as such a professional.

Kirkham (1987) had also decided not to initiate action as a midwife, but to continue a course of action already started if asked, if the person taking that action was to be absent for a short time. On several occasions she continued rubbing a woman's back or holding her hand whilst the midwife went out of the room. Nevertheless, there were occasions when this rule was not able to be observed: e.g. when a woman started to vomit and she was the only person with her. To not give the woman a bowl to vomit in would have been inexcusable and could have spoilt all future rapport Kirkham (1987) may have had with her. As communication and interaction between health professional and client was the very nature of Kirkham's (1987) study, it may be questioned however, as to why she was ever left alone with the client, thus placing herself in such dilemmas. Furthermore, she affirms that any questions directed to her were swiftly redirected to the midwife or doctor concerned. For Kirkham (1987) to answer on behalf of the health professional no doubt could have affected the findings of the study. However, should she have been asked a question by the client in the absence of other health professionals, it is difficult to appreciate she would not have responded herself before summoning the midwife or the doctor to the woman. As this particular study involves the complex concept of informed consent, being left alone with a woman that may lead to initiating an action would certainly affect the study's findings. It was therefore decided to always accompany the last health professional out of the room where the observation was taking place to avoid such difficulties and conflict of interests. However, it could be argued that some women may perceive such an act to be associated with the role of the health professional and therefore consider the researcher to be in a similar position of authority and power.

In attempting to establish a role to adopt when researching the issue of informed consent, a decision had to be made on how to behave and the exact parameters of participation in intrapartum care. It was believed that it would be totally unethical to adopt the more covert methods to obtain the data. Being part of any intrapartum care experience is a very private and intimate occasion and one that should be viewed as a privilege to be there. Therefore, it would seem appropriate that the details of the study are known to the participants and that consent to the researcher's presence be obtained at the very start of the research experience.

Being a complete participant, initially, may seem a very exciting role to adopt in some settings, but it would be extremely difficult to conduct this type of research using complete participation, whether or not it be covert or overt. If it was possible to work in the area as a full-time practising midwife, with a personal caseload, observing the communication and interaction between individual women and the health professionals regarding consent to procedures would be particularly limiting and biased in its data collection, if not totally impossible.

On the other hand, it may also be difficult in a labour ward setting of individualised care based in separate contained rooms to be a complete observer. Should the role be undertaken overtly, the researcher could be viewed with caution by the staff being studied, possibly resulting in them modifying their behaviour with the women in labour. Similarly, if covert means were used, such as a one-way mirror, there would be ethical issues to consider. However, Posner (1980) points out that the mere presence or reactivity effect is transitory and that after a brief period, those participating in the study tend to forget, or choose to overlook, the fact that they are being observed, and behave naturally.

Adams (1989) found it difficult to examine the nature of communication during the second stage of labour from the parents' point of view, and in order to remove the reactivity of taking notes or spying, she made video recordings. Such data had the advantage in that for the purposes of analysis the recordings could be played in private as many times as it was necessary to record the speech. However, from a legal perspective, there is no mention in her study as to whose property these recordings were, nor what happened to them after the analysis stage was complete. Dimond (1996), warns that potentially any recording could be subpoenaed for use in cases where clinical practice is being questioned, and it is for this reason, such a tool to collect data regarding the research on informed consent was disregarded for this study.

It would therefore seem more appropriate to adopt the role of a participant observer, using overt methods, in the study. Individual circumstances and the number of research participants involved at any one time, will determine how feasible it is to move between the role of participant-as-observer and that of observer-as-participant. When there are other participants available to assist the midwife, (e.g. a student midwife), the role

adopted would tend to be more of the observer type, and in contrast, when others are unavailable, that role may become more participatory. It must be stressed, however, that the very fact it was decided to wear ordinary clothes, as opposed to uniform, (as did Kirkham [1987]) limited the extent of the activities that could be pursued. Basic tasks, such as giving the women glasses of water, rubbing their backs and giving out wet flannels, as highlighted in Kirkham's (1987) research, seemed appropriate to undertake if initiated by one of the participants in the study. However, Kirkham (1987: 26) was also known to take on more of a complete participant role on occasion and claims she had more opportunity to appear useful to the staff. She states the extent of her usefulness:

"I offered to help on the ward when I had no patient in labour, and often bed bathed "my" patients after delivery. But, I stressed that I would take no part in the care of my patients during labour... Thus, I was "useful" to staff and patients in the ward...but... I was also not useful all the time. Indeed, when the ward was most busy, I was least likely to be available to help as I was then most likely to be observing a labour."

It could be argued that by adopting the extremes of the participant observer role as in Kirkham's (1987) study, some of the spontaneity and quality of the actual data collection must have been affected. It has been previously highlighted by Danzinger (1979) that attempting to optimise data collection possibilities around activities as a complete participant can be difficult, and it is not ideal to be writing observational field notes retrospectively. It is for this reason (as well as the practical implications of undertaking the research on a part-time basis) that it was decided to adopt the observer-as-participant role in this research study.

It is recognised that role marginalisation is particularly important in ethnographic studies to ensure that the data collected are always via a critically analytical perspective. In this particular study, as the researcher was also a midwife, she needed to be reflexive about her role and position. In order to determine how marginal a position to adopt within the labour ward and among the participants depended on the type of role adopted at that given time. Furthermore, whilst four role types have been identified, it is clear from the literature studied that there is really no clearly defined role type to adopt throughout a course of study as the role will be determined by the type of research being undertaken, and the range and type of participation being studied. As Oleson and

Whittaker (1967) suggest, there is therefore a tendency for the role to be dynamic with the researcher adopting a variety of roles with different subjects at different stages in the study.

Although data from observational studies may be collected using video and audio-recorders, the most commonly used method is in the form of field notes. It was decided that field notes would be the most appropriate method to adopt to collect the data pertaining to the study into intrapartum informed consent, as this was considered to be the least likely to disrupt the flow of activities likely to be observed.

3.2.2. Field Notes.

Field notes are the traditional means in ethnography for recording observational data. They consist of relatively concrete descriptions of social processes and their contexts. The aim is to capture these in their integrity, noting their various features and properties, though what is recorded will clearly depend on the purpose of the research. Hammersley and Atkinson (1995) recommend that events are recorded as soon as is practically possible, either as they take place, or immediately as the events have occurred so that valuable information is not lost. It is therefore essential to be disciplined and keep up to date in processing notes.

Taking field notes constitutes the use of a notebook or clipboard, which some researchers may consider to be obtrusive for the participants being studied. If the research is covert, then taking notes in the course of participation will be practically impossible. In most settings as Hammersley and Atkinson (1995) state, participants are not visibly engaged in a continual process of jotting down activities, seizing notebooks during conversations and similar activities. In many circumstances, such activity would prove totally disruptive to any natural participation. Others may view the notebook as an overt tool of their trade that acknowledges their position of researcher rather than teacher or midwife. Nevertheless, if notes are taken in a setting where such an activity is already considered part of the normal activities, such as in a classroom or a labour room, they may appear less obtrusive to those being observed and also cause less disruption.

Knowing what to record in the field notes is a challenge for all researchers undertaking ethnographic studies that use observation. Hammersley and Atkinson (1995) state that there is little explicit advice available as it has not been the tradition of anthropologists to share their field notes in the public domain. Consequently, ethnographers embarking on their first study have to find their own way of doing things. Maykut and Morehouse (1994) express that the researcher's primary task is to record what took place without inferring why or how something happened and so the field notes should contain what has been seen and heard without any interpretation. However, should the researcher have any hunches or wishes to make some interpretation of the events, this must be clear and distinct from the observations. Using brackets or parentheses to indicate commentary by the researcher can achieve this quite easily, or as Taylor and Bogdan (1984) suggest, including the initials "OC" in their field notes can indicate the "observer's comments". When considering what exact details should be recorded, it has to be appreciated that this will change during the course of the observation. Early notes may be very broad to try and establish some form of pattern of activity taking place. It is then expected they may become more focused depending on earlier observations and the questions arising from the field notes. Hunt (Hunt and Symonds 1995: 48) provides details of her field notes as follows:

"The field notes were generally descriptive accounts of events observed in the field. Direct quotations were included whenever possible as were descriptions of such aspects as the tone of voice and body language of the contributor. The field notes also included sketches of some aspects of the environment and maps to remind me of the unit".

Maykut and Morehouse (1994) believe that it is also useful to draw a diagram of the physical layout of the setting in as much detail as possible, noting such things as where people stood or sat, important objects and unused spaces. This type of diagram can also assist in recalling events and conversations at the time of preparing field notes. It was therefore acknowledged that it would be appropriate to draw a diagram of the layout of a typical labour room (all being similar in design, containing comparable equipment) in order to put the research in context for the reader.

When it comes to the data analysis where the categorising, comparing and contrasting of the observational field notes is undertaken, it may be crucial that the context of the data

(the participants, setting etc.) can be identified. Using Spradley's (1980) checklist for recording observational data as detailed in Figure 3.3 can be a useful guide in order to preserve the sense of context. Such a guide can also be particularly beneficial for any novice ethnographer to use. However, although Hammersley and Atkinson (1995) argue that such lists are very crude and rest on arbitrary classifications they also suggest that they indicate a range of relevant features of context that might be noted. Field notes cannot possibly provide a comprehensive record of the research setting and as Hammersley and Atkinson (1995) add the ethnographer also acquires a great deal of tacit knowledge that is ever contained in the written record.

• **Figure 3.3: Checklist for Observational Field Notes**
(Spradley 1980:78).

- **Space:** *the physical place / layout of the room.*
- **Actor(s):** *the description/ characteristics of the people involved.*
- **Activity(ies):** *a set of related acts people do.*
- **Objects:** *the physical things that are present / effects on people.*
- **Acts:** *single actions that people do.*
- **Event:** *set of related activities that people carry out.*
- **Time:** *the sequencing that takes place over time.*
- **Goal:** *the things people are trying to accomplish.*
- **Feelings:** *the emotions felt and expressed by those studied (and researcher).*

Participant observation is but one approach used in the study. Follow-up interviews with the women and midwives were also carried out to compare with the data obtained via participant observation.

3.2.3. The Philosophy and Techniques of Interviewing.

In situations where it is intended to explore the phenomenon through the eyes of the participant by providing them with an opportunity to recall their experiences in some depth using their own words, a questionnaire would be too superficial a tool to use. In ethnographic studies, interviews are another means of collecting in depth data through direct interaction between researcher and participant where answers to questions are gathered verbally. Although in some instances the interview may be the sole data collection tool it can also be used as an additional tool, to either confirm or refute observations, as in this particular study. In addition to participant observation, the study involved interviews being undertaken with the women and midwives within 24 hours of the woman giving birth. This was to enable the researcher time to discuss in more depth, with the woman, details of her labour and the extent to which she had been involved in making informed decisions about her care, and thus compare such data with those that had previously been observed. Furthermore, interviewing the midwives who had provided intrapartum care to women in the study about their own understanding of informed consent and their perceptions of how the woman had been involved in making decisions about her care, provided further comparative data to base the overall findings on. Adopting such data collection methods was aimed at ensuring the data reflected an authentic and trustworthy picture of what was going on and sought to eliminate any biases (Hammersley 1992).

Interviews can vary in the degree of structure they contain and range from the highly structured format to the unstructured or non-standardised interview. The structured interview (which is generally used in quantitative surveys and telephone interviews), takes the form of reading out questions from a questionnaire / interview schedule and recording the responses according to the researcher's agenda, allowing little, if any, scope for exploring issues in more depth. However, conducting a telephone interview may reduce the effect of observable characteristics that could influence the research process, such as the gender, age, class and ethnicity of the researcher. Newell (1994) states that of all the interviewing techniques, the structured interview is the one that differs the most from normal conversational interaction. Areas of relevance to the study may be omitted because the researcher has not considered them and respondents may be forced

to choose from a list of options, of which none may apply to their situation. It was therefore considered inappropriate to use such an interview format when seeking to explore issues of intrapartum informed consent from the perspective of the women and the midwives in the study.

On the other hand in the unstructured interview, the researcher responds to the experiences or situation of the participant using non-directive and relatively open-ended questions, such that the information is not forced or channelled into a limited number of options as in a structured interview. Stevens et al (1993) stress that the last participant may in fact be asked different questions from the first one as the researcher is not mainly concerned with how many people subscribe to a particular perspective or viewpoint, but more so in the different perspectives which participants hold. As a result in the unstructured interview, Arksey and Knight (1999) state that the participants are encouraged to be open and spontaneous and use their own words, expressions and ideas rather than those of the researcher. This indicates that whilst the participant is more active in terms of directing the flow of information, the researcher is more passive than is usual in interview situations. The researcher therefore not only requires the skill to encourage the participant to talk, but also to assimilate what is being said. Issues can be explored in an unrestricted manner, allowing the voice of the individual to be heard and so enable the researcher to understand the phenomenon from the other person's perspective. However, the difficulty of having such a loose structure can make analysis difficult and time consuming as each interview may cover very different topics and issues.

In between these two extremes are semi-structured interviews, containing some standard questions that are asked of each participant with the flexibility to probe and explore areas that seem appropriate to the individual concerned. Patton (1990) refers to the checklist of questions or prompts used by the researcher in this situation as an "interview guide". Hammersley and Atkinson (1995) state that ethnographers adopt a flexible approach to allow the discussion to flow in a way that seems natural. On different occasions, or at different points in the same interview, the approach may be non-directive or directive, depending on the function that the questioning is intended to serve. This is usually decided as the interview progresses. However, the amount of

direction researchers want to give the interview process, will dictate the extent of control they have.

It has been claimed by Burgess (1993, 1988) that an ethnographic interview is closer in character to a conversation rather than survey interviews. However, it must be acknowledged that they are never simply conversations as the ethnographer has a research agenda and must maintain some control over the proceedings. Hedges (1985: 77), remarks that the researcher:

".....will have to make decisions throughout the interview as to whether a given line of enquiry is proving useful and worth pursuing, or fruitless and to be headed off: and this has to be done in the light of his understanding of the problem and hence of the possible relevance or irrelevance of particular kinds of information".

The setting in which the interview takes place is also of vital importance so that data collection can be maximised. A spontaneous, informal conversation usually occurs in an environment that can be used for other purposes, for example, in a corridor or coffee room, whereas a formally arranged meeting takes place in bounded settings out of earshot from other people, such as in an office. In the former, the distinction between participant observation and interviewing is less clear than in formal interviews. It may be argued that should an individual be taken out of their natural setting to be interviewed, the setting consequently becomes artificial. Hammersley and Atkinson (1995) however, believe that this can actually allow the researcher to understand how participants would behave in other circumstances: when they move out of a setting or when the setting changes. Nevertheless, in whatever setting the interview takes place, the participant should feel relaxed and comfortable and ideally there should be as few disturbances and distractions as possible.

Whilst it is recognised that interviewing people on their own territory, such as at home, and allowing them to organise the context the way they wish, is the best strategy, the researcher's control of the setting is drastically reduced. In some situations, interruptions have to be accepted and may be inevitable especially when there is a young baby around. In addition, there are also issues of access and personal safety to consider should interviews be conducted in the participant's home. The decision to undertake interviews in the hospital setting in the study was made mainly due to the

convenience of being able to access the participants within 24 hours of the baby's birth and the flexibility to arrange them in conjunction with the observation of further intrapartum cases and other personal work commitments within the university. It was however, accepted that interviewing the women within the hospital setting may influence how they responded for fear of the care they subsequently received being affected.

Another issue to consider with interviewing is the influence of the researcher and the fact that it is a social situation where the characteristics of each of the individuals concerned can play a part in the authenticity and credibility of the information produced. Hammersley and Atkinson (1995) recognise the importance of the researcher being able to build a rapport with the individual being interviewed to maximise the potential for data collection. This will include paying attention to the seating arrangements to avoid the participant feeling that their personal space is being invaded or they are being interrogated should they find themselves to be in direct eye contact with the researcher facing them square-on, almost in a head-to-head position. Rees (2003) stresses the importance of the researcher being relaxed and displaying appropriate body language so as to encourage the participant to similarly relax. Although the interview process is extremely complex, involving many skills, Coombes (2001) states that it is important for the researcher to really listen and avoid rephrasing the participant's answer in their own words as this can lead to bias.

It is usual that qualitative interviews average 1½ hours to 2 hours in length, allowing for prolonged engagement with the participant. Although such a time frame also enables the researcher to establish a rapport and foster a climate of trust with the participants (Maykut and Morehouse 1994), the time-consuming factor of interviews can also be considered to be a major disadvantage of this particular method of data collection. Furthermore, as participants are encouraged to tell their story, the interview may also touch on very sensitive areas that can lead to the individual reliving painful memories and consequently trigger heightened emotional responses, such as anger, fear and sadness. In such situations it would be wise for the researcher to abandon or delay the interview until the participant makes the decision as to whether they wish to continue, or the researcher feels that it would be in the participant's best interest to abandon or reschedule the interview. Some individuals however, appreciate having the opportunity

for someone to listen to and acknowledge their experiences and feelings and find such interviews therapeutic. It is therefore appreciated that conducting interviews can be very intense and exhausting for the researcher with the possibility that a great deal of other people's emotional baggage such as trauma associated with previous childbirth experiences, is absorbed through the process that the researcher must then deal with.

In some studies, participants may be interviewed more than once in order to pursue in further detail those issues that emerge as important from preliminary data analysis. Anderson (1991) claims that this kind of persistent involvement with the participants makes it more likely for the researcher to come to understand their perceptions of the phenomenon under study at a deeper level. In this study in the majority of cases, access to women after 24 to 72 hours of giving birth, would be more difficult due to the fact they may be transferred home around this time and so such an exercise could also prove very time consuming. However, it could be argued that as prolonged periods of participant observation covering the entire duration of each woman's labour once in the hospital setting was also undertaken, one interview with each of the participants would probably provide the sufficient depth of understanding expected. On the other hand, as some midwives were in fact involved in more than one labour in the study, they consequently were interviewed on more than one occasion. This could therefore be seen as further adding to the understanding of the midwives' role and behaviour concerning intrapartum informed consent.

Although their effects are never entirely determinate, the personal characteristics of the researcher and how these relate to the individual being interviewed can be important. Such characteristics can be controlled to a degree by the researcher's presentation of self. Measor (1985) found that taking care to dress appropriately according to the age of the teacher she was interviewing and drawing on shared interests and biographical experiences, helped to facilitate the interview process. However, where the research has a participant observation component (as in this study) it is considered that little further work is required to develop such a rapport as contact will have already been made with those being interviewed. Careful self-presentation can avoid the attribution of damaging identities and encourage ones that might facilitate rapport in interviewing participants as in participant observation. Whilst it had been decided to simply not wear a uniform when undertaking participant observation and thus avoid being identified as a member

of the midwifery staff, it became apparent that the dress code for the interviews was a little more complex and required some consideration. The clothing worn was not only influenced to some extent by the age and background of the individuals being interviewed but also the range of other responsibilities the researcher had scheduled for the same day in her capacity of midwife teacher. In general, the dress code tended to be less formal when interviewing the younger participant (trousers and jumpers / blouses) in comparison to the older / professional participant (skirts and blouses / suits).

Hardy and Mulhall (1994) recognise that the status of the researcher can influence the type of answer from the respondent where the researcher is seen as a powerful figure, such as a health professional, with the participant being a member of the public. As a result socially desirable answers may be given in which people say what they feel will show them in a positive light or what they think the researcher wants to hear. These issues were particularly important to consider as to their effect in this study as the interviews were carried out by a midwife who was also an experienced midwife teacher known to many of the midwives and staff in the area and of whom some had been former, or were current, students. The midwives' responses were therefore compared with the earlier observational data to assess whether their perceptions were indeed a true reflection of how they communicated and behaved in the natural setting of the labour ward.

At the outset of any interview Hammersley and Atkinson (1995) state that it is usual to inform the participant of the reason for the interview and the form it will take, along with reassurances about confidentiality and their right to refuse to answer any question to which they would prefer not to respond. The researcher is often the only other person present at an interview and the guarantee of confidentiality implies that no one else will ever hear what the participant has said in a way that is attributable to him or her. Under these circumstances, information may be divulged and opinions expressed by the participant that they would not usually do in front of others. Hammersley and Atkinson (1995) suggest that some participants may even doubt the researcher's assurances of confidentiality and seek to use them to leak information to others. However, in situations where the researcher is also a health professional, the code of professional conduct: standards for conduct, performance and ethics, (NMC 2004a) does not permit that all information should be kept secret. As a health professional, the researcher had a

moral duty to report any concerns regarding the health and well being of individuals or the professional conduct of colleagues. It was therefore important to consider aspects of this study where confidentiality may be breached in the interests of the participants and to make this clear at the beginning of each interview before information was disclosed that may later be regretted.

The method of recording the answers given will also influence the nature of the interview. Arksey and Knight (1999) suggest that using an audio recorder is probably the most popular method of recording qualitative interviews. Such a method not only has the advantage of enabling researcher and participant to maintain eye contact, but also provides the researcher with the freedom to concentrate on the conversation with the participant rather than trying to quickly write down everything that is said. As a result, and depending on how unobtrusive the recording is in encouraging the free flow of information, the audio recorder can be successful in capturing almost all of the comments from the participant in their own words.

However, Hammersley and Atkinson (1995) note that audio recording does not produce a perfect and comprehensive record for in some instances background noise may make the recording virtually unintelligible. This was apparent when Hunt (2004) undertook her ethnographic study of women living in poverty. In addition, recording interviews is also highly selective as non-verbal communication cannot be captured and it may not be clear as to which individual is being addressed should interviews be conducted in groups. Hunt (2004) found this also applied to her recordings when the mothers and sisters of the women in the study stayed and joined in the interview.

Whilst some participants find audio recorders intimidating, they can be an additional worry for the researcher, such as possible technological failure, should the tape get stuck or the batteries run out. Furthermore, Hammersley and Atkinson (1995) warn that there are considerable costs involved in the preparation of recorded materials as they must be transcribed. They state that the ratio of transcribing time to recorded time is always high: often in the range of 5:1 or more (Hammersley and Atkinson 1995). In this study, as interviews were used as a secondary source of data collection to either confirm or refute earlier observations, it was considered that there was no real need to record their content on audio-tape. However, had it been decided that interviews were to be the

prime source of data collection, recording their content would then be appropriate to ensure accuracy of response.

3.3. DATA ANALYSIS.

3.3.1. Methodological Considerations.

In undertaking any small-scale investigation or large-scale study, the researcher must be able to understand the methods by which the information or data collected may be analysed and presented. Interpreting the data collected and presenting the findings of the study is not easy and consequently computers have been increasingly utilized in social science research for decades: although mainly in the context of quantitative research data analysis. Analysis and interpretation (referred to by the umbrella term “analysis”) are crucial foundations for clarity, rigour and a systematic approach to qualitative research. They are however also creative and challenging processes requiring continuous reflection.

Analysis is not a distinct stage or phase of qualitative research. It begins in the pre-field work phase, shapes the formulation and use of data collection methods and continues into the process of writing up. Nevertheless, as many reviews of the literature have revealed (Miles and Huberman 1984 and Burgess 1982), there are relatively few detailed accounts of how researchers approached and carried out data analysis.

Qualitative data, such as interviews, field notes and extracts from documents are used in pure and applied research in a number of social science disciplines, and because by definition, such data cannot be easily quantified, Fielding and Lee (1995) state that qualitative data present practical, technical and methodological problems when the analysis stage arrives. The large amount of data (predominantly unstructured), generated in qualitative research needs to be appropriately managed so as to aid systematic analysis and interpretation. It could however, be argued that this is no different to quantitative research where large amounts of numerical data have to be managed. The difference lies in transparency. It is easier for numerical data to be checked for accuracy of data entry and calculations using statistical tests and correlation tables. In comparison, in qualitative research, Miles and Huberman (1994) state that the

researcher has to make analytical choices to reduce the data before it can be presented effectively and meanings and conclusions deduced. It is therefore important that in order to demonstrate rigour in interpreting and presenting qualitative data, the strategy of using multiple perspectives is adopted that demonstrates thorough searches for negative, or differing instances, and uses a colleague to check for consistency.

The process of qualitative data analysis takes many forms, but as Maykut and Morehouse (1994) indicate it is fundamentally a non-mathematical analytical procedure that involves examining the meaning of people's words and action. Strauss and Corbin (1990) describe three approaches to analysing qualitative research which can be thought of as varying along a continuum ranging from a low level of interpretation and abstraction engaged in by the researcher to a high level of interpretation and abstraction required for theory-building. The first approach may be compared to the work of a journalist whereby the researcher presents the data without any analysis. The aim is to enable the research subjects to speak for themselves as much as possible, relating their experiences without any interpretation. However, the second approach requires some selection and interpretation of the data and the skilled researcher, according to Strauss and Corbin (1990: 22):

"..... using this approach becomes adept at weaving descriptions, speaker's words, field note quotations and their own interpretations into a rich and believable narrative."

Although this approach could be classed as primarily descriptive, Belenky (1992) adopting the same approach, has referred to it as "interpretive-descriptive". Some of the interpretations found in descriptive research suggest an interest in theory building, which Strauss and Corbin (1990), classify as the third approach to qualitative data analysis. The development of theory requires the highest level of interpretation and abstraction from the data in order to arrive at the organizing concepts and tenets of a theory to explain the phenomenon of interest.

Whilst descriptive analysis tends to be the traditional approach to analysing ethnographic data there appears to be a wide variety of approaches to analysis with a gradual move towards the process of developing and testing explanations or theories. Hammersley and Atkinson (1995) recognise that the iterative process in which the

analysis of the data feeds into research design and data collection of ethnographic studies is also central to “Grounded Theorising” (Glaser and Strauss 1967). However, whilst it may be argued on the one hand that theorised accounts involve a narrowing of focus and consequently present a more selective representation of the phenomena (unlike traditional ethnographical accounts), on the other hand, assuming that the theoretical ideas are well founded, such accounts begin to provide much more knowledge about why events occur in the ways they do. It was therefore considered more appropriate to adopt an approach that would try and explain the complexities surrounding informed consent during labour so as to increase the existing body of knowledge regarding intrapartum communication and interactions. Consequently, it was decided to use principles from the grounded theory approach.

3.3.1.1. Grounded Theory.

Grounded theory is inductively derived from the study of phenomena it represents and was developed in the 1960s by two American sociologists, Barney Glaser and Anselm Strauss as a result of their research on hospital staff’s behaviour towards dying patients. Richardson (1996: 76) affirms that Glaser and Strauss chose the term grounded theory:

“.....to express the idea of theory that is generated by (or grounded in) an iterative process involving the continual sampling and analysis of qualitative data gathered from concrete settings, such as unstructured data obtained from interviews, participant observation and archival research. “

As data are collected, each piece is coded or named in words that the subjects themselves have used, or in the researcher’s own words that give meaning to the data. Glaser and Strauss (1967) advocated the development of an open-ended indexing system where the researcher works systematically through a basic body of data generating codes to refer to both low-level concepts and to more abstract categories and themes, with maximum flexibility being allowed in the early stages to generate new categories from the data. Each piece, or set of data is compared with another and as new ideas emerge, further comparisons are made. Codes with similar meanings are then linked together to form categories and connections made between these categories and subcategories by determining their relationship to each other, known as axial coding (Strauss and Corbin 1998). By a process of selective coding the emergence of a core

category (story line) occurs. The core category relates to all other categories and provides an explanation of how people behave in a particular social environment according to their personal values, beliefs and culture. Just as themes or concepts emerge from the data, through a process of inductive analysis, so should the theory. The model highlighted in Figure 3.4 has been devised from the stages of data analysis using the principles of grounded theory, as discussed by Strauss and Corbin (1998).

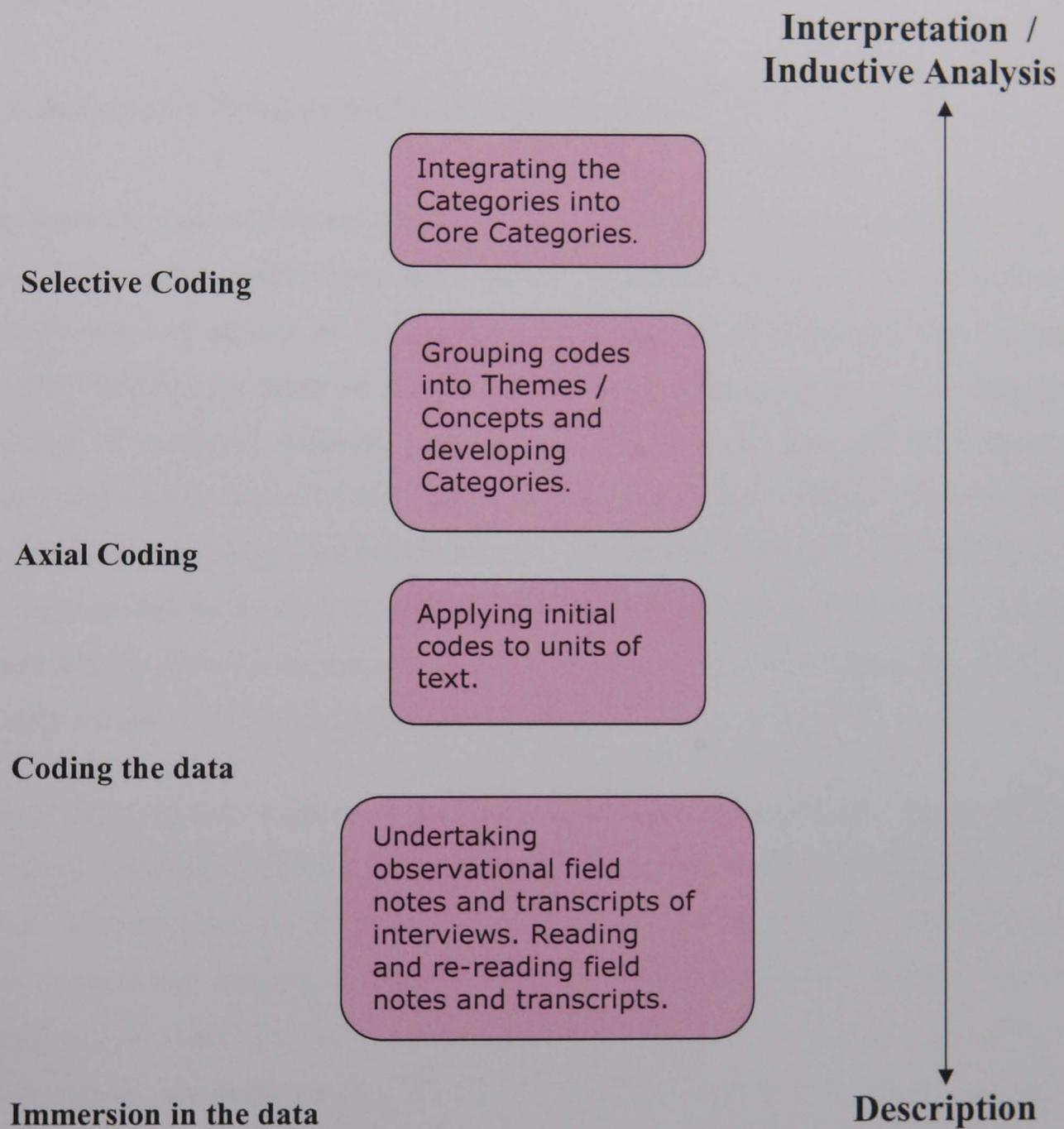


Figure 3.4: Stages in the Data Analysis.
(adapted from the work of Strauss and Corbin 1998).

With such an approach, data are collected and analysed in parallel and stops once “saturation” occurs. This is what Strauss and Corbin (1998) refer to as the point in category development in which new properties, dimensions or relationships no longer

emerge during the analysis. The analysis also consists of the method of constant comparison whereby there is a continual sifting and comparing of elements such as basic data instances, cases, emergent categories and theoretical propositions, during the duration of the study. By making such comparisons, the researcher becomes sensitised to similarities and differences as part of the exploration of the full range and complexity of the body of data and these are then used to promote conceptual and theoretical development.

3.3.1.2. Influence of Previous Studies on Data Analysis.

As the depth and type of data analysis of any research study is a serious consideration, it was thought essential to first assess the tools used in similar research studies concerning communication and aspects of intrapartum care. However, on reflection, this was not particularly helpful. As many of the studies had been undertaken at a time when the availability of computer software packages was limited, the data had been mainly collected and sorted manually and analytical comments made without any assistance from computer technology. This would appear a satisfactory approach given sufficiently small samples and ample time to work through the endless data generated, in order for the researcher to give the appropriate depth of analysis required to ensure the findings were truly representative of the population studied.

In recent times, to take account of the increasing number of qualitative studies being undertaken, computer software packages have been developed for qualitative data analysis. The computer is therefore viewed by Frankfort-Nachmias and Nachmias (1992), as a tool that enables the researcher to store, process, access and analyse the data collected in their study. The aim is to generate theory from the data, unlike quantitative research, where one begins with a theory or hypothesis that is then tested. However, According to Weitzman and Miles (1995), two decades ago, most researchers using qualitative methods typed up their hand written field notes, made photocopies, marked them with pencil or coloured pens, cut them up, sorted them, pasted them on file cards, shuffled them and typed their analyses. A few were beginning to use word processors for their written-up field notes, and even fewer were exploring database computer programmes as a means of storing and accessing their voluminous data.

When Henderson (1984), conducted her ethnographic study into informed consent to rupturing the membranes in labour her research report does not state exactly how the wealth of interview data she collected from the 50 participants was first categorized and then analysed. As qualitative computer software packages would have been fairly limited at this time, it could be assumed that these processes were probably conducted manually. Furthermore, in Adams' (1989), research into communications in the labour ward, a total of 11 participants were studied, from which she collected data via video recordings that she then transcribed, coding each phrase spoken by the participants into one of seven categories, but subsequently found this very limiting. In comparison, Hunt's data (1989), which were collected via interviews from a total of 24 visits to the labour ward, culminated in the emergence of a total of 43 possible themes (Hunt 1989). However, she did claim that the reading and re-reading of the interview data line-by-line was extremely time consuming and tedious.

When Kirkham (1987) conducted her research using participant observation and interviews to collect data from 113 cases studied in the intrapartum period, she too carried out the practical aspects of the data analysis by hand. She claimed that during the fieldwork period she made additional analytical comments in the margin of her notes and that most of the analysis took place at the end of each case studied. She subsequently developed a card index system to categorize phenomena from her data. Such categories required refining as new data emerged and before any conclusive comparisons could be made. Considering the wealth and volume of data likely to be collected from approximately 100 cases using participant observation and follow-up interviews, it was felt such laborious and time consuming methods to analyse the data used in other qualitative studies, would be impractical to adopt for this particular study into intrapartum informed consent.

In 1994 when Patterson conducted her study of 23 participants that involved the issue of informed consent in labour, she analysed her data manually by constantly comparing and contrasting the postnatal interview scripts she had obtained, looking for similarities and differences in experiences recalled. Her work does not state however, whether she actually had access to computer software packages to assist in her data preparation and analysis, nor the reason for opting for manual analysis. Fraser (1999) however, did use a computer-assisted package to analyse her interview transcripts and tapes involving a

total of 41 participants. Her data were then transcribed in *ASCII format using Textbase Alpha computer programme. After a sorting and resorting of themes, it emerged that the data could be clearly represented in three themes. The research report however, did not specify the rationale for choosing this particular computer programme as opposed to all others available.

Over the past 15 years, there has been a phenomenal development in computer technology in respect of qualitative research methodology. In 1991, a survey of qualitative researchers conducted by Miles and Huberman (1994), revealed that 75% of respondents reported using computer software for data entry, coding search and retrieval display and concept-building, with a mixture of satisfaction and dissatisfaction. However, many qualitative researchers have felt bewildered and uncertain about the numerous software packages presently available and which specific programme would be most appropriate for their own qualitative research methodology and data analysis.

The following section will discuss the advantages and disadvantages of using computers in the analysis of qualitative data, such that some analysis may be made in order to justify the suitability of using a software package to manage the analysis of the data collected in this study into intrapartum informed consent.

3.3.2. The Use of Computer Assisted Qualitative Data Analysis Software Packages (CAQDAS).

The numerous advantages of using computers for qualitative data collection and analysis has been summarized by Conrad and Reinharz (1984) in terms of time, tedium and rigour. Although it is acknowledged that computers can save researchers valuable amounts of time, it is difficult to analyse how much time is actually saved at specific stages of the data analysis (possibly some of the claims of speed and accuracy could be validated by further comparative research studies). Fieldwork, interviews and other data can be entered into the system as quickly as they can be typed.

*ASCII = "Pure" text that does not have special formatting commands like those inserted by word processors or other programmes (e.g. underlining, boldfacing, centring) From American Standard Code for Information Interchange.

When data are stored on disks, they can be retrieved much more rapidly than by conventional manual procedures. The speed would be an advantage when dealing with large quantities of data. Once the data are coded, they can be retrieved in various forms: as a whole, part or by word. The ease of retrieval can also encourage early exploratory analyses even while data are being entered: this simultaneity is one of the hallmarks of grounded theory (Glaser and Strauss 1967).

Most fieldwork studies produce voluminous pages of data that need to be coded and ordered. The cutting, pasting and filing can be done on a computer terminal much more easily and rapidly than with paper, scissors and tape and the hours spent searching through file after file for the appropriate piece of data can be done in minutes. However, Seidel (1991: 112) warns of the problems researchers may face when attempting to analyse volumes of data:

"..... because computer technology allows us to deal with large volumes of data we will be lured into analytic practices and conceptual problems more conducive to breadth analysis rather than depth analysis. We will start trading off resolution for scope."

However, it could be argued that by taking over many of the mechanical aspects of qualitative research data analysis, the computer can allow the researcher more time to devote to the interpretive or analytic work, which is more significant and rewarding. This fact in itself has the potential for increasing the rigour and comprehensiveness of qualitative studies. Coding the data for future retrieval purposes forces the researcher to consider useful categories and specify certain functions required. The computer is less likely to miss any piece of coded data and therefore makes all examples available to the researcher. Conrad and Reinhartz (1984) suggest this aspect of computer application may therefore enhance the reliability of the findings since all coded material would be presented to the researcher simultaneously for analysis. Furthermore, one would assume it possible to locate deviant cases that are often critical in analysis.

Mills (1959) suggested the importance of a flexible filing system that allows for the convenient grouping and regrouping of data as the conceptual organization of the study changes. Unfortunately, his practical suggestions for accomplishing this are limited in value. Placing all the data collected on the floor every few months and then re-sorting

them according to the needs of the moment is probably workable only if there are relatively small files and some means of retaining their previous order. It is critically important to have a system which permits flexible reorganization at will in order to be able to take advantage of new insights and to provide for new lines of study.

Larger files of materials, such as those generated in the course of a long-term participant observation study (such as in this particular study), pose other problems. It is inevitable that a large number of related events, situations, categories and variables will appear in the analyses. In order to make effective sense of these, some sort of cross-referencing system would need to be used so that all the pertinent data to a given idea or cluster of ideas can be grouped together for detailed analysis. The sheer bulk of a large file of notes and data means that some form of index arrangement is necessary in order to conveniently retrieve documents according to many criteria.

Effective collaboration in research is one of the most powerful ways of generating new ideas and alternative lines of inquiry on the one hand, and of identifying flaws on the other. Utilizing computer software packages and being part of a network with fellow researchers enables convenient access to each other's data and opportunities for secondary analyses, therefore increasing the credibility of the study and the trustworthiness of its findings. Furthermore, not only do computer networks allow data to be sent directly from field sites to a central unit, their portability makes fieldwork less tedious, even in settings away from individual offices. However, as this particular study was not intended to be part of a large collaborative study, others did not have access to the data and consequently contribute to the data analysis.

There are nevertheless, certain disadvantages to consider of introducing technology into what used to be largely a craft-orientated approach to conducting research. The major concern is probably allowing the technological abilities of computers and software define the research question or problem. Smith (1996) states that software packages should support the analysis and not do the analysis for the researcher, as the complex and multi-faceted activities that are involved in interpretive analysis remain human functions. Thus, in the text reviewed in this area, the term "computer-assisted" qualitative research is emphasised, suggesting that the computer should be used to enhance, not control, the work of the researcher. It is therefore important that while the

researcher should take advantage of the computer's abilities, they should not allow the analyses to hinge primarily on what the particular software package can do.

Another potential disadvantage of computer-assisted qualitative research is the financial expense of setting up such a system and subsequently maintaining it, as well as the time invested in learning how to use the programme effectively. There is also a danger (although usually avoidable), of losing data through operator mistake, a computer error or power failure. Finally, unless the researcher has their own system (or keep their own disks), access to others and confidentiality of data could also become an issue of concern. However, on balance, it could be argued that the potential advantages of using computers in the recording and analysis of qualitative research significantly outweigh the disadvantages.

Whilst there are six major types of software packages presently available: namely: Word Processors, Text Retrievers, Textbase Managers, Code-and-Retrieve Programmes, Code-based Theory-Builders and Conceptual Network-Builders, the three generic programmes (Word Processors, Text Retrievers and Textbase Managers) were not necessarily developed with the needs of the qualitative researcher in mind. Furthermore no one programme is of a pure type as there are plenty of overlaps across the types.

An example is the Code-based Theory-Builders that are often researcher developed. These usually include code-and-retrieve capabilities, but also enable the researcher to make connections between categories of information (codes), to develop higher order classifications and categories, to formulate propositions or assertions, implying a conceptual structure that fits the data, and / or to test such propositions to determine whether they apply. These programmes are often organized around a system of rules or are based on formal logic. Examples are AQUAD, ATLAS/ti, HyperRESEARCH, NUD*IST and QCA.

More recently, and since the study was undertaken, another package: NVivo, has been developed. Although similar to NUD*IST, NVivo, has improved graphics and text editing facilities with variations in colour and fonts. Furthermore, as its name suggests, coding can be done “live” as the data are being entered, in comparison to NUD*IST

where the data have to first be transcribed into a word document before they can be imported into the software package to finally then be coded. It is important to remember that no programme will actually build theory for the researcher: computers do not think and they cannot understand the meaning of qualitative data. Each programme differs in the amount and kind of support they can offer the researcher's theory-building attempts.

3.3.3. Considerations Regarding Choice of Package.

When considering choosing which specific computer software package would be the most appropriate to use in the data analysis, Miles and Huberman (1994) point out that the programmes should be both flexible and user-friendly. The specific functions that the computer software package is capable of must be first assessed for flexibility, ensuring that its functions would be able to meet the demands of the research data collected with the facility to make any adaptations, if necessary, whilst attempting to undertake analysis of the data.

The second consideration, which is very fundamental, is the user-friendliness of the programme. It should be relatively easy to learn as well as operate. The time and effort required to learn the functioning of the programme must be justified by the results obtained. It is also important that there is a good support system regarding the use of the software programme: this would involve the programme manual, other relevant documentation, tutorials, help screens, as well as technical support being readily available at the end of the telephone.

With all the wealth of information available in this area, it was quite difficult to decide which specific computer software programme would be most suited to this particular study into intrapartum informed consent. As Richardson (1996: 200), states:

"..... there is in my own experience, considerable variation in the specific tasks that even apparently similar packages can perform and in how they carry them out. If possible, therefore, it is useful to try out a number of sample disks before committing yourself to buying any particular one."

Therefore, on reflection, using a code-based theory builder programme, such as NUD*IST, HyperRESEARCH or ATLAS/ti, that has a code and retrieve function as well as the facility to develop the data by creating links in the data, was considered to be

the most appropriate for this particular study to assist in ordering the endless data collected, and subsequently assist in the data analysis stage. Taking Richardson's (1996) advice, it was planned to first access such programmes using data from the pilot study (discussed in the following chapter). This provided an opportunity to assess each one for their flexibility, user friendliness and back-up support before making any final commitment to one particular programme.

3.3.3.1. Statistical Analysis.

Although it has been recognised in this chapter that participant observation and interviewing can be lengthy processes, Bell (1991) also states that as in case studies, critics point to the problem of representativeness. If one group is studied in depth over a period of time, it can be questioned that such a group is typical of other groups who share the same title. As a result, statistical analysis using cross-tabulation and chi-squared tests from SPSS (a quantitative research computer software package) was undertaken to compare demographic details of the women in the study with the total childbearing population of the locality (Puri 2002). This would also confirm that the sampling method had not resulted in a skewed / biased group of participants. Furthermore, as Rees (2003) and Polit et al (2001) claim, generalisation may also be a problem in such studies, as it cannot be accepted that midwives and doctors in the labour ward, involved in the research, are typical of such health professionals in a similar labour ward in another part of the country. This fact must therefore be borne in mind when discussing the findings from the study and finally drawing conclusions.

3.4. SUMMARY.

In this chapter a case for using qualitative research methodology, and in particular, ethnography, to explore how consent to intrapartum procedures is obtained from women has been presented and supported with reference to text and other ethnographic studies specifically undertaken in the environment of the labour ward. In addition, an attempt has been made to explore the principal method that is used in field research: participant observation, as a means of data collection. This method of investigation involves taking a particular role within a culture in order to examine, at first hand, a social situation from the research participants' point of view. Furthermore, the

challenges of analysing qualitative data have been discussed with particular emphasis being made to the role of CAQDAS and the relevance of using principles of grounded theory for this particular study into intrapartum informed consent.

The following chapter discusses how the main study was undertaken, including issues of access to the study site and the participants. An examination of the labour ward in context will first be presented followed by an assessment of the pilot study that assisted in informing the appropriateness of the tools proposed to undertake the data collection and analysis in the main study.

CHAPTER 4. UNDERTAKING THE STUDY.

4.1. THE LABOUR WARD IN CONTEXT.

The research was undertaken on the labour ward of a maternity unit within one of two recognised Teaching Hospitals that serve the needs of the community of a large East Midlands city and neighbouring towns. The two hospitals and their maternity units, as well as the many health services offered in the community setting are independently managed by their own individual Executive Boards set up within the NHS Trust system. The majority of women living in and around this city give birth in either of the two maternity units, as there are only approximately 2% of births undertaken in the home by the community midwives. This remains the case despite the Expert Maternity Group (DoH 1993), findings that 72% of women surveyed expressed they would like to have the choice of a different system of maternity care and birth. In 1997, at the time that this study commenced, a total of 5699 women gave birth in the maternity unit of the hospital in the study, giving rise to 5771 live babies. A small number of births were to women of minority ethnic origin: 8.4% (494) of the 1997 total births in the maternity unit.

The Expert Maternity Group (DoH 1993) highlighted the Domino Scheme with care in the community by midwives known to the woman as an option many women find appealing compared to hospital care. It further stated that purchasers / providers should consider establishing a midwife-led / GP service alongside the specialist facility, however this service is not fully functional in the maternity unit in the study. Despite all GPs being entitled to undertake the full range of intrapartum care, the increasing cost of medical insurance over recent years has led to most GPs in this locality abandoning the provision of intrapartum care.

The maternity unit that is situated on the outskirts of the city within the vast complex of the hospital campus, was purpose-built and opened in 1994. At the time the study was undertaken, the unit comprised of the antenatal clinic, the Maternal and Fetal Surveillance Unit (MAFSU), the labour ward, with its 17 rooms and birthing pool, and three maternity wards providing both antenatal and postnatal care. There is also an

obstetric operating theatre attached to the labour ward that is resourced by staff from general theatres and specialist neonatal intensive care facilities.

At the time of the study there were a total of 150 (116 Whole Time Equivalents [W.T.E.]) midwives and seven consultants in obstetrics, (one of whom was female), employed within the maternity unit. An extensive In Service Education programme is in operation for all staff to further develop their clinical skills and enable them to provide holistic care in labour: such sessions include resuscitation of the newborn, interpretation of CTGs and intra venous cannulation. As part of continuing professional development, a number of midwives have also been awarded a first or higher degree by successfully undertaking further studies, including small-scale research studies that challenge contemporary midwifery and obstetric practices.

All student midwives are presently prepared by a diploma / degree in midwifery education programme that emphasise a balance of theoretical and clinical knowledge. Such programmes should enable the student to become competent to practise in both hospital and community settings at the point of registration as a midwife, but to date, none from the university serving the maternity unit, have gained initial employment other than in the hospital setting. This is also apparent nationally as Fraser et al (1997) revealed in a study commissioned by the ENB. They found that whilst students completing a 3 year pre-registration midwifery programme were committed to women-centred, midwifery-led caseload practice in the community, the realities of practice in their first midwifery post upon qualification meant that they were more likely to work in busy, often short-staffed hospitals. Here they were expected to have ward management skills and be able to participate in caring for women with complications and pre-existing medical conditions. For students undertaking training within the university serving this hospital, the majority of their clinical work is currently experienced within the hospital setting where they are also exposed to high risk pregnancies, obstetric management and interventions. Consequently the extent that students feel confident to offer a more woman-centred, midwifery-led service and support women in making appropriate decisions about their maternity care, is variable. Needless to say, in order to try and further address this imbalance in clinical competence and confidence the RCM (2003) recommendations suggesting that the clinical experience of all student midwives should be focussed more in the primary

sector, rather than in obstetric-led units, would appear to be a valid proposition in the locality of the study.

In many instances, the newly qualified midwife therefore finds herself requiring considerable support in her first post (particularly in the provision of intrapartum care). Within the maternity unit there is a 3-6 months preceptorship scheme in operation to support newly qualified midwives. This is expected to enable them to broaden and deepen their competence and ability, as well as improve their own confidence as autonomous practitioners. The nature of this support depends on the needs of each individual midwife and the type of clinical experience she was exposed to as a student. Whilst for some this may involve caring for women with complications and pre-existing medical conditions, for others it may be caring for low-risk women.

According to Walton and Hamilton (1995), if the woman gives birth in hospital the environment should be such that it can instil a feeling that positive empathetic support is available for her and her birth partner. Women attending Preparation for Childbirth classes in the maternity unit being studied, have the opportunity to visit the labour ward prior to the onset of labour to familiarise themselves and their partner with the environment and the many pieces of machinery that occupy a labour room. However this visit is generally for first-time parents rather than all women who expect to give birth in the unit. However, efforts are made to accommodate multigravid women should they have given birth prior to the maternity unit being opened in 1994, or had their babies elsewhere in an alternative maternity unit.

At the time of the study, a senior midwife with a core staff of midwives managed the labour ward. On each shift there is always an experienced midwife coordinating the labour ward, be it the senior midwife, or a deputy, whom Hunt (1989: 35) refers to as: "*the King Pin in charge of her castle*". The majority of midwives are based in a team of midwives on one of the three antenatal / postnatal wards, and work a flexible rota system during each week, incorporating experience in the antenatal clinic, on the wards and on the labour ward. This enables the majority of midwives to maintain their skills in all areas as opposed to developing expertise in any one area. Internal rotation operates regarding night duty experience. Such a system is an attempt to provide some continuity

of care, but in reality, particularly in labour, this does not always apply, as care can be fragmented due to the 8 hour shift pattern resulting in midwives not always being able to provide care for the woman throughout the entire intrapartum period.

The design of the labour ward is such that the midwives on duty are divided into two teams each allocated to one side of an “L” shape ward. It is here where women generally meet with their intrapartum carers for the very first time. The Expert Maternity Group (DoH 1993) were told by consumer groups that one of the most comforting factors, especially at the onset of labour was seeing a familiar face, whether this be the midwife or the doctor. The Patients Charter (DoH 1991) also required that there is a named midwife for every woman in order to improve continuity of carer, particularly in the community, so she can be with the woman when and where needed and respond to her individual needs as appropriate. This was reiterated in the Government’s response to the Winterton report (House of Commons Health Committee 1992), and further endorsed by the Expert Maternity Group (DoH 1993). However in “Your guide to the NHS” (DH 2001b) that has now superseded the Patient’s Charter, there is no longer an explicit reference made to the “named” nurse or midwife, nor continuity of carer.

In order to provide continuity of care, Wraight et al (1993) state that over 40% of maternity units have turned to team midwifery. However, the Expert Maternity Group (DoH 1993) noticed that very few teams had actually managed to achieve continuity of care and carer. There were 13 midwives working in a community-hospital integrated team during the time the study was undertaken in an attempt to operate continuity of care and carer for their clients throughout pregnancy, especially in labour. A total of 472 births were undertaken in the maternity unit in 1997 under this scheme but only a minority of 12 births under the Domino scheme. However, these statistics do little to fulfil the 5th Indicator of Success specified by the Expert Maternity Group (DoH 1993) that recommended at least 75% of women should know the person caring for them during labour. However, it could be argued how relevant the familiarity of the carer in labour actually is. Further information collated by the Expert Maternity Group suggested that, providing there is the continued presence of a qualified carer during labour, together with reassurance and a comforting touch, there should be a beneficial effect on the physical and psychological outcome of childbirth (DoH 1993). Proctor

(1997) also found similarities in her study. She reported that whilst antenatal women felt continuity of carer to be important as well as it being desirable to know their midwife prior to labour, postnatal women on the other hand, perceived continuity as a nice but unessential feature of the service provided they had a pleasant, competent midwife during the labour. These findings were also discovered in Fraser's (1999) study. Nevertheless, such facts should not make the providers of the maternity service complacent: the aim of achieving continuity of care and carer should still remain high on the agenda as a means of improving the quality of communication between women and the midwife (and doctor) during labour. Furthermore, one of the fundamental aims of this study was to determine what factors influenced the midwives' and doctors' communication with women about intrapartum procedures within the local system of maternity care provision.

When a woman is admitted to the maternity unit in labour, there should be opportunity for her to discuss her needs with the midwife caring for her, as far as it is practicable. This may be by the use of a birth plan or other methods of recording her wishes regarding the birth. However, in practice this does not always happen and at the time of the study there were no data available locally to determine the number of women actually using birth plans in the maternity unit and whether or not they found them to be of any benefit. Although Whitford and Hillard (1998) had found in their study a high proportion of primigravidae had completed a birth plan prior to the onset of labour, other studies point to there generally being small numbers of women who actually formulate a birth plan prior to labour (Green et al 1998, Jones et al 1998).

It would be interesting to discover whether or not there is a link between a change of midwife resulting in fragmented care during labour, and the effect this has on the overall management, for example, the woman's need for analgesia. Walton and Hamilton (1995) suggest that continuity of carer may have an effect on reducing the need for analgesia in labour. In the labour ward being studied, 41.4% of women had epidural analgesia during labour in 1997. Furthermore, only 45 women used the birthing pool during labour for analgesic purposes out of a total of 238 requesting to use it. Although there was insufficient evidence as to why the number was so low, the suitability of women requesting to use the birthing pool needed to be investigated. Labour ward statistics for 1997 indicated that 3647 births were in fact spontaneous

vaginal births, with little evidence suggestive of any intrapartum complications that would have prevented women from using the pool, had it been their choice. Flint (1986) suggests that continuity of care schemes could enable more women to fulfil their wishes to use the birthing pool as discussions would have taken place in advance of labour commencing with a midwife who felt confident to provide such care when the time came, and who would continue to do so until the baby was born. This is an ideal situation that is difficult to fulfil with the present delivery of maternity care in the labour ward in the study. It could however, be addressed by extending the Domino scheme or by implementing a more integrated community-hospital team approach to care where the woman would already know the midwife / midwives providing her care throughout the whole of the childbirth process.

In 1997, of the 5699 women giving birth on the labour ward in the study, 3647 women had spontaneous vaginal births (63%) which were attended by midwives as the senior professional, thus acknowledging the midwife's role in the management of low-risk women and normal childbirth. In fact the 6th Indicator of Success according to the Expert Maternity Group (DoH 1993) was that at least 30% of women giving birth in a maternity unit should be admitted under the management of the midwife. This is actually happening within the labour ward in the study and medical staff concentrate on attending those women who develop complications in later pregnancy and in labour. To a certain degree, the midwife therefore is enabled to work as an autonomous, accountable practitioner within her defined sphere of practice, and to work with the obstetricians as part of a team to provide the best possible outcome for women who develop complications later in pregnancy. This sometimes means consulting anaesthetists and paediatricians, as well as physicians, as early as is practicable. Even when complications occur, women should be involved in the decision-making process and continue to be cared for by the named professional as far as possible.

Within the maternity unit, professional teams that include midwives, have worked together to produce protocols and guidelines for care, e.g.: nutrition in labour, criteria for use of the birthing pool, but so far consumers have not been involved in this process despite the suggestion from the Expert Maternity Group to utilize their experience and opinion (DoH 1993). Proceduralization has been described by Schon (1987), as a means of reducing professional practice to a set of absolutely clear, precise, implementable

procedures, coupled with controls which are designed to enforce the procedures and eliminate, what he describes as, surprise. As a consequence, if something went wrong in practice, the response would be to increase and improve procedures to prevent them from recurring. According to Garcia and Garforth (1989) procedures can be seen as limiting the wisdom, skill, professional judgment and creativity of the midwife as well as inhibiting the woman's choice. It could be argued nevertheless, that policies and procedures concerning normal midwifery do provide standards for good practice, particularly for students in training, and should be seen as a guide based on the individual needs of the woman, offering some degree of flexibility as far as is possible, considering the wellbeing of woman and baby.

There are regular audits pertaining to the intrapartum standards set, that are undertaken by a senior midwife employed for achieving this task and ensuring quality of service to all women and their families whilst receiving care in the maternity unit. This would comply with the recommendations of the Expert Maternity Group (DoH 1993). Representatives from the maternity unit are on the local Maternity Services Liaison Committee, where there are also lay representatives from consumer groups, such as the NCT. This is an ideal forum for debate and a means for women to provide information towards the future planning of the maternity services in this area.

It would therefore appear that within the maternity unit in the study there are a number of recommendations as well as Indicators of Success from the Expert Maternity Group (DoH 1993), that have been addressed and that over recent years amidst all the Government reforms that have occurred, there has been some recognition of the need to value the woman as being central to all maternity care. It is important however, that women's needs are fully respected, particularly when midwives complete their shift and handover the care to colleagues, so that communication difficulties often associated with fragmentation of care, be minimised (Kirkham 2000).

4.2. GAINING ACCESS.

4.2.1. Access to the Study Setting.

It has been recognised by Maykut and Morehouse (1994) that gaining access to the setting where the research is to be undertaken requires both tact and persistence. In the first instance, the Midwifery Manager of the maternity unit and the Head of the Academic Department of Obstetrics and Gynaecology were consulted to discuss the feasibility of undertaking the study. Support was duly obtained from both departments after which a formal application to the local hospital Research Ethics Committee was submitted in July 1996.

Based on the evidence from the literature review and the methodology adopted in other similar studies, it had been decided to adopt an ethnographic approach using overt observation methods with follow-up interviews to collect the data as this would seem more appropriate with the focus of the study being intrapartum informed consent. Initially, the Research Ethics Committee had expressed some reservations concerning the proposed methodology and the likelihood of the researcher's presence inducing behaviour changes in the participants being observed. Consequently they had suggested the data be collected by using a video camera over an extended period of time to ensure that any changed behaviour reverted back to normal. Although previous ethnographic studies by Bergstrom et al (1992) and Adams (1989) both used the video camera to collect data, this had only been during the second stage of labour and not throughout the entire labour as was being suggested for this study. The impracticalities of using a video camera throughout every labour, including the legal and ethical implications of using such covert methods for the nature of this study, had clearly ruled out this approach from the outset. Following a meeting with the Research Ethics Committee to justify the chosen methodology and discuss the study in more depth, officer approval was finally granted on 10th December 1996 (appendix 1) subject to the committee receiving a copy of the client information regarding the research (appendix 2). This leaflet was to be given to all women attending the hospital antenatal clinic at 32 weeks gestation to notify them of the study well in advance of the onset of labour. This would give them ample opportunity to discuss the study with their partners and members of staff before making

a final decision to participate or not. An additional means of informing the women and their partners of the study in advance of labour was to display laminated posters on the notice boards in the waiting areas and consulting rooms in the hospital antenatal clinic (appendix 3). These sources of information were both printed on coloured paper (green) in order to distinguish them from the rest of the information leaflets and maternity records women received during pregnancy.

4.2.2. Access to the Participants.

Once permission had been granted by the local hospital Research Ethics Committee, accessibility to the labour ward in the hospital was fairly straightforward. It had been decided that the midwife about to provide the intrapartum care would obtain the woman's consent to participate in the study upon admission to the hospital. This was to enable the women to make a more objective decision to participate in the study by not feel pressurised into taking part should they have been approached in person by the researcher. It was therefore important that these midwives were fully aware of the purpose of the research.

A number of meetings were held on all the maternity wards of the hospital that coincided with shift handover in order to inform as many midwives as possible about the research, discuss the client consent form with them (appendix 4), and consequently gain their cooperation by consenting to take part and recruit women to the study. As a number of the midwives had previously been assessed in clinical practice by the researcher in her role of midwife teacher, either as student midwives or whilst undertaking the mentor and mentorship module, it was thought that some of them may be apprehensive about taking part in the study and as a result be reluctant to recruit suitable women on behalf of the researcher. In order to allay any anxiety among these midwives, it was therefore stressed at these meetings that the purpose of the study was to examine the communication between health professionals and women that involved gaining consent to intrapartum procedures and was not to assess and criticise their clinical practice. Some midwives also sought clarification as to the exact position of the researcher during the data collection and whether this would include undertaking midwifery activities, such that should they need to summon assistance from a colleague,

the researcher could fulfil this function instead. It was reaffirmed that as the researcher had not intended to be associated with any particular group of participants in the study, such that her involvement in intrapartum activities would be limited, a decision to not wear a uniform that would identify her as a midwife was made.

The entry criteria to the study was that the woman was classified as being low risk so that there was nothing of obstetric significance at the outset that could affect her decision-making and choices during labour. In such cases, the midwife would therefore be the main provider of the intrapartum care. The entry criteria to the study were identified as follows in Figure 4.1:

Figure 4.1: Entry Criteria.

Women who were:

- **To give birth at the local hospital.**
- **In good health with no medical / surgical / fetal complications.**
- **37 weeks or more into their pregnancy (term).**
- **In spontaneous labour.**
- **English speaking.**

4.3. THE PILOT STUDY.

Prior to conducting the main study a total of four labours were observed. These comprised of one primigravida and three multigravidae (two in their second pregnancy and the one in her third) and involved observing health professionals during all three shifts of the 24-hour day. Such an exercise assisted with increasing the familiarity with the layout of a typical labour room and clarifying the role of participant observer and to what extent (if any) that the participation in intrapartum care should take. The pilot study also provided an opportunity to utilise the proposed tools for data collection: e.g. field notes for the observation, and formulate a series of prompts for the follow up interviews with the women and health professionals observed in the study. In order to put the intrapartum observation in context, it would seem appropriate at this stage to describe the design and layout of a typical labour room within the maternity unit and the role and function that certain pieces of equipment played within the labours observed. Figure 4.2 offers a pictorial representation of such a room.

4.3.1. The Labour Room.

All labour rooms are quite spacious and square in shape and are painted in pastel colours with a patterned border to appear more home-like to the woman and her partner. Each room has its own sink unit and clinical waste disposal / dirty linen bins that are used mainly by health professionals. However, between each room is a shared shower room and toilet / sluice area for women to use. In addition to the centrally situated birthing pool, there is only one bathroom at the end of one of the corridors, for women to relax in during labour if they wish.

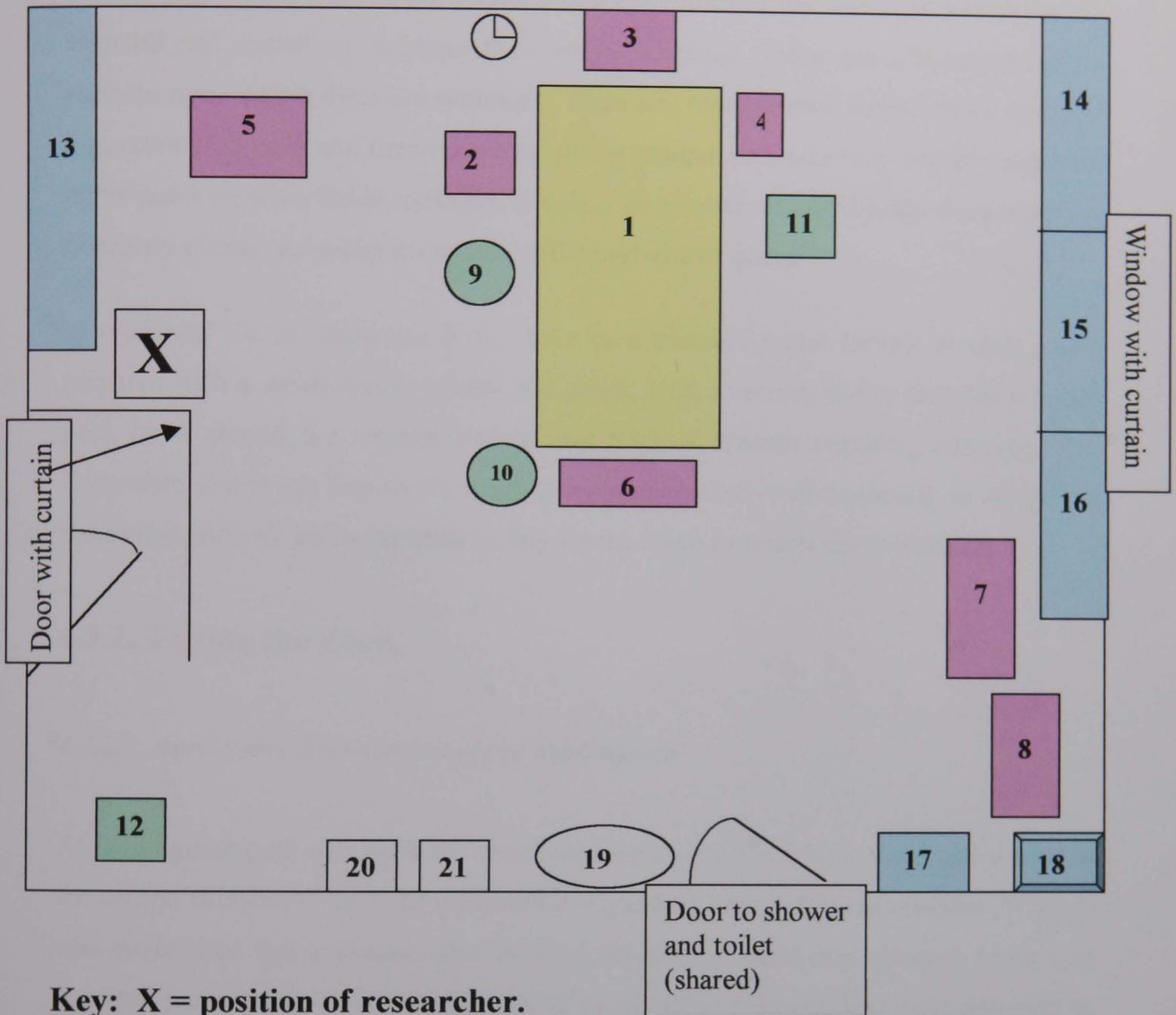
In every room there is a small frosted window (with curtains) through which a degree of natural light can enter. An additional curtain is situated around the door as a further means to protect the woman's privacy. The main lighting can be controlled with a dimmer switch, and there are softer wall lights for use during the night with a main overhead spotlight beam for instrumental deliveries and suturing procedures.

On the wall opposite the bed, there is a framed print to further brighten up the room, and make it appear less clinical, as well as a television with radio facilities for the woman to utilise and focus on during labour, if she chooses. However, if the woman is immobile and labouring on the bed, the large wall clock that is situated above the bed head is strategically positioned to be out of her vision.

In the centre of each room is a multi-purpose birthing bed that can be adapted into a chair. However, no adaptation was attempted during the pilot study other than fixing lithotomy poles for instrumental deliveries or suturing the perineum. It could be argued that the central position of the bed does little to encourage women to remain mobile and seek alternative positions for their labour. Should a rocking chair, beanbag or birthing ball be requested, these have to be brought into the room from the store room by the midwife and consequently were not offered to any of the women in the pilot study. In direct contrast, equipment such as CTG machines, Intravenous Additives Calculator (IVAC) machines, neonatal resuscitaires, as well as suction, oxygen and gas and air facilities (which do little to affirm a home-like environment for the low risk woman),

are all positioned around the bed in every room, and are therefore much easily accessible to the midwife.

Figure 4.2. Layout of a Typical Labour Room (not to scale).



Key: X = position of researcher.

1: Bed.	9, 10: Metal Stools.
2: CTG Machine.	11, 12: Easy Chairs.
3: Oxygen, Suction, Gas and Air wall unit.	13: Work Surface (lithotomy poles stored underneath).
4: Drip stand / IVAC.	14, 15, 16: Work Surface and Cupboard Units.
5: Neonatal Resuscitaire.	17: Wall fixed Drug Cupboard.
6: Bed side Table.	18: Television / Radio.
7: Delivery Trolley.	19: Sink.
8: Suturing Trolley.	20, 21: Clinical Waste and Linen Bins.

There are usually two armchairs in each room for the woman and her birth partner(s) to use with a couple of stools for the midwife or doctor. However, the bedside table, initially for the woman's personal use, such as drinks, tends to be placed at the foot of the bed rather than close to the woman where it consequently serves as a desk for the midwife and doctor to maintain their record keeping. There are a couple of work surfaces upon which there are stationary, linen and incontinence sheets, and a series of three cupboard units and drawers where sterile equipment packs (e.g. urinary catheters, intravenous infusion fluids, syringes, needles, amnihooks and fetal scalp electrodes) are discreetly stored, yet easily accessible to the midwife or doctor.

In readiness for an imminent birth, there is a portable metal trolley in each room, prepared with a sterile birthing pack and gown, with a second trolley that has a suture pack on it should the woman sustain any perineal trauma requiring suturing. Non Controlled Drugs are kept in each room within a locked wall cupboard, to which the individual midwife holds the specific key for the room in which she is working.

4.3.2. Testing the Tools.

4.3.2.1. Access and Recruitment of the Participants.

At the beginning of each shift the researcher went onto the labour ward and waited at the central midwives' desk for information regarding intrapartum admissions. When it was established that a woman who fulfilled the entry criteria was about to come into hospital, the midwife-in-charge was asked as to which midwife had been assigned to undertake the intrapartum care. The researcher subsequently approached this particular midwife for their assistance in recruiting the woman to the pilot study at the time they admitted her to hospital. Each midwife appeared willing to do so without question or hesitation and spoke with the women, explaining the purpose of the study, thus giving the women the opportunity to refuse to take part before ever meeting with the researcher. As a result, recruitment was successful with the midwives obtaining written consent from the four women with relative ease. All the women and health professionals participating in the pilot study were of caucasian origin. The primigravida was the only woman who was married, had attended Preparation for Parenthood classes

and had written a birth plan prior the labour. Although the other three women were all multigravidae, none had attended any classes in their previous pregnancies.

In order to assume an unobtrusive presence and minimise the reactivity of the participants being studied (Maykut and Morehouse 1994), it was decided to occupy a less prominent position near the door within the labour room. Furthermore, as the study involved the complex issue of informed consent, a decision was made to always accompany the last health professional out of the room. This was to avoid the difficulties and conflict of interests that Kirkham (1987) had experienced should the woman ask questions in the absence of other health professionals that could consequently affect the results of the study.

4.3.2.2. Field Notes and Participation.

Throughout the pilot study details of the observations of how women were involved in making informed decisions about their care in labour, were made in the format of notes, using Spradley's (1980) checklist for observation field notes as a guide. These notes were continually revisited and reflected upon as the data collection progressed. Such notes were made from the time the woman had consented to taking part in the study when the researcher was first given access, up to the time she was transferred to the postnatal area following the birth of her baby. In one case, the data collection ceased when the woman went to the operating theatre for a manual removal of placenta for which she had signed a consent form for the procedure. This was the only case where the observation also included medical staff (obstetricians and an anaesthetist) as midwives were the most senior health professionals observed in the other three cases.

In the pilot study the time spent observing ranged from 120 minutes (2 hours) to 450 minutes (7½ hours). However, as it was appreciated that as some labours could in fact be much longer than those experienced in these four preliminary cases, the range in length of the observation stage of the pilot study may not necessarily be a reliable guide for the main study.

As Stevens et al (1993), point out, it is important to understand the context in which the observations were made, how the data were recorded and the subjective selection and

interpretation of phenomena under study when reading reports: these were obvious considerations for the final written report. In collecting the data, an attempt was made to write down what had been observed and heard, providing the clearest and most complete narrative of what went on without any interpretation. In situations where the role of the participant-as-observer became more evident, e.g. opening packs for the midwife when the birth was imminent and assisting with the woman's comfort, making notes became more difficult as they consequently had to be written retrospectively following completion of the activity. Kirkham (1987) and Danzinger (1979) had previously highlighted that attempting to optimise data collection possibilities around activities as a complete participant can be difficult, as it is not ideal to be writing observational field notes retrospectively. This was one of the reasons that the role of observer-as-participant was adopted in this study.

In the pilot study, the extent of participation varied and depended on whether or not the midwife had a colleague or student in the room at the time who could assist her. In an attempt to clarify the role, it was decided that in the absence of another midwife, assistance would be permissible should it be a task the woman's partner may be expected to perform, and not a second midwife. Table 4.1 highlights typical tasks either accepted / declined in the role of observer-as-participant.

ACCEPTED TASKS.	DECLINED TASKS.
Supporting the woman: e.g. rubbing her back, holding her hand, making her comfortable.	Checking and administering drugs / intravenous fluids.
Fetching items for the woman: e.g. water, wet flannel, telephone.	Discussing options of care available to the woman.
Fetching items for the midwife: e.g. amnihook, suture material.	Offering a professional opinion about the intrapartum care and management.
Being a messenger / summoning assistance.	Relieving the midwife from her duties while she takes a break.
Opening items in an emergency: e.g. delivery pack when birth imminent.	Assisting with procedures: e.g. epidural, instrumental deliveries.

Table 4.1: The Range of Tasks Accepted / Declined.

4.3.2.3. Undertaking the Interviews.

Before leaving the labour ward following completion of the observation, arrangements were made to undertake interviews with the midwives and women the following day, within 24 hours of the baby's birth. As one of the midwives was not on duty the next day, arrangements were made to interview her before the end of the shift after she had completed her records and the woman had been transferred to the postnatal ward. This was to ensure that her recall of events was still clear, rather than waiting for her to return to work some 4 days later.

The interviews with the midwives took place in either the midwives' coffee room (when unoccupied) or in the resource room where privacy could be ensured and interruptions minimised. Each midwife stated that by about an hour into the study, they had become oblivious to the fact they were being observed, with only one midwife admitting to doing things in a different order to what she was generally accustomed during the initial admission of the woman. This would concur with the work of Posner (1980) that stated that the mere presence or reactivity effect of the researcher in observational studies is but transitory.

As each woman occupied a bed within a four-bedded room where facilities were shared with other mothers and their babies, they were consequently offered a choice for the interview to be undertaken in private, in an alternative room or office. They all chose to remain by their own bed and be interviewed. As one woman had given birth shortly after midnight, arrangements had been made to interview her later on that same day in the early afternoon. However, she had unexpectedly gone home within 10 hours of the birth, so the interview did not take place, thus only 3 follow-up interviews were actually undertaken with the women. Furthermore, it proved difficult however, to arrange interviews with the medical staff following their involvement in the 3rd case as they were either involved in other theatre cases or had gone off duty. Although contact was attempted by pager, there was no response from the medical staff and so these interviews were never undertaken. The difficulties experienced in arranging interviews with all those taking part in the observation stage were carefully considered to ensure that every participant in the main study would be successfully interviewed within 24 hours of the baby's birth.

Each interview lasted between 45 minutes and 1 hour. It was found that the interviews conducted with the women and midwives were particularly useful as a secondary source of data and an appropriate means of comparing their individual perceptions and understanding of consent to intrapartum procedures to what had been observed. Prompts were used to help keep the dialogue within the focus of the study should the participants stray from what was originally asked. This also enabled more selectivity in the data collection based on the earlier observation. However, as each labour was a unique experience for all involved, the original interview prompts, although useful as a guide, needed some modification for each interview, taking into account what had been observed. This is supported by Stevens et al (1993) who argues that in qualitative interviews, the last interviewee may be asked different questions from the first one as such research is mainly concerned with the different perspectives participants hold.

One woman used the interview as a means of debriefing to help clarify certain aspects related to her intrapartum care and management. This was a further reason to decide not to use an audio-tape to record the interviews. Not only could the spontaneity of the participant's response be affected, it could also result in there being endless irrelevant data transcribed from the tape. When a lengthy response was given, rather than attempt to write it down verbatim, which would have proved to be very time-consuming, annotated notes were therefore made. However, when a response was considered pertinent to record verbatim, the participant was asked to wait until her exact words were noted. These notes were subsequently offered to each participant at the end of the interview to check for accuracy and authenticity with the opportunity for them to add or delete details if they wished. No changes were in fact suggested by any of these participants in the pilot study.

4.3.2.4. Issues Relating to the Data Analysis.

The extensive notes that may be written as a result of observation studies can, however, provide a challenge to any researcher when the data preparation and analysis stages are apparent. This was particularly enlightening when undertaking the pilot study as a wealth of data was obtained from the copious field notes taken from the four labours, where a variety of intrapartum procedures involving informed consent, and number of personnel, had been observed. It was therefore important that as it had been decided to

use principles of grounded theory and CAQDAS to assist with the analysis of the data, an appropriate computer software package was identified as soon as was practicable so that the data could be entered and the analysis started alongside the ongoing data collection.

In pursuit of a suitable qualitative research computer software package where there may also be a degree of back-up support available for the novice user, it was discovered that one of the most popular packages used within the university was NUD*IST. Furthermore, the School of Nursing and Academic Division of Midwifery had recently acquired the package for staff and students to use, which subsequently improved personal accessibility and affected the final decision to adopt this particular package.

Once the data from the pilot study had been transcribed as word documents, they were then entered into the package with support from members of the university staff who could demonstrate the coding, retrieval and theory building functions of the NUD*IST package. However, in comparison to the actual coding of the data, transcribing the data from the observational field notes and the interviews proved to take much longer than initially anticipated: this was probably to be expected with the type of data generated by qualitative research. The decision to utilise the NUD*IST package was made primarily on its functions in managing the analysis of large quantities of data and its accessibility and back-up support. Using the data from the pilot study repeatedly to test out the functions of this package in order to become familiar with its use did take some time. However, certain issues arose from the findings that were consequently considered when collecting and analysing the data in the main study. These are listed in Figure 4.3. Furthermore, once it was felt that a degree of confidence had been reached with handling the computer package, the pilot study data was subsequently destroyed.

Figure 4.3: Issues to consider in the Main Study.

- **the amount of information and depth of explanation given to the woman,**
- **whether the person giving the information / explanation reveals any personal influences / biases to the woman,**
- **the timing of when the information / explanation is given in relation to the procedure being undertaken,**
- **how much the woman understands about the procedure:**
 - **whether the health professional checked that the woman understood what the procedure entailed prior to it being carried out,**
- **the woman's previous childbirth experience (if any):**
 - **the extent to which the health professionals assume the woman understands because she is parous,**
- **the type of consent obtained:**
 - **whether health professionals follow ethical, medico-legal and professional principles.**

4.4. THE MAIN STUDY.

4.4.1. Clinical Records.

The main study began on 24th April 1997 following an assessment of the pilot study and suitability of the chosen data analysis package. Demographic data, such as age, parity and ethnic origin were obtained from the woman's clinical record and hand-held records and entered into SPSS by the Research Associate from the Academic Division of Midwifery. Such data were then analysed to ensure that women included in the study were representative of the total local childbearing population in such details in order for the study sample to be neither skewed nor biased. However, as the maternity unit had not collected details of the woman's social class for the total childbearing population during this period, comparisons were unable to be made with the study sample data in this element. Caution, however needed to be taken when classifying the social class of women since the constraints of motherhood frequently lead to women giving up work or

undertaking jobs of lower status than those for which they are qualified. A number of women, however considered themselves to be “housewives” with no discernible income, so for the purposes of the study data pertaining to the higher status job they had had since leaving school was used. This was similar to how Green et al (1998) attributed social class to the women in their study of women’s birth expectations and experiences.

4.4.2. The Observational Stage.

From the commencement of the data collection, the labour ward was visited on a total of 137 occasions in order to recruit suitable participants to the study who fulfilled the entry criteria. This was on the basis of one day per week. The total length of time spent on the labour ward during the data collection stage was **76240 minutes** (1270 hours 40 minutes), which averaged **556 minutes / visit** (9 hours 16 minutes) However, as not all visits to labour ward resulted in recruiting a suitable participant to the study, the average time that was consequently spent in achieving the study sample of 100 cases was **762 minutes** (12 hours 42 minutes). These data are represented in a tabular format in Appendix 5. Presence on the labour ward was maintained until either a suitable recruit to the study was achieved, or the shift came to an end. This waiting time was constructively used to revisit the field notes and interview transcripts previously collected, make further notes and attempt to code the data.

As in the pilot study, whenever it was established which midwife would be assigned to undertake the intrapartum care of the first woman to attend the labour ward fulfilling the entry criteria, she was asked to seek the woman’s consent to participate in the study. The majority of midwives did not hesitate to seek consent from the woman as they felt their own participation could only benefit their practice of obtaining consent to intrapartum procedures and further develop their communication skills. Whilst this was in direct contrast to Adams’ (1989) study into the nature of communication during the second stage of labour where the video camera may have influenced her data collection, there were three midwives who appeared less willing to inform the woman of the study and seek her consent. Although each of these midwives stated that they had forgotten to ask the woman to take part in the study, it was possible that they may have felt

threatened by the presence of the researcher being also a midwife teacher, that their clinical practice would be under scrutiny: as did the midwives in Adams (1989) study.

The purpose of the observation was to observe the participants in as natural setting as possible. However, whilst it was recognised that the midwives would be working within the familiar surroundings of the labour ward with all its known resources and staff, the women in the study, by labouring and giving birth in a hospital, would be outside their own natural setting, that could therefore have some influence of what was observed. Throughout the time of the observational data collection, the researcher was in and part of the setting, either waiting around the central desk, nearby office or coffee room on the labour ward, for suitable recruits, or undertaking the role of observer-as-participant: being a constant reminder to the midwives as to the purpose of such presence. As a consequence, in addition to the midwife who was co-ordinating the labour ward for the shift, some midwives would actively assist in looking out for eligible women and then inform the researcher whenever the woman was to be admitted to the labour ward.

During this waiting time, should the labour ward be busy, the researcher tried to assist with simple tasks, such as the preparation of labour rooms and light refreshments for women and their partners in order to feel useful, rather than be a hindrance to the staff (Kirkham 1987). In addition, whenever a break for refreshments was taken, either during the waiting period or whilst undertaking the participant observation, this was usually in the midwives' coffee room at their invitation. It could be argued that although these activities associate the researcher more with the midwifery staff than the position of women experiencing labour, they did provide opportunities for some informal dialogue with the midwives. Should this include discussing issues regarding intrapartum care and consent to procedures, particularly in relation to a woman participating in the study, notes were made as soon as possible after such contact. However, on the labour ward there are two distinct coffee rooms that segregate midwifery and medical staff and so access to informal dialogue with the doctors never took place to the same extent.

Whilst undertaking the data collection, having a short break away from the labour room was particularly important to not only provide an opportunity to write down any additional personal thoughts and feelings of what had recently been observed, but also maintain personal comfort and hydration. Taking into account the possibility of a

woman's labour continuing through to the following day, sufficient food was usually prepared by the researcher and stored in the labour ward fridge. However, as there was not always the opportunity to take a break and eat it, should the period of observation without a break be unduly prolonged, in order to avoid becoming faint or dehydrated, bottled water and glucose sweets were taken into the labour room.

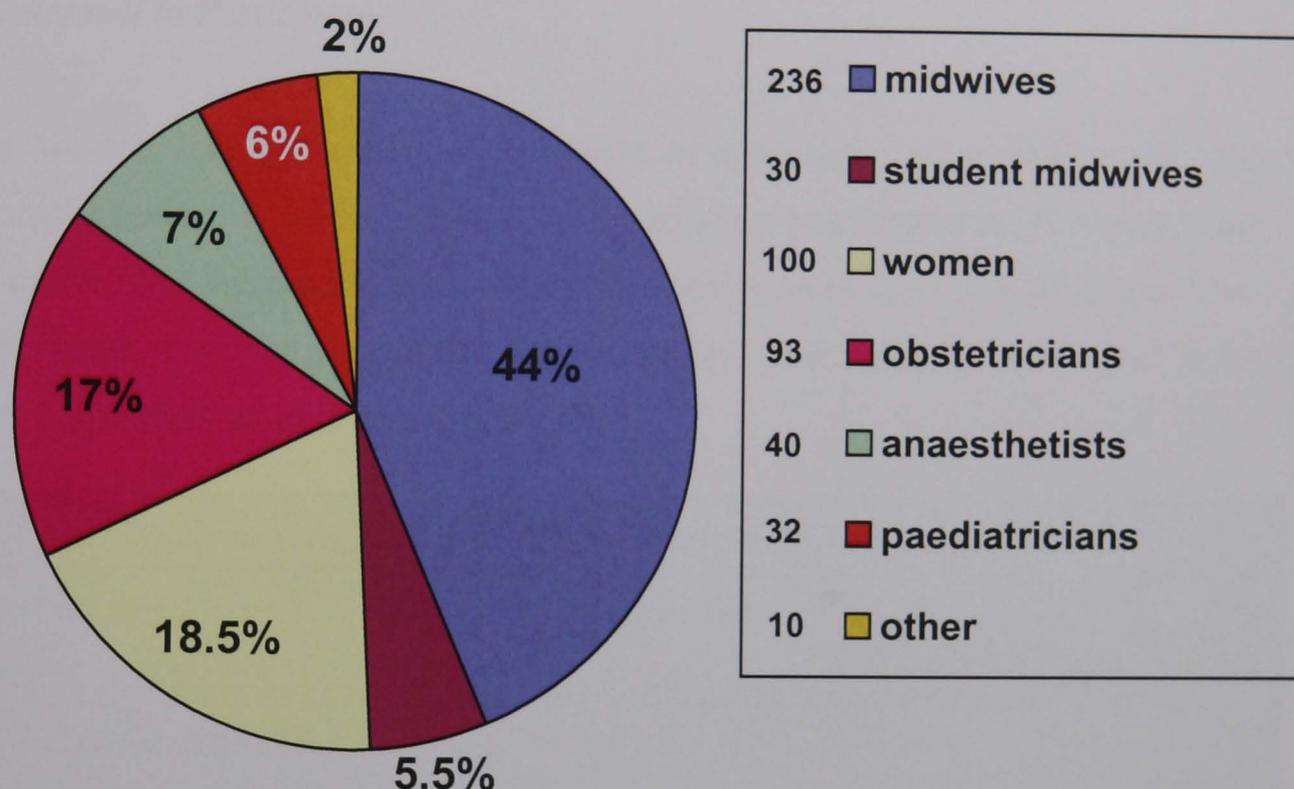
The field notes consisted of recording what had been seen, heard, felt and thought during the woman's labour. Initially as in the pilot study, Spradleys' (1980) checklist was used as a guide to collect the richest possible data during each labour observed. In the initial stages there was an eagerness to record all conversation between the health professional and woman regardless of the relevance to intrapartum care and informed consent. Whenever the television or radio within the labour room was switched on, the conversation between the midwife, the woman and her partner often involved some discussion about the current programme that had little significance (if any) to the focus of the study, and so were not recorded. Occasionally, it was difficult to hear everything that was said if the volume was particularly loud or to write everything down when a number of personnel were in the room should some deviation or complication have developed in labour. However in such instances and as the data collection progressed, a form of "shorthand" began to develop. This included writing down any personal comments felt at the time regarding consent to procedures, in the margins of the notes to distinguish them from what had been observed or heard. These notes were then developed soon after leaving the labour ward whilst the observations and sequence of events were still clearly remembered. In addition, as the researcher became more confident with observation techniques, the checklist was soon discarded.

As the data collection continued with preliminary analysis using the NUD*IST package, it became apparent that by the time the 100th case was observed, saturation point had been reached as new issues were no longer emerging (Strauss and Corbin 1998). The data collection therefore concluded on 29th December 1999. This sample size would also seem comparable to that of Kirkham's (1987) study of 113 labours. The actual total length of time spent observing the 100 labours in the study was **38195 minutes** (636 hours 35 minutes: the range being from 90 minutes (1½ hours) to 1095 minutes (18¼ hours), which resulted in an average of **382 minutes / case** (6 hours 22 minutes), as illustrated in Appendix 6. In addition, the median length of time undertaken during the

observational stage was calculated to be **335 minutes** (5 hours 35 minutes) and is highlighted in Appendix 7. As there were 5 labours where the woman gave birth within 30 minutes of arriving on the labour ward and consequently observation of consent to intrapartum procedures was limited, these were not included in calculating the median observation time.

During the observation stage of the data collection a total of 541 participants were observed, including the 100 women. The range and distribution of personnel involved are represented as total figures and percentages in Figure 4.4.

Figure 4.4: Observation Episodes (541).



In addition, some health professionals were observed on more than one occasion that provided further data to compare with earlier observations. The tables in Appendices 8, 9, 10, 11, 12 and 13 demonstrate the range in number of episodes various health professionals were observed throughout the data collection stage: the maximum being on 9 occasions (Midwife 5). A few health professionals were not only observed on more than one occasion, but also in the capacity of a different grade of staff. This included 5 midwives who had been observed during the early stages of the data collection when they were student midwives, and 2 Senior House Officers (SHO) who were also observed in the role of paediatrician.

4.4.2.1. Abandoned Cases.

During the period of the data collection there were 38 occasions when recruitment to the study was unsuccessful as women admitted on these occasions fell outside of the entry criteria. In addition, there were a further 22 occasions where midwives had sought the consent of the woman to take part in the study, only to experience that she was not in established labour. Consequently, the woman was either discharged home or admitted to one of the maternity wards to await labour to establish, and the observation abandoned. The time spent observing this abandoned sample ranged from 45 minutes to 540 minutes (9 hours), and averaged **164 minutes** (2 hours 44 minutes).

4.4.2.2. Refusal to Participate.

Once a woman had consented to take part in the study, there were none who subsequently decided to withdraw once the observation was underway. However, there were a minority of women (6) who refused to participate in the study from the outset and their wishes were duly respected. The reasons given in refusing to take part in the study are highlighted as follows in Figure 4.5:

Figure 4.5: Reasons for Refusal to Participate in the Study.

- **Too anxious.**
- **Previous caesarean section for fetal distress of twins at 32 weeks / intrauterine fetal death of Twin 2.**
- **Too distressed / “*want pain relief sorting out first.*”**
- **“*Want experience to be special for my partner and I / no observers / students.*”**

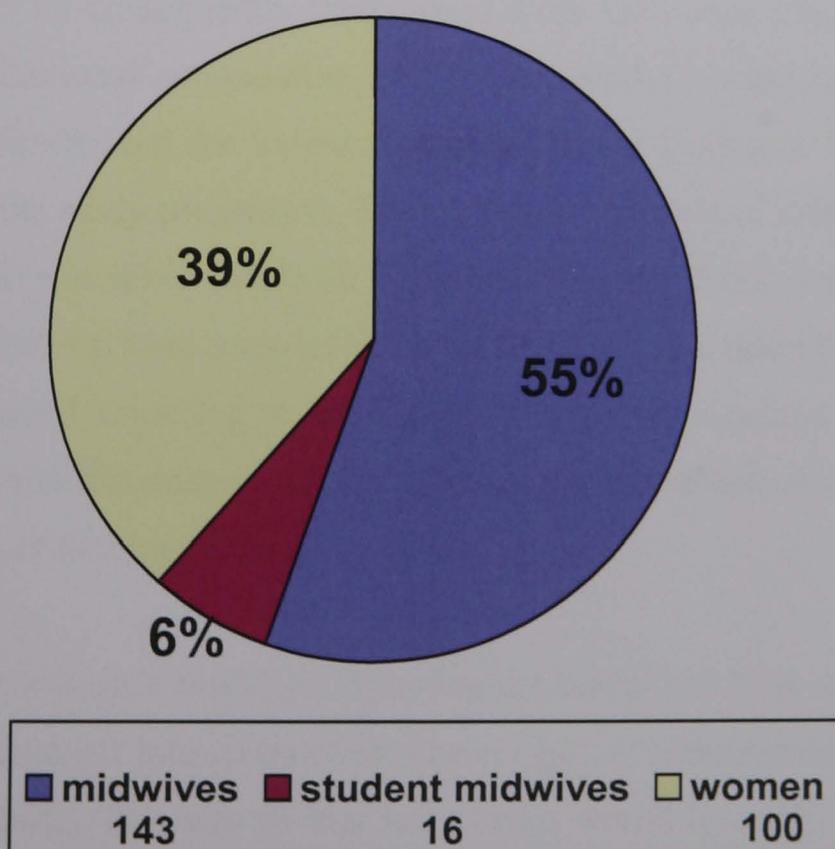
4.4.3. The Interviews.

Initially it had been anticipated that all health professionals involved in providing intrapartum care to the women in the study would be interviewed. However, as the entry criteria to the study was low risk women, there was limited scope for medical staff to become involved in intrapartum procedures unless some deviation occurred or the

woman required an epidural / spinal analgesia. In five of the first 10 cases observed, a total of 12 doctors, including obstetricians (ranging from SHOs to Registrars), anaesthetists and paediatricians, were involved in the intrapartum care and management in varying degrees. Although an attempt was made to interview all 12 doctors, only one interview with an SHO actually took place. The practicalities of arranging interviews with medical staff within 24 hours of the baby's birth proved to be difficult (as in the pilot study) due to their patterns of work and on-call systems. Furthermore, as their involvement was not only very fleeting and limited, it was therefore decided to concentrate on undertaking interviews with the midwives and the women as it is predominantly midwives who provide intrapartum care. As a result, there was no formal opportunity within the study to investigate the doctors' knowledge and understanding of informed consent from an ethical, medico-legal and professional perspective. Nevertheless, a total of 159 interviews were undertaken with the midwives that included interviews with 16 student midwives who had played a substantial role in intrapartum care (Figure 4.6).

Figure 4.6: Interview Episodes (259).

(The interview with the 1 SHO is not represented).



Due to the duty rota, it was not always possible to interview the midwives within 24 hours of their involvement in intrapartum care. If midwives subsequently had days off following the observational stage, so that their memory recall of intrapartum events would not be affected, they were interviewed before they went off duty, upon their return to work, or at home by telephone if this time was to exceed more than 2 days. Although the researcher gave all midwives a choice of place to undertake their interview, they usually made the decision for it to take place within the familiarity of the midwives' coffee room. However, this venue was not always ideal. Whilst the room was usually unoccupied at the commencement of the interview, interruptions were common as other midwifery staff would come in and break the flow of the conversation or even join in. On a few occasions when the labour ward was particularly busy and the midwife's assistance was needed to support her colleagues, the interview therefore had to be curtailed or resumed later during the shift or even the following day. These experiences were recorded in the margins of the interview notes including any additional data obtained from the informal contributions of staff interrupting the interview should they be in respect of the research study.

Midwives and student midwives who had been observed on more than one occasion in the study, were consequently interviewed more than once (Appendices 8 and 9). This provided additional comparative data for the analysis regarding the interpretation of their experiences and the extent to which informed consent was obtained with each woman as the study progressed. The maximum number of interviews undertaken with one midwife was seven (Midwife 5). It was appreciated that some of the midwives and student midwives were wary of the researcher being a midwife teacher and therefore tried to respond according to what they thought was expected of them. However, the degree to which the interview data compared with the observational data determined the authenticity of their responses.

Pending the woman's condition following the labour and birth and her arrangements for returning home, all interviews (with one exception) were conducted within 24 hours of the baby's birth. This was so that the woman would not only have had some time to reflect on her labour, but also that the recall of events would still be clear in her memory. In the one exception, the woman had returned home 30 minutes before the pre-arranged interview. However, she did complete a pre-paid postal questionnaire based on

the adapted interview prompts and returned it within 6 days of her baby's birth. All other interviews were successfully undertaken in one of the postnatal areas before the woman was transferred home: each lasted between 45 minutes and 1½ hours. However, in another case where the woman was transferred home within 6 hours of her baby's birth, the interview was conducted in the labour room after the woman had taken a shower.

Although all women were interviewed out of their natural home environment, every effort was made by the researcher to offer them the privacy of an alternative room such as a single bedroom, the ward sitting room or dining room (if unoccupied) should they be occupying a bed in a four-bedded room. All decided to remain in what some women considered to be "their territory" as this area was a more familiar and secure setting that contained some of their personal possessions. It was noted however, that the conversation was more spontaneous when the environment was quieter and there were no other persons present in the room with distractions / interruptions at a minimum.

As the researcher had not been present when the midwife first recruited women to the study, any information given about the status of the researcher was therefore unknown to her. Initially, some women appeared cautious and defensive until they had established the researcher's background, whereas others did disclose that they only consented to taking part in the study knowing that the researcher was both female and a midwife. It could therefore be considered that the responses they gave during the interviews may also have been influenced by these facts and the extent to which trust had been built with the researcher throughout the time of the study.

As in the pilot study, all midwives and women in the study were offered the opportunity to review the interview data collected in order to assess that what had been written was an accurate account. They were encouraged to make any amendments bearing in mind that the data would subsequently be used in the final account and disseminated to others working within the midwifery profession and the field of research.

4.5. ANALYSING THE DATA.

The observational field notes and interview data were typed up into word documents and subsequently entered into the NUD*IST software. In order to ensure that data had been accurately entered into NUD*IST, a random selection of case documents were checked against the original field notes and interview transcripts by an independent party. Although personally undertaking this task proved to be very time-consuming, the process did provide the opportunity to revisit the data and secure any additional comments or initial analytical thoughts as they emerged from the data, in the form of memos.

All data were eventually stored in NUD*IST and hard copies of the field notes, interview transcripts and memos were also made as a back-up and kept with the original data. However, demographic details of the participants were kept separate in order to preserve their identity. Having hard copies as a back-up was particularly useful whilst learning to master the package in the initial stages of data entry, as on occasion, data had to be re-entered due to either failing to save documents appropriately or computer failure. Additional hand written comments were added in the margins of these hard copies and highlighter pens used to mark any similarities, differences and emerging themes.

Analysis commenced after data resulting from the observation of five labours with the subsequent follow-up interviews, had been entered into NUD*IST. All data were read and re-read from each of the five cases so as to become immersed in the data. This was to allow themes to emerge by constant comparison and inductive coding so as to develop theory that is grounded in the findings (Glaser and Strauss 1967). Each text unit was coded as shown in the extract from Case 15: a housewife / cleaner (Appendix 14). At this elementary stage, codes were given to all the various intrapartum procedures / activities in the chronology that they had been observed regardless of whether or not they had a direct bearing on intrapartum informed consent practices. This gave rise to a total of 99 different codes. These basic codes were then grouped into themes and categories by axial coding (Strauss and Corbin 1998) using NUD*IST to assist in the retrieval of information and the development of connections between categories of data. This stage appeared fairly straightforward as the codes were simply grouped into themes

according to the intrapartum procedures and activities observed. This resulted in the emergence of a total of 21 themes (as shown in Appendix 15) These 21 themes were subsequently categorised according to the timing and amount of information disclosed about each procedure, the source of information, the assessment of the woman's understanding, her choice of intrapartum procedures and the type of consent she experienced: thus resulting in six categories.

When undertaking selective coding (Strauss and Corbin 1998), to further develop these six categories into core-categories such an approach had to be reconsidered. Initially connective links had been made to the various stages of labour: e.g. admission, first, second and third stage of labour, and immediate postnatal care, with a further core-category emerging to take account of complications of labour. However, it was discovered that some of the themes and categories that had so far emerged were likely to fit into more than one of these core-categories. The whole list of themes was therefore inspected with a colleague to cross-check the consistency with which the original codes had been applied to the data in accordance with the overall focus and aims of the study (LeCompte and Goetz 1992, Silverman 2000). The coded segments were retrieved and those data that did not directly involve consent to intrapartum procedures, e.g. interventions / interruptions by domestic staff, breastfeeding, etc., were subsequently deleted from the list of codes. Furthermore, the activities pertaining to the admission data codes were revised and incorporated into similar coded activities and procedures found elsewhere in the original list.

Including comparisons between the perceptions of the women and the midwives in the study with personal observations of the labours, to either support or refute claims, was an additional means of demonstrating the credibility and trustworthiness of data interpretation and explanation. However, the limitations of using a triangulation approach (Denzin 1978) in qualitative research studies was also borne in mind, appreciating that by the end of the data analysis, there may in fact be different accounts generated by the participants.

As well as constantly comparing each new set of data with previous sets and reviewing the coding process, an interim analysis of the first 25 cases in the study was undertaken. This assisted with the selective coding process as well as developing a better

understanding of the workings and functions of NUD*IST. It was appreciated however, that this interim analysis would only be a snapshot of the wider picture pertaining to the whole study sample at the point that saturation is reached (Strauss and Corbin 1998). Some of the themes that had so far emerged were in fact changed or considered less important as further data were collected and the final analysis completed.

The interim analysis proved invaluable and resulted in further modification of the original themes and categories. What emerged was a total of 14 categories relating to four core-categories: pre-labour preparation, information disclosure, role of the woman and professional, legal and ethical issues. However, as the data collection and analysis continued and there became further immersion in the data and reflexivity, the issue of the impact of the labour ward culture and influence of its staff on women's choice of intrapartum procedures and the legal and ethical considerations of informed consent as far as information disclosure and assessing understanding was concerned, became increasingly more evident. This was both in the context of low risk labours and also those that developed complications. Consequently this gave rise to the three core-categories (Experiencing the Labour Ward Culture, The Quality of Intrapartum Communication and The Health Professionals' Awareness of their Professional Obligations regarding Informed Consent) and their respective six categories and 17 themes to finally emerge from the data (as illustrated in the next chapter in Table 5.1).

Demographic details of the total childbearing population (13960) who gave birth at the same hospital during the time of the study, were obtained in the format of Excel spreadsheets from the midwife for Quality Assurance issues in the maternity unit. Data pertaining to age, parity and ethnic origin were extracted from the spreadsheets to assess whether the study sample (100) was a true representation of the total population in these attributes. The data from both these populations were entered into the quantitative SPSS software package with support from the Research Associate. Statistical analysis was subsequently undertaken using cross-tabulation and chi-squared tests to compare the two populations and the results are presented in the following chapter.

4.6. SUMMARY.

This chapter has provided a detailed account of the data collection and analysis pertaining to the study concerning intrapartum informed consent. The environment in which the data were collected was initially examined within the context of contemporary midwifery practice and government reforms affecting maternity care, client choice and consent to procedures and treatment.

The practicalities of undertaking the study have been critically discussed including the extent of time taken to collect and analyse ethnographic data. Issues of reflexivity and the personal influence that the researcher may have had on gaining access to both the study setting and the participants involved have also been explored. The pilot study was not only useful in testing out the data collection tools but also in exploring the extent of participation and which tasks were acceptable to engage in, so as being less likely to interfere with the process of collecting the data and making field notes.

The specific details of the complexities surrounding the analysis of the qualitative data from this study using principles of grounded theory (Glaser and Strauss 1967) supported by CAQDAS in the form of NUD*IST, have been presented in the final section of this chapter. Through undertaking the analysis in such a systematic way and including multiple perspectives to search for differing or negative instances, three core-categories finally emerged from the data. It is therefore anticipated that by providing such detail, the study may be considered to have been conducted in a rigorous and transparent way and consequently, the findings presented in the following chapter, be judged to be both credible and trustworthy.

CHAPTER 5: FINDINGS FROM THE STUDY.

5.1. INTRODUCTION.

During the qualitative data analysis using the NUD*IST software package, a number of emerging themes developed that were subsequently grouped under certain categories that had some relevance to communication and intrapartum informed consent within the context of a hospital labour ward. These were further integrated into three core-categories: *Experiencing the Labour Ward Culture*, *The Quality of Intrapartum Informed Consent* and *Health Professionals' Awareness of their Professional Obligations regarding Informed Consent*. Table 5.1 (page 138) presents the themes and categories of data that make up the three core-categories. This chapter will present each of these three core-categories in turn, with discussion of their respective categories and themes that emerged from the analysis of the observational field notes and the interviews conducted with the women and midwives within 24 hours following the birth of the baby. Including excerpts from the observational field notes and interviews in the form of either verbatim quotations or annotated notes, will attempt to highlight pertinent points that will assist in finally drawing appropriate conclusions from the study. The findings from the statistical analysis will be presented first.

5.2. DEMOGRAPHIC FINDINGS.

Using cross-tabulation and chi-squared tests from SPSS, statistical analysis was undertaken to assess that the study sample (100) was a true representation of the total childbearing population (13,960) attending the local hospital maternity unit during the time the study was undertaken. The results revealed no significant difference in respect of demographic details such as age, parity and ethnicity (Caucasian and other ethnic origins). The comparative results can be seen in the format of Charts 5(a), 5(b) and 5(c) / 5(d) illustrated in Appendices 16, 17 and 18 respectively. Further statistical analysis of ethnic origin of those women who were classified other than Caucasian, did however, reveal a significant difference as a wider range of origin was evident in the total population. This is shown in Chart 5(d) of Appendix 18. There were no women of Mediterranean, Far Eastern or Middle-Eastern origin in the study sample. Considering that these three ethnic groups collectively only form 0.9% of the local

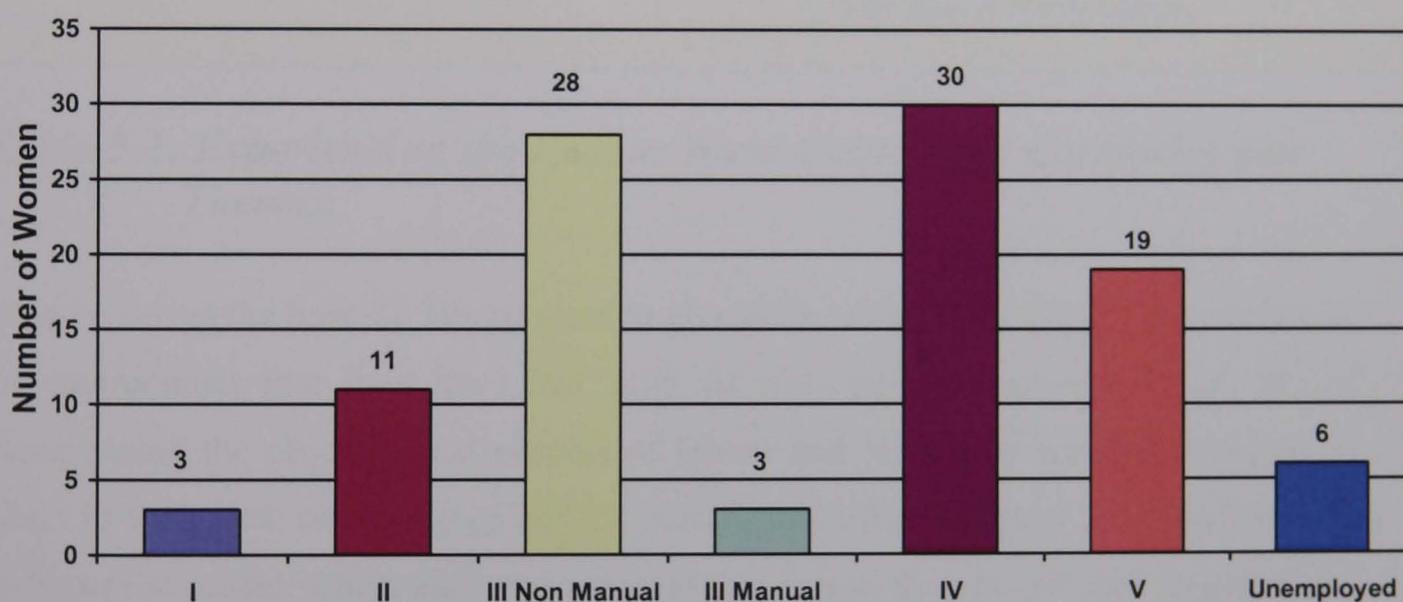
population and given the sample size of 100 women, not only was this to be expected, but also it probably would not make any difference to the findings.

CORE - CATEGORY	CATEGORY	THEME
1. Experiencing the Labour Ward Culture.	COMPLIANCE AND CONFORMITY.	Routines, policies and procedures. Knowledge / biases of the health professional. Complications in labour.
	EMPOWERMENT AND CONTROL.	Being in control and feeling valued. The use of birth plans.
2. The Quality of Intrapartum Communication.	HEALTH PROFESSIONALS' COMMUNICATION SKILLS.	Stereotypical roles of the midwife. The role and ability of the doctor. Acquisition of authoritative knowledge. Experiencing the effects of labour.
	WOMENS' ABILITY TO COMMUNICATE IN LABOUR.	Stereotypical roles of the woman in labour.
3. Health Professionals' Awareness of their Professional Obligations regarding Informed Consent.	LEGAL ISSUES.	Duty of care to inform. Assessment of understanding. Consent or trespass to the person. Record keeping and the threat of litigation.
	ETHICAL ISSUES.	Respect for autonomy. Benefit or potential harm to the woman and baby. Standards of practice.

Table 5.1: The THREE Core-Categories with Categories and Themes that emerged from the final data analysis.

As there were no data pertaining to social class for the total population of women who gave birth at the study hospital during the time the data collection was in progress, comparisons could not be made with that of the study sample. The range of social class of the women in the study sample is illustrated in Figure 5.1. It seemed more appropriate to classify the woman's occupation independent of that of her husband's / partner's (especially if he was unemployed) so as to be a better indication of her own social class. Furthermore, some women in the study were either divorced or separated (9%) and consequently data pertaining to their husband / partner were not readily available. The six unemployed women consisted of four schoolgirls and two other women who had never had any paid work since leaving school.

Figure 5.1: Social Class of the Study Sample (according to the Registrar General's Classification).



Part of the entry criteria to the study was that the woman was classified as being low risk so that there was nothing of obstetric significance at the outset that could affect her decision-making and choices during labour. It was also expected that such criteria would consequently affect the labour outcome in the study sample resulting in there being a considerably higher proportion of spontaneous vaginal births compared to that in the total population. Midwives were therefore the main carer to the woman in labour with medical staff only becoming involved should the woman request an epidural (31%), or when a problem arose / complication developed (41%). The medical staff in the study were predominantly male as a total group i.e. 69 male : 28 female but in

comparison, there was a more even gender split between the 49 obstetricians observed with 27 being male and 22 female. The effect that the health professional's gender had on women consenting to intrapartum procedures will be presented within this chapter.

5.3. EXPERIENCING THE LABOUR WARD CULTURE.

CORE - CATEGORY	CATEGORY	THEME
Experiencing the Labour Ward Culture.	COMPLIANCE AND CONFORMITY.	Routines, policies and procedures. Knowledge / biases of the health professional. Complications in labour.
	EMPOWERMENT AND CONTROL.	Being in control and feeling valued. The use of birth plans.

Table 5.2: *Experiencing the Labour Ward Culture: Its Categories and Themes.*

When entering the hospital labour ward to give birth, women are usually embarking on an environment that they have had little (if any) personal experience of. Whilst experiencing the physiological process of labour and birth they are also expected to adapt to their new surroundings and its culture that often is based on a medical and technocratic model, whilst also attempting to understand the professional language and form a trusting relationship with a midwife they have probably only just met. The first of the core-categories is concerned with the influence that the culture of the birth environment had on health professionals seeking, and women giving, informed consent to intrapartum procedures. The core-category: *Experiencing the Labour Ward Culture* was developed from the two categories: *Compliance and Conformity* and *Empowerment and Control* that further contained a number of themes from the data analysis as illustrated above in Table 5.2.

5.3.1. Compliance and Conformity.

Unlike in other hospital settings, the woman in labour is unlikely to see another labouring woman and consequently she becomes dependent on the health professionals to acquire her information about what to expect and what is expected of her. Holding such knowledge places the health professional in a very powerful position such that it influenced the extent to which women complied with the midwife / doctor or were empowered to make intrapartum decisions concerning consent to procedures. Within this category there were three commonly expressed issues that affected this aspect of intrapartum consent. These were: *Routines, Policies and Procedures, Knowledge and Biases of the Health Professional and Complications of Labour.*

5.3.1.1. Routines, Policies and Procedures.

Upon arrival on the labour ward, it was observed that the woman was always taken through the rituals of the admission procedure by either the midwife or student midwife as this appeared to be their main priority. The only exceptions to this were if the woman was in established labour and the birth was imminent or there was an emergency. The admission procedure consisted of the woman having an identity bracelet placed around her wrist, being asked to undress and either put on her own night clothes or a hospital gown, pass urine and then get onto the bed: activities associated with the role of “the patient”. Only on a few occasions were women encouraged to keep their day clothes on or sit in the armchair that was by the bed while they were being admitted to the labour ward.

Following the initial form-filling that included a detailed history of the woman’s pregnancy and labour up to the point of coming into hospital as this was usually the first encounter with the woman, the midwife then informed the woman of the various procedures she “*needed to do*” that were classed as part of the admission procedure routine. Such procedures included an assessment of her temperature, pulse and blood pressure, an abdominal examination, electronic fetal monitoring and a vaginal examination. It was observed that midwives routinely used similar phrases when beginning a dialogue with the woman, such as “*what I’d like to do is.....*”, “*what I need to do is.....*” or “*what we’ll do is.....*” that clearly implied to the woman that

such procedures were considered to be part of the normal intrapartum practice. As a result, no woman was ever observed to refuse these procedures when described in such a way, especially if no alternatives were given. Presenting the woman with a list of procedures, especially if in professional terminology that the woman may have not fully understood, gave little opportunity (if indeed any) for her to consider each procedure in turn. Thus, when the woman gave her permission, the midwives often assumed this was “collective consent”.

As a means of further introducing women to the technology of the labour ward, some midwives at this point, also discussed the workings of the various pieces of machinery contained in the labour room, such as the CTG machine and consequently gained the woman’s acceptance to use them should they be required as labour progressed. The following annotated extract from the observational field notes of Case 78 (a Communications Assistant) demonstrates some of the above issues:

- **Midwife 76** informs **Case 78** that *“I’m just going to check that you and your baby are OK..... this means checking your observations (temperature, pulse and blood pressure), doing a CTG trace of the baby’s heartbeat to make sure it’s alright and then a vaginal examination: All part of the admission procedure.”*
Case 78: “OK.”.....SHE GETS UP ONTO THE BED AND HAS A CONTRACTION.....
Midwife 76: *“Now, can I do a trace of the baby’s heartbeat for about 20 minutes? If it’s OK, you can come off the monitor, get up and move around and make yourself comfortable.”*
Case 78: *“OK. That’s good.”*.....
As Case 78 has not had a tracing done before, **Midwife 76** then tells her how the CTG machine works with its two abdominal straps to monitor the contractions and trace the baby’s heartbeat. She also states that the heart rate should range between 110-150 beats / minute.
MIDWIFE 76 APPLIES THE TWO BELTS AROUND CASE 78’s ABDOMEN, CONNECTS THEM TO THE TRANSDUCERS AND COMMENCES THE CTG.

It was routine practice that soon after entering the labour ward, the subject of pain relief would be raised as it was expected that at some point in the labour the woman would request to have analgesia. Midwives mainly offered pharmacological methods to women, rather than suggesting relaxation techniques such as psycho-prophylaxis, gentle back massaging, ambulation, the birthing pool or TENS. This further endorsed the western culture of medicalisation within the labour ward that would suggest women are incapable of experiencing labour without the help of technology. Needless to say, there

were some women covering the range of social class from unemployed to a solicitor, who expected a “*pain-free*” and “*easy labour*” and requested epidural analgesia upon admission to the hospital as the fear of unrelieved pain was a major concern for them. As a result of women’s requests, 31% of women in the study had epidural analgesia: 18 primigravidae and 13 multigravidae. However, it was ultimately the midwife who controlled the timing and type of pain relief that women received which usually necessitated a further vaginal examination being undertaken to assess the cervical dilatation. This is highlighted in the annotated field notes pertaining to the labour of Case 97 (an unemployed 17year old) who at this point is becoming increasingly distressed with the pain:

- 02:22: Case 97:** *“I think I need an epidural.”*
Midwife 32: *“OK. I’ll need to check you over first: do an internal examination to see how far dilated you are before I get an epidural sorted out for you.”*She then explains to Case 97 how the epidural works including some of the side effects.
 CASE 97 EXPERIENCES A CONTRACTION. MIDWIFE 32 WASHES HER HANDS, PUTS ON A PAIR OF STERILE GLOVES AND WAITS FOR THE CONTRACTION TO END.
 02:40: MIDWIFE 32 UNDERTAKES A VAGINAL EXAMINATION.
Midwife 32: *“You’re doing wonders here.....you’re about 7cms dilated: that’s brilliant. I’ve left the waters intact. You’ve only got another 3cms to go: shouldn’t be that long. Do you still want an epidural?”*
Case 97: *“Yes.”*
Midwife 32: *“OK, I’ll just write up my notes and then I’ll get the anaesthetist for you. Why don’t you try using the gas and air in the meantime?”*
 MIDWIFE 32 HANDS CASE 97 THE GAS AND AIR AND SHOWS HER HOW TO USE IT.
 02:48 MIDWIFE 32 EXITS TO CONTACT THE ANAESTHETIST.

Where an epidural was used for intrapartum analgesia, midwives and women appeared to perceive it as enabling the woman to “*be in control*”. However, observing the woman on the birthing bed anaesthetised from the waist down to her knees, strapped to a CTG machine on one side of the bed with an intravenous infusion being administered through a vein in her arm on the other, barely resembled a woman who was in control with freedom to make her own decisions and do as she chooses. The epidural merely acted as a controlling agent on behalf of the labour ward staff, ensuring that not only the woman’s behaviour did not get out of control, but also she was more likely to be compliant. In addition, the epidural increased the woman’s dependence on others to

attend to her needs, such as catheterisation of the bladder when she no longer had sensation to void urine herself as well as obstetric interventions / assisted deliveries.

If women were too advanced in labour when they arrived at the hospital, not only was the opportunity for the midwife to fully discuss options available to them reduced, but also any choice or request they may have had was often ignored. As a consequence the woman then complied with “the alternatives” offered by the midwife. The following annotated interview excerpt from Case 98, a solicitor, who disclosed that she wished she had come to the hospital earlier in order for her requests to be fulfilled, is a typical response from women in such a situation particularly when the requests concerned pain relief.

- **Case 98** stated that*“I wanted an epidural as it had worked well last time.....but I was too advanced so I was given gas and air to help ease the pain: I had no choice. I didn’t really take an active part in making decisions about my labour and delivery. C (Midwife 35) was very approachable, but I wished I’d had more time on labour ward before I was ready to deliver.....I could have taken a more active part and had an epidural.....”*

It was also observed that had the woman already experienced the intended procedure on an earlier occasion during labour, such as a vaginal examination, the midwives and doctors simply announced their intentions and continued to proceed, assuming that the woman would not challenge their decision as they had not done so before. As a result, the midwife or doctor then undertook the ritual with little or no discussion with the woman. This consequently affected the woman’s decision in giving consent to experience such a procedure as in Case 42: a Local Government Officer.

- **Midwife 51 to Case 42:** *“I think its about time for me to re-examine you and according to the textbook you should be about 8cms: OK?”*
Case 42 IS IN THE MIDDLE OF A CONTRACTION AND DOES NOT RESPOND.....MIDWIFE 42 WASHES HER HANDS AND PUTS ON A PAIR OF STERILE GLOVES.....
Midwife 51: *“Right, this is going to be exactly as before. I’ll be as gentle and as quick as possible.”*
MIDWIFE 42 PROCEEDS TO UNDERTAKE A VAGINAL EXAMINATION.
NO COMMUNICATION FROM CASE 42.

When a procedure was referred to as “hospital policy”, women regardless of their social class were even less inclined to oppose the midwife from carrying it out. The nature of

the midwife's conversation implied that refusing such a procedure would be seen as a deviation from what was expected within the culture of the labour ward. Even when a woman was offered the opportunity to refuse, there was never any real alternative offered, so she duly complied in order not to antagonize the staff by challenging hospital policy as is shown below in the observational field notes and annotated interview transcript with Case 94 (a housewife / civil servant).

- **Student Midwife 17:** *"Do you mind if I listen to the baby's heartbeat and do a trace for about 20 minutes? It's hospital policy to do a trace to get a base line of the baby's heart alongside your contractions. You don't have to have it done if you don't want to."*
Case 94: *"I don't mind really."*
Student Midwife 17: *"OK. If the trace is OK, we can discontinue it so you can get up and mobilise and get more comfortable. Is that all right?"*
Case 94: *"Yes that's fine."*
- **Case 94** stated that K (Student Midwife 17) had asked her for permission to monitor her baby for 20 minutes when she first came in, but whilst she appreciated *"that it was to make sure the baby was OK when I was contracting, I was told it was hospital policy so I had no choice did I? I wasn't given an alternative anyway."*

It appeared that midwives felt duty bound to follow intrapartum policies and procedures, the extract from the observational field notes of Case 47 (a housewife / secretary) demonstrates that although the more experienced and confident Midwife 5 complied with other aspects of the admission procedure ritual, she never stated that undertaking electronic fetal monitoring for 20 minutes on admission was "hospital policy". She was observed to offer an alternative and as a result, Case 47 was enabled to make her own decision for her baby's heartbeat to be intermittently assessed:

- **Midwife 5:** *"What I need to do is check your temperature, pulse and blood pressure, then feel your tummy to see how the baby's lying, then examine you to see how far you're in labour. I'll then do a short tracing of the baby's heart, but it's up to you though if you want to be monitored intermittently or continuously."*
Case 47: *..... "I'd prefer to walk around instead as I've got a lot of back pain. I had it last time as well: its worse if I'm lying strapped to the bed."*
Midwife 5: *"OK, I'll just have a listen in with the pinard's now and then for the time being."*
MIDWIFE 5 LISTENS TO THE FETAL HEART USING THE PINARD'S STETHOSCOPE.

In the follow-up interviews when discussing the routine intrapartum practices, both midwives and student midwives expressed the difficulties of being duty bound to follow intrapartum policies and procedures working within the culture of a consultant-led unit, despite believing they were not always appropriate in all instances. As in the previous example, having the experience and confidence in their own practice was a factor midwives considered important for them to challenge intrapartum policies and procedures and make autonomous decisions. This is demonstrated in the following annotated extracts from Student Midwife 17 and Midwife 88 concerning the routine practice of cardiotocography and the administration of syntometrine respectively.

- **Student Midwife 17** stated: *"the only procedure I was unhappy about and shouldn't have done, was the routine CTG at the beginning. I don't think that it was justified as it restricted T's (Case 94) mobility..... I suppose as I get more confident and experienced I'll feel able to challenge standard hospital routine and policy. If I had supportive research to back me up.....I'd have felt more confident not to do one."*
- **Midwife 88** claimed that: *".....I had to comply with the policy of administering syntometrine, despite L's (Case 93) Hb (haemoglobin) being 13.5g/dl. As an employee, though, you do have to comply with protocols and policies that sometimes limits practising as an autonomous practitioner."*

However Case 2, a teacher, and Case 41, an unemployed woman who had never worked, were the only two women in the study who expressed they wanted to experience physiological management of the third of labour even if this meant deviating from the accepted routine labour ward practice of administering an intramuscular injection of syntometrine. This is highlighted in the extract from the observational field notes concerning Case 2 and Midwife 3. Whilst Case 2 and Case 41 would be viewed to be at different ends of the social class system, their ability to articulate their wishes regardless of the pressure put on them by the midwife to accept the practice was observed to be comparable. The fact that Case 41's mother not only accompanied her in labour, but was also a midwife, may have helped in supporting such a decision. Both women proceeded to experience a physiological third stage as they had expected.

- **Midwife 3:** *"OK so you want no drugs for the afterbirth? If you start to bleed heavily we'd give you the injection to help your uterus contract.....You do*

realise that it'll take longer to deliver your placenta if you don't have the injection?"

Case 2: *"Yes, that'll be the only reason for me to decide to have the injection: the time."*

Midwife 3: *"Right well, we'll see how things go: it's still early days yet."*

As the above extract also shows midwives did not always give women the full details of the effects of the procedure before seeking their consent to undertake it and consequently presented a biased view from which the woman was expected to make a decision and comply. The findings relating to *Knowledge and Biases of the Health Professional* are presented in the following section.

5.3.1.2. Knowledge / Biases of the Health Professional.

During the interviews none of the midwives argued against the formulation of policies and procedures for the safety of those receiving and providing intrapartum care however, they did express concern about the procedures they undertook where they felt bound by the maternity unit policy. In these situations, such as the administration of syntometrine for the management of the third stage of labour, midwives were observed to present a biased opinion by not always informing the woman of all the facts, such as any disadvantages or side effects that would enable the woman to make an informed decision to either consent or refuse. This was regardless of the midwife's personal knowledge of current research in this area and with little difference between the information disclosed to primigravidae and multigravidae. As a result in the follow-up interviews, the women could only relate that the injection was to *"help the afterbirth / placenta out"*, *"get the afterbirth / placenta out quicker"* and *"reduce the bleeding"*. The following annotated excerpts from the observational field notes and the interviews first reflect on Case 25, a packer and multigravida and then on Case 92, a care assistant and primigravida in order to highlight these findings. Where a student midwife was involved in discussing procedures with the woman as in Case 25, there was the additional pressure of them also conforming to the preferences / biases of their midwife mentors.

- **Student Midwife 5 asks Case 25 if she remembered *"being given an injection in your leg when you had your two babies previously?"***
CASE 25 LOOKS BEWILDERED AND SHRUGS HER SHOULDERS.

Student Midwife 5: *“You probably can’t remember it with everything going on at the time, but it’s given as the baby’s shoulder is being delivered. It’s to help speed up the delivery of the afterbirth (the placenta) and reduce the risk of bleeding. You don’t have to have it if you don’t want.”*

Case 25: *“I don’t mind.”*

- **Student Midwife 5** felt that although she tried to inform S (Case 25) about syntometrine, *“my information was biased. She wasn’t anaemic but I know that S (Midwife 29), my mentor, would be against a physiological third stage anyway, so I had to go along with her.”*
- **Midwife 41 to Case 92:** *“Are you aware of the syntometrine injection we give as a routine to help deliver the placenta (the afterbirth) and reduce the amount of bleeding? You don’t have to have it, but we do advise you to. What do you think?”*
Case 92: *“Yes, OK, that’s alright.”*
- **Midwife 41** stated that although she got S’s (Case 92) consent for syntometrine to be administered at the birth and explained that it was routine practice to give it to *“help the placenta to come out and reduce the bleeding”*, she was aware that: *“I did not tell her of any side effects.”*

Where there was no specific hospital policy influencing the midwife’s practice, such that a procedure was not part of the midwife’s usual routine, there appeared to be increased scope for the midwife to provide a more balanced discussion with the woman: e.g. the procedure of amniotomy. Midwives in the study were observed to openly disclose to women the benefits and risks of performing an artificial rupture of the membranes and the possible effects it might have on them and their labour compared to only disclosing the benefits of active management of the third stage of labour. Consequently by entering a dialogue with the midwife, there was more likelihood for the woman to verbally express her consent and depending on how extensive the information disclosure was, would also determine if the consent was informed. However, some women, including those who were inquisitive and generally well informed, still looked to the midwife as the expert for her opinion before making a decision as in Case 44, a legal secretary:

- **Case 44:** *“You know my waters haven’t gone yet? What does that mean?”*
Student Midwife 10: *“The waters at the moment, are acting as a cushion to the baby’s head and when they break, labour tends to speed up as the baby’s head comes onto the cervix. It can be more painful.....”*
Case 44: *“It’s not painful is it..... breaking the waters?”*

Student Midwife 10: *“No, not the actual rupturing, but it usually speeds up the labour, so your contractions will probably become more painful.”*

.....NEXT SHIFT.....

Midwife 54: *“.....would it be OK to examine you again to see if we need to break the waters?”*

Case 44: *“Yes that’s fine. I know it gets more painful.”*

Midwife 54: *“That’s right, once the waters are broken, the contractions tend to speed up the labour. We’ll see how far you’ve progressed first.....”*

MIDWIFE 54 UNDERTAKES A VAGINAL EXAMINATION.

Midwife 54: *“You’re 8cms: you’ve done well. Do you want me to break them?”*

Case 44: *“It’s up to you: what do you think? You’re the expert.”*

Midwife 54: *“I don’t think you’ll be much longer in any case if I get on and break them now.”*

ARTIFICIAL RUPTURE OF THE MEMBRANES UNDERTAKEN:

(baby born 48 minutes later).

- Although **Case 44** could not recall at what point her membranes were actually ruptured (when cervix was 8 cms dilated) she was fully aware that: *“my labour speeded up after that and it was more painful: mind you the baby was born soon afterwards”* She also felt that she had been given sufficient information by Student Midwife 10 and Midwife 54 to be involved in making decisions and *“was pleased the midwife had not decided to break the waters earlier: I couldn’t have coped with the pain much longerI’d have liked to have known how they would be broken though.”*

5.3.1.3. Complications in Labour.

In the majority of labours observed (83%) the outcome was a spontaneous vaginal birth (at which the midwife was the most senior health professional in attendance), with instrumental deliveries occurring in 15% (9% being forceps and 6% ventouse deliveries) and emergency caesarean sections in the remaining 2%. The assistance of the obstetrician, be it the consultant, registrar or SHO, was sought by the midwife in 41 of the 100 labours observed. This was mainly when the midwife was either concerned about the well being of the fetus or when there were signs that labour may be prolonged, which may in turn be significant to the woman’s health and well being, as well as that of the fetus. Assistance from the paediatrician occurred in a total of 33 cases, which included the 17% instrumental and operative deliveries, as detailed above.

Whenever the midwife felt it necessary to refer the management to the obstetrician, it was observed that the woman’s opinion was rarely consulted: she was merely told by the midwife of the intended actions. The midwife never fully informed the woman of

their concern and the potential implications it could have for them and their labour. Midwives were therefore seen as gatekeepers of information. They used the power of their position to conceal or minimise issues that they thought could cause unnecessary worry or distress to the labouring woman and were reluctant to disclose information they believed the woman could do nothing with. However, the act of summoning medical assistance in itself was significant. It indicated to the woman and her husband / partner that something was wrong and the doctor, having the authoritative knowledge, was expected to alleviate and cure. As a result, even those women who up to this point in their labour, had been involved in the decision making process, were observed to become compliant. Whilst these women recognised that when complications had occurred, health professionals seldom involved them in making decisions about intrapartum procedures and interventions, this was of lesser importance to them than the health of their baby or the fulfilment of any birth plan they may have made earlier. The following annotated excerpt from an interview with Case 66: a cleaner and Case 60: a pharmacy technician, show similar responses regarding how the nature of a woman's control over the intrapartum events changed once fetal distress became apparent. Both women submitted to the authority of medical knowledge and technology, assuming that the health professionals "*knew what was best*" despite the consequential effects on their own health and well being:

- **Case 66** stated that she wanted to be in control of her labour this time as she had not been informed what was happening before and had been told what to do "*I felt comfortable to say what I wanted in my labour this time with my birth plan and C (Midwife 39) and S (Midwife 59) gave me so much information about the procedures they undertook..... When Dr L (SHO 20) and the anaesthetist (Anaesthetist 20) came in I was in too much pain to question what they were doing. I just wanted them to get on with it..... Dr L didn't ask me for permission when he examined me and broke my waters. He just went ahead telling me it was necessary for the baby's sake: I had no choice.....He put a clip on the baby's head to monitor her heartbeat as she was distressed. I had no choice as it was for the baby's benefit..... You can't control what happens if your baby becomes distressed*".
- **Case 60** expressed that she was unhappy about having an episiotomy. She had had one previously with a forceps delivery and the healing was painful and sore. "*I wanted to avoid being cut this time but I really had no choice as the baby was showing signs of distress. G (husband) questioned the need to do a cut as I was in no position to do so myself: I was actually pushing when it was first mentionedAt the very hint of urgency or emergency, there's no informed*

consent: I mean with the episiotomy. We respect that the professionals know what's best for us."

Once a labour was classed as "complicated" or "abnormal" the care and management was ultimately under the control of the medical staff to which both woman and midwife were expected to comply. This meant that these woman were also subjected to the ritual of the labour ward round that was usually conducted at the doctor's convenience: such as prior to undertaking an antenatal clinic or an operating theatre list rather than at the woman's or midwife's convenience. Being faced with a group of between four and seven health professionals (that sometimes included medical students) discussing the woman's intrapartum management at the foot of the bed further served in reinforcing the doctor's position and authority over the woman's powerlessness and that her labour was a "public affair". In addition, midwives were often seen to get equipment ready for the doctors to use and then clear it away afterwards in order to save the doctor time. Such activity demonstrated the midwives compliance to the unequal power structure within the labour ward where in the presence of medical colleagues the midwife assumed the lesser role of the doctors' subordinate by waiting on them rather than attending to the needs of the labouring woman.

It was usual for the doctor to undertake an abdominal examination that in some instances was also followed by a vaginal examination despite how recent the latter procedure may have been carried out by the midwife and further emphasised the doctors' authority to undertake procedures as they wished. Regardless of the doctor's gender there was rarely any permission sought from the woman by the doctor before proceeding with the examinations or any challenge of their decisions by the woman or midwife. Subsequent management decisions were usually made with little involvement of the woman and thus the doctor was seen to be the gatekeeper of information by controlling the extent that was ultimately disclosed, often leaving the task of informing the woman to the midwife. Such observations are highlighted in the annotated extract from the field notes pertaining to Case 96, a dance teacher and Registrar 20:

- **Midwife 90:** *"L (Case 96), P (L's partner), this is Dr S, (Registrar 20) the registrar who saw you earlier. Can we put your legs up into these steps now?"*
CASE 96 NODS. MIDWIFE 90 AND SHO 27 ASSIST CASE 96 INTO THE LITHOTOMY POSITION.

Registrar 20: *“You’ve cracked on well, but you’ve run out of steam so we need to give you a hand. R (SHO 27), you put on a pair of gloves as well.”*

REGISTRAR 20 UNDERTAKES A VAGINAL EXAMINATION, FOLLOWED BY SHO 27, WITH NO COMMUNICATION TO CASE 96. TOGETHER THEY DISCUSS THE POSITION AND DESCENT OF THE FETAL HEAD. REGISTRAR 20 THEN UNDERTAKES A FURTHER VAGINAL EXAMINATION.

Midwife 90 to Case 96: *“The doctors are just checking to see how the baby is lying to see how best to deliver it.”*

Registrar 20 to Midwife 90: *“OK, we’ll commence with the ventouse.”*

REGISTRAR 20 AND SHO 27 EXIT TO GET CHANGED FOR THE DELIVERY. MIDWIFE 90 EXPLAINS TO CASE 96 AND HER PARTNER ABOUT HOW THE VENTOUSE SUCTION CAP WORKS.

The female obstetricians in the study were observed to be in an ambiguous position. Whilst they were physically of a female body, through their medical training they had been socialised into the culture of technology and intervention that is perceived traditionally to be masculine and thus were often observed to act with the mind of a male. Consequently when undertaking intrapartum procedures, their practice bore little difference to their male counterparts where they appeared to exert the same dominance over the labouring women to which the women regardless of their social class, readily accepted as the norm.

This section has examined factors within the culture of the labour ward environment that encourage compliance to medical technology and conformity to its routine practices, policies and procedures and consequently limit the extent of power women and midwives were observed to possess during the intrapartum period. It was also observed that within this same culture there were midwives who attempted to empower women into making decisions about their intrapartum care and management including consent to procedures. These findings will be presented in the following section.

5.3.2. Empowerment and Control.

Throughout the study it was observed that those midwives who were both confident with their own clinical practice and more challenging of medicalisation demonstrated that they could empower some women into taking control and play an active part in intrapartum decisions. However, not all women wanted to be empowered to make intrapartum decisions and looked to the midwife to undertake this on her behalf. This

category therefore examines the themes of *Being in Control and Feeling Valued* and *The Use of Birth Plans*.

5.3.2.1. *Being in Control and Feeling Valued.*

During the observational stage of the study there were some midwives who did not always adhere to the routines of the labour ward. In comparison to the pilot study these midwives made some effort to humanize the labour ward environment by bringing in a rocking chair or bean bag and mat for the woman to use during labour. These items however, were placed amidst the existing technological machinery rather than replacing any of them. On admission to the labour room, one midwife in particular (Midwife 7) always suggested the woman's holdall / suitcase be initially placed on the birthing bed to detract the woman from getting onto it and assuming the "patient role" from the outset. As a result, the woman was influenced into sitting in the armchair or rocking chair or remaining mobile and adopting various positions she found most comfortable whenever further contractions were experienced. Some of these women expressed in the follow-up interviews that being encouraged by the midwife to remain as mobile as possible, they felt "*at ease.....*", "*in control.....*" and "*free to let my body dictate what to do during contractions*".

Except from instances where labour was advanced or an emergency was apparent, it was observed that midwives always complied with undertaking the rituals associated with the admission procedure. However, regardless of the woman's social class there were a few instances where the midwife was seen to deviate from the admission routine and discuss with the woman to undertake certain procedures, such as a vaginal examination or cardiotocography as labour advanced or whenever analgesia was requested. This in turn gave the woman the power to be involved in making her own decisions from the outset. One such midwife being Midwife 2 with Case 70, a cleaner:

- **Midwife 2:** "*Right, I can see that you're in labour: I'll have a listen into the baby's heart and then you can have a wander around. There's no need to do an internal examination for the moment, unless you want something for the pain?*"
Case 70: "*No I'm fine at present. I might have some gas and air later. Do I need to have a trace done?*"
Midwife 2: "*Not at the moment. There's nothing in your history that means I should have to do one: I'll just keep listening in from time to time.*"

In addition, it was observed that vaginal examinations were never undertaken as part of the admission procedure routine in instances where one had already been undertaken prior to the woman coming to the labour ward: either by a community midwife in the woman's home or by a hospital midwife on one of the maternity wards to determine if labour was established.

Despite the 8-hour shift system and it often being common practice for midwives to care for more than one woman in labour, within the labour ward in the study, some women did receive continuity of care from the one midwife for the duration of their labour. Where continuity occurred there was more likelihood of a trusting relationship to have developed, such that these midwives were observed to empower women sufficiently enough for them to take control and make decisions about their intrapartum care. In some instances this could even mean going against what the midwife had originally intended to do. This is highlighted in the following annotated extracts from the field notes and interview with Case 11, a civil servant who had earlier been informed by Midwife 14 that at the next vaginal examination, should her progress be less than what was expected (i.e. the cervical dilatation "should be about 7-8 cms") an amniotomy would be advisable "*to speed labour along*":

- **19:45: Midwife 14:** "*Are you ready now?*"
CASE 11 NODS. MIDWIFE 14 UNDERTAKES A VAGINAL EXAMINATION.
Midwife 14: "*Same as before.....You've made some progress: the cervix is more central and much thinner. It's about 6cms dilated.*"
Case 11: "*Could you leave the membranes for the moment?*"
Midwife 14: "*OK: what about wandering about to get things moving more?*"
Case 11: "*Yes, that's fine.*"
- **Case 11** felt that D (Midwife 14) "*valued my opinion especially about breaking the waters. I'd not made as much progress as I should have done but I knew it would be more painful if she broke themI asked her to leave them alone and agreed to walk about to get things moving.*"

In the above example, despite the woman's refusal of amniotomy being respected by the midwife, she was still aware that her progress was not according to what the midwife had expected. Midwives such as Midwife 14 were faced with a conflict of interests. Whilst they attempted to enable women to make intrapartum decisions they still demonstrated some degree of compliance to the culture of "processing women" through

the medical model of intrapartum management by undertaking vaginal examinations every four hours to ensure that the woman was making sufficient progress according to medical expectations.

Some midwives believed that providing continuity of care enabled them to gain a better understanding of the woman's preferences towards intrapartum procedures and interventions. This became more significant as labour advanced or developed complications when the woman's power to challenge obstetric interventions herself reduced. If the woman was particularly distressed when the doctors undertook their labour ward round, midwives were seen to request that the review be conducted outside the labour room in the corridor or that only a couple of members (usually the senior obstetrician and the midwife coordinator) enter the room. As a result, these midwives readily took on the role of advocate by informing medical colleagues of the woman's wishes. An example of the midwife taking on the role of the woman's advocate is highlighted in the following extract from Case 81, a schoolteacher, where Midwife 32 was able to protect the woman from further unnecessary intervention:

- **16:30: Midwife 32** notices that Dr W (SHO 25) had been in the room during her absence to try and attach a fetal scalp electrode: but without success. She reviews the CTG trace: *"The trace looks OK. I can't see any reason to put a clip on at the moment."*
Case 81: *"She (SHO 25) said she would wait until you came back."*
Midwife 32: *"I think at the moment I'll leave well alone....."*
17:00: SHO 25 RETURNS.
SHO 25: *".....I've come to try and put a clip on the baby's head."*
Midwife 32: *"Do you really think we need to? The external trace looks fine."*
SHO 25 EXAMINES THE TRACE.
SHO 25: *"It does, doesn't it? OK we'll not bother.....If there are any problems let me know."*
17:08: SHO 25 LEAVES.
- **Midwife 32** recognised that she had a duty of care to Case 81 and needed to protect her interests once labour had become complicated. *"I discouraged Dr W (SHO 25) from applying a fetal scalp electrode as the external trace was fine. I couldn't see any need for further invasion of privacy with yet another unnecessary V.E."* (Vaginal Examination).

In comparison, should the care be fragmented with more than one midwife being involved, it was not as easy for women to exert any control of their labour. In such circumstances where care was subsequently handed over to another colleague,

midwives perceived there to be value in the woman having a written birth plan to ensure her wishes and decisions regarding certain intrapartum procedures continued to be respected. *The Use of Birth Plans* in empowering women in labour is explored further within the following section.

5.3.2.2. *The Use of Birth Plans.*

Formulating a birth plan during the antenatal period can provide evidence of the discussions between the woman and midwife over the options available for labour and birth and reflect the woman's wishes at a given moment in time, based on the information she has acquired. In addition, it can provide information of those intrapartum procedures to which the woman would happily consent, having made an informed decision prior to the onset of labour, being free from any pressure or the effects of pain / analgesia. A total of 51 women in the study, 24 (69%) being primigravidae and 27 (42%) multigravidae, completed a birth plan either prior to, or during their labour and had actually had some dialogue regarding its content with either the community midwife or one of the hospital midwives on the labour ward. Those midwives who were part of a community / hospital integrated midwifery team had already discussed the birth plan with the woman during the antenatal period, claimed that they had an increased awareness of the woman's level of understanding of the birth process than their hospital colleagues.

During the time of the study, not only did the maternity services in the city where the study was conducted, introduce client-held antenatal records containing a section on the back cover for the woman to complete a birth plan with the assistance of a midwife, the maternity unit also introduced a standard birth plan for midwives to discuss with women upon admission to the labour ward. It therefore was expected that every midwife would discuss the woman's birth plan during labour regardless of whether one had been completed antenatally such that this practice would eventually become part of the midwife's routine intrapartum admission procedure. A total of 34 women (19 primigravidae and 15 multigravidae) who were all from social classes I, II and III, had formulated a birth plan prior to labour. However, the extent that midwives used the birth plan to fully explore what the woman actually knew and understood about childbirth, varied regardless of the stage of labour at which the woman presented. This is illustrated

in the extract from Case 41 (an unemployed woman) where Midwife 5 did not explore what the woman understood about physiological management of the third stage of labour or what she meant by being “active in labour”. Whilst Case 41 was one of the few women outside of social classes I, II or III to have completed a birth plan prior to labour, her mother, who was also a midwife, had played a major role in informing her of labour and birth which had consequently had some influence on her decision to construct a birth plan.

- **Midwife 5:** *“Do you have a birth plan?”*
Case 41: *“Yes, it's in the front of my notes.”*
MIDWIFE 5 READS THROUGH THE BIRTH PLAN WITH CASE 41.
Midwife 5: *“You want a natural third stage with no syntometrine?”*
Case 41: *“That's right, unless for some reason I need to have the injection, then I'll have it.....”*
Midwife 5: *“OK..... I see that you want to be active in labour, but you're happy to deliver on the bed?..... You also want to use the bath in the first stage of labour, but not for the delivery?.....”*
Case 41: *“That's right..... Would it be OK to listen to my own music?.....”*

Of those women who had not completed a birth plan prior to labour, only 17 (five primigravidae and 12 multigravidae), were encouraged by the midwife to formulate a birth plan during labour. This was despite the expectations of the maternity services managers that the birth plan should become an integral part of every midwife's discussion concerning intrapartum care. Although these women represented the range of social class, there were proportionally less women from the lower social classes who were given such an opportunity. Where a birth plan was compiled upon arrival at the hospital, the midwife recorded the woman's choices for labour and birth either on the partogram or on the standard hospital birth plan. In these cases, there appeared to be increased discussion and exploration of the woman's knowledge and understanding where formulating a birth plan also enabled the woman to express her own opinions and consequently contribute more to the decisions that were made about her intrapartum care. These issues are illustrated in the following excerpt from the observational field notes of Case 94 (a housewife / civil servant):

- **Student Midwife 17** has discovered that **Case 94** has not completed a birth plan and sought permission to discuss her ideas regarding the labour and birth..... *“Have you thought about pain relief? You said you had gas and air last time.”*

Case 94: *"I think I'll try and manage without."*

Student Midwife 17: *"Do you know what's available? There's pethidine, which is an opiate, and the epidural."*

Case 94: *"I don't really want those."*

Student Midwife 17: *"There's also water: we have a pool you could use."*

Case 94: *"I've heard that the water can slow down labour?"*

Student Midwife 17: *"Not really, if the labour is established. It can help to relax you....."Did you have the injection to speed up the delivery of the placenta?"*

Case 94: *"Yes."*

Student Midwife 17: *"What do you know about how it works?"*

Case 94: *"It helps the afterbirth to come away quicker and reduces the bleeding."*

Student Midwife 17: *"That's right, but it may cause you to feel sick afterwards and have painful after pains. You don't have to have it."*

Case 94: *"No, it's fine."*

The interviews discovered that five women (one primigravida and four multigravidae) had discussed a birth plan with a midwife in advance of the observational field notes being undertaken. Three of these women had been admitted to the labour ward in very early labour during which time a birth plan had been discussed and documented in the records. However, as they were not in established labour on these occasions, the women were later transferred to the antenatal ward or returned home with their records, including the birth plan.

Of those 51 women who had experienced the formulation of a birth plan, some expressed that the birth plan had enabled them to take an active part in the decision making process and as a result they had felt valued by the midwife. This was particularly evident if the labour proceeded without any complication as the following annotated excerpts from the interviews with Midwife 4 and Case 77: a staff nurse, illustrate:

- **Midwife 4** went through L's (Case 77) written birth plan and used it to include her in the decision-making. *"I respected her birth plan: it was straightforward anyway..... It's not always possible to communicate with women if they're concentrating on their labour, using gas and air..... to get informed consent. A birth plan helps in such a situation.....it informs the midwife of the woman's wishes for labour and delivery in a written format."*
- **Case 77** thought her birth plan was sensible and was pleased that her labour went according to her plan..... *"I feel that it's important to be open-minded as both my labours were very different. It does not hurt to write a birth plan, but*

you need to discuss it with your midwife to make sure your wishes are realistic.....It's useful if you're unable to express yourself fully when admitted in labour: your opinions are still valued."

Although there were a total of 49 women who were mainly from the lower social classes and who had not made a written birth plan, all of them stated during the interviews that they did have a mental plan that tended to focus mainly on their choice of analgesia. Some of the reasons given for having not compiled a written birth plan are illustrated in the following excerpt from an interview with Case 72, a Reprographics Administrator and a primigravida whose opinion also deviated from that of others from within her social class:

- **Case 72** had not made a birth plan as *"I only really wanted to have an epidural and for P (partner) to be with me.....I didn't want an episiotomy or forceps though.....It's pointless writing a birth plan unless you've experienced labour before. I've heard that they usually 'go to pot' anyway, so what's the point? I wasn't that bothered: I just let the midwife get on with things.....I got my epidural and I watched the tennis on TV."*

Women recognised that a birth plan could not always be fulfilled should their labour develop complications and in contrast to the above extract, some women, such as Case 80, a ward manager, felt that it had a value in representing the woman's voice if they were unable to do so themselves. As a result and despite her own birth plan being abandoned because of fetal distress, Case 80 stated that regardless of the outcome of her first labour experience, she would still complete a birth plan a second time and advise women to also do so.

- **Case 80:** *".....it's a tool for discussion between you and the midwife regarding normal labour procedures where your opinion also matters..... At the outset you do not know if your labour will go according to the plan anyway."*

As only 51 women in the study had been encouraged to complete a birth plan, it was apparent that not all midwives recognised its value as a means of empowering the woman to make her own intrapartum decisions. The birth plan was therefore not always used as effectively as it could have been by the midwives to determine the woman's knowledge and understanding of intrapartum procedures prior to seeking consent. As effective communication between the health professional and the labouring woman is

considered to be a major factor influencing informed consent, the second core-category to emerge from the data analysis centres on *The Quality of Intrapartum Communication*.

5.4. THE QUALITY OF INTRAPARTUM COMMUNICATION.

Of the 100 labours observed, the median length of time that 95 women spent on the labour ward from the time they were admitted to transferring to the postnatal areas or for operative procedures, was 5 hours and 35 minutes, (range: 2 hours to 18¼ hours) with the remaining five women having given birth to their babies within 30 minutes of arrival in the maternity unit (range: 1½ hours to 2¾ hours) (see Appendix 7). This would therefore suggest that there was sufficient time for the midwife or doctor to disclose pertinent information to the majority of women in order for them to take part in making decisions about their care and give informed consent to intrapartum procedures.

From observation, the extent and depth of information disclosed prior to intrapartum procedures being carried out varied from the midwife or doctor giving a full explanation of the benefits and risks of such a procedure, to virtually no communication at all. The second of the core-categories therefore relates to the factors that affect the quality of communication between health professionals and women during labour. The two categories: *Health Professionals' Skills and Women's Ability to Communicate in Labour* and a number of themes that emerged from the data analysis pertaining to this core-category are illustrated in Table 5.3.

CORE - CATEGORY	CATEGORY	THEME
The Quality of Intrapartum Communication.	HEALTH PROFESSIONALS' COMMUNICATION SKILLS.	Stereotypical roles of the midwife. The role and ability of the doctor.
	WOMENS' ABILITY TO COMMUNICATE IN LABOUR.	Acquisition of authoritative knowledge. Experiencing the effects of labour. Stereotypical roles of the woman in labour.

Table 5.3: *The Quality of Intrapartum Communication: Its Categories and Themes.*

5.4.1. Health Professionals' Communication Skills.

The high priority given to health professionals' possessing good communication has been widely recognised such that these skills are seen to be fundamental to seeking and gaining informed consent to procedures from clients / patients. As a group of health professionals and within the context of this study, midwives were observed to demonstrate better communication skills than their medical colleagues. To an extent this was to be expected as it is usual for the midwife to have continual presence during labour such that she is in a better position to develop a trusting relationship with the woman compared to the limitations and brevity of any medical involvement. This category will therefore present the findings relating to how health professionals communicated with women in labour regarding seeking and obtaining consent to intrapartum procedures with reference to the themes *Stereotypical Roles of the Midwife* and *The Role and Ability of the Doctor* that emerged from the data analysis.

5.4.1.1. Stereotypical Roles of the Midwife.

Whilst labour was considered to be progressing well, it was observed that midwives usually tried to encourage the woman, regardless of her social class, age and perceived intellect, to play an active part in making decisions about the care and management she received. As the observational stage continued, three types of midwife were seen to eventually emerge in respect of how they communicated with the woman and to what extent information concerning intrapartum procedures was disclosed. Where midwives had been observed in providing intrapartum care to more than one woman in the study, the stereotype that was attributed to them with the initial case, was rarely seen to change in subsequent cases. The three stereotypes that emerged from the data as shown in Figure 5.2, were as follows:

Figure 5.2: Stereotypes of Midwife.

- *The policy following midwife,*
- *the biased informing midwife and*
- *the informing enabling midwife.*

5.4.1.1(i) The Policy Following Midwife.

Where there was a specific policy or procedure regarding intrapartum management, the *policy following midwife* such as Midwife 76 (page 142) felt duty bound to follow these practices and exerted her power over the woman by stating that to undertake such a procedure was the policy of the maternity unit. An example of this would be the ritual of undertaking electronic fetal monitoring and a vaginal examination upon admission to the labour ward. No alternatives based on evidence-based practice, or specific details of the procedures were ever given. By complying with intrapartum routines and policies associated with the culture of medicalisation and technology, these midwives appeared to lack the confidence to challenge unit policy or demonstrate any flexibility by making decisions based on the needs of the labouring woman. Consequently, the policy following midwife never demonstrated her professional accountability and duty of care to fully inform women of the significance of any procedures she intended to undertake. These midwives mainly used closed questions and professional language when communicating with women. This in turn gave no scope for the woman to seek further information and clarification, such as an alternative she could choose, or challenge the midwife's decision and refuse the procedure. Thus the policy following midwife never obtained the woman's informed consent to any procedure she undertook.

5.4.1.1(ii) The Biased Informing Midwife.

There were other midwives such as Midwife 41 as well as some student midwives for example, Student Midwife 5 (pages 147 / 148) who unlike the policy following midwife, demonstrated characteristics of the *biased informing midwife*. These midwives were observed to disclose more information about the proposed procedures and use open questions when communicating with the labouring women. As a result, they demonstrated an awareness of current research findings in that particular aspect of care. However, as the majority of information disclosure tended to focus on the benefits of the procedure being carried out with little, if any, acknowledgement of any risks, these midwives were in fact offering a biased opinion. This was more evident when there was also a unit policy regarding such a procedure. The biased informing midwife did not always recognise that she could be held accountable should anything adverse result from her failure to fully inform the woman. An example of this was the

administration of syntometrine where 93% of women in the study were observed to receive the drug regardless of the majority of them being considered to be of low risk in respect of experiencing a postpartum haemorrhage. Although the biased informing midwife did attempt to involve the woman in making decisions in labour and openly sought her consent before undertaking any intrapartum procedure, the extent to which it was “informed” was questionable as the information given did not always include the potential risks.

5.4.1.1(iii) The Informing Enabling Midwife.

In direct contrast to the policy following midwife, the third stereotype of midwife to emerge from the data analysis, the *informing enabling midwife*, appeared fully conversant with evidence based practice and attempted to present to women a more balanced view of the intended procedure than the biased informing midwife. These midwives, such as Midwife 2 (page 153) demonstrated confidence in both their knowledge and practice and fully appreciated their duty of care to inform. Such a midwife demonstrated good communication skills using open-ended questions and clues from certain aspects of the woman’s body language to ascertain how much the woman understood about labour and intrapartum practices. As a result, these midwives displayed some flexibility in the language they used in order to empower women regardless of their social background to articulate their decisions given relevant unbiased information. By disclosing to women specific detail concerning both the benefits and risks of the procedure based on the individual circumstances, when the informing enabling midwife sought consent to intrapartum procedures, it was usually informed. Regardless of unit policy, these midwives believed that women should be empowered to feel an equal partner when making decisions about their intrapartum care and that individual choices should always be respected as far as the circumstances permitted. However, the constraints of working within the culture of the medical and technocratic environment of a consultant-led labour ward, limited the extent to which this type of midwife was observed within the study. Whilst the informing enabling midwife readily accepted that as a professional, she was ultimately accountable for any decisions that were made that did not follow unit policy, she also appreciated that such decisions were also made in the best interest of the woman and her baby and that her intrapartum records should always reflect such details.

Whilst it was observed that unless they were of the informing, enabling type, midwives did not fully recognise the labouring woman's body language as being a trigger to her pursuing further clarification of detail, the interviews did reveal an increased number of midwives who demonstrated some awareness of how nodding / shaking of the head and facial expressions could reflect the woman's knowledge and understanding of intrapartum care. The following two excerpts from the interviews with an informing, enabling midwife and a biased informing midwife who respectively cared for women from different social classes, Case 44 a legal secretary, and Case 95 a housewife / cleaner, compares how the midwife's perception of her own communication skills and assessment of the woman's understanding could be affected by her interpretation of the woman's specific body language:

- **Midwife 53** felt that she was able to have a coherent conversation with Case 44 and that she fully understood what was happening and what each procedure entailed: "*.....V (Case 44) was articulate and very much in control. It was important to assess how much knowledge and understanding of her previous labour she had, and build on that, and not assume she fully understood and then deny her information this time..... She nodded her head and her body language told me whether or not she understood. She shrugged her shoulders or frowned if she wasn't sure. She also asked questions if she wanted more information.*"
- **Midwife 55:** "*I did try and get permission from S (Case 95) before I actually undertook any procedure, but it was debatable as to how informed the consent was as there was very little eye contact and feedback from her. You can't assume that she understood from her past labour experiences either.*"

When student midwives actively participated in the intrapartum management it was difficult to place them in any one of the three categories of midwife stereotypes independent of their mentor's stereotype as they tended to emulate some of her attributes. This was due to the fact that whilst student midwives aimed to empower women into being an equal partner in making intrapartum decisions, to what extent this could be achieved in practice not only depended on the student's abilities but also the influence of their mentor and the labour ward culture to which they were exposed. Where the relationship between student and midwife was less established, or the student less confident and competent in her knowledge and clinical skills, the student tended to comply with the expectations of her mentor in order to avoid any conflict developing as highlighted by Student Midwife 5 (pages 147 / 148). In comparison, where student

midwives provided the majority of intrapartum care with indirect supervision from their mentor, they generally demonstrated good communication skills and attempted to fully inform women of the benefits and risks of procedures as far as their knowledge allowed and so tried to involve women in making decisions about their care as did Student Midwife 17 (pages 157 / 158). The student midwives also recognised that the limitations of their position meant they were accountable to their mentor. As a result their information disclosure appeared biased towards the midwife's expectations and the maternity unit's culture of compliance to obstetric-led policies and procedures and dependence on technology.

5.4.1.2. The Role and Ability of the Doctor.

In cases where midwives had summoned medical assistance (41 labours), the doctors inevitably entered the labour room expecting to promptly undertake some activity, such as determine subsequent intrapartum management, insert an epidural / spinal anaesthesia or appropriately resuscitate the newborn baby. As a result, compared to the midwives in the study, the doctors' time with the woman was often brief that consequently affected their ability to effectively communicate with the labouring woman. As one woman (Case 96, a Dance Teacher) commented:

- **Case 96:** *"..... I presume they (the doctors) have a job to do and see it as a 'production line' going from one labour to the next..... The doctor (SHO 27) got better as time went on though and spoke more with me."*

The communication that the obstetricians in the study demonstrated with the women was limited and often consisted of a minimal statements such as *"I'll examine you"*, or sometimes nothing at all was said and the doctors continued to undertake the procedure assuming their position gave them the authority to do so. A lack of communication from the doctors and submission to medical decisions and routine intrapartum practices served in reinforcing the woman's powerlessness in a situation that essentially should be a normal physiological process. This is demonstrated in Case 28, an Accounts Officer:

03:53: REGISTRAR 7 ENTERS. CASE 28 IS EXPERIENCING A CONTRACTION

Registrar 7: *“Hello, I’m Dr M, the Registrar on call tonight. I’ll examine you in view of your lack of progress.”*

NO COMMUNICATION FROM CASE 28. REGISTRAR 7 UNDERTAKES A VAGINAL EXAMINATION. CASE 28 HAS ANOTHER CONTRACTION.

Registrar 7: *“Your baby is in the OP position. We’d best take some blood for group and save..... (To Midwife 33) Organise an epidural first to give her some pain relief.....Then get the synto (syntocinon) sorted to allow the baby to rotate and then we’ll decide on the mode of delivery.”*

04:07: REGISTRAR 7 EXITS.

Rarely did the obstetricians try and ascertain how much the woman and her husband / partner understood about the recent developments in her management and care or inform them of any options given the situation. As a consequence the woman was not offered a part regarding the decisions finally made. However, where doctors attempted to converse with women not only did they tend to use closed questions and professional terminology, but also it usually occurred as the woman was experiencing a contraction or in the middle of a procedure being undertaken that gave little scope, if any, for the woman to respond as shown in the last example. In addition, as the above example also demonstrates some obstetricians were observed to issue a series of instructions to midwives of which they were expected to duly carry out: thus reaffirming the doctors’ authoritative position within the labour ward.

Where women tried to seek further information from the obstetrician, the doctors either ignored their request or gave such a response that did not appear to add to the woman’s knowledge and understanding: thus the doctors were able to retain control of the situation. Midwives were observed to attempt to answer the woman’s questions in these circumstances. Without the knowledge, women were unable to participate in making decisions about their labours or give their consent to the procedures that doctors subsequently undertook. Rather than communicating with the woman and seek information directly from her in order to make intrapartum decisions, the doctors usually referred to other sources such as the CTG machine and / or the midwife. One of the labours where some of these issues were observed involved Case 26, a kitchen assistant, and concerned the invasive procedure of fetal blood sampling:

16:12: REGISTRAR 5 AND SHO 8 ENTER: THEY BOTH REVIEW THE CTG TRACE.

Registrar 5: *"OK the trace looks slightly better." (To Case 26) "I'm Dr L. I'm going to do the blood test in any case. You understand what it's for?"*

Case 26: *"I'm not too sure....."*

REGISTRAR 5 INSERTS THE SPECULUM INTO CASE 26's VAGINA.

Case 26: *"What are you doing?"*

NO RESPONSE FROM REGISTRAR 5.

Midwife 31: *"Dr L is inserting a tube over the baby's scalp so she can then see where to take the blood from....."*

AFTER SOME DIFFICULTY, REGISTRAR 5 MANAGES TO GET A BLOOD SAMPLE AT THE SECOND ATTEMPT. SHO 8 TAKES THE SAMPLE FOR ANALYSIS

Registrar 5: *"We'll wait for the result. If it's OK, I'll apply a fetal scalp electrode to monitor the heart rate directly. If it's not, we'll need to do a caesarean straight away."*

Case 26: *"You're joking? Do I have to? I've never had a caesarean before."*

16:38: REGISTRAR 5 OBSERVES THE CTG TRACE. SHO 8 RETURNS: RESULT IS BORDERLINE.

Registrar 5: *"OK, I'll examine you now.....Turn onto your back when this contraction's gone..... I'll repeat the blood test in about 45 minutes....."*

VAGINAL EXAMINATION UNDERTAKEN BY REGISTRAR 5 AND SCALP ELECTRODE APPLIED.

16:48: REGISTRAR 5 AND SHO 8 EXIT.

- **Case 26** was fully aware that the fetal blood sample had been taken and the fetal scalp electrode applied as her baby was showing signs of distress. *"Looking back, I'd have liked more information as I was concerned for the baby. The doctor didn't tell me what she was doing or answer my questions. I wasn't sure how big the scratch would be on the baby's head and how much harm it would do to her. I was in a lot of pain at this point, which didn't help either."*

In comparison to the obstetricians, anaesthetists were usually summoned to the labour room at the woman's request for pain relief and so obtaining consent for epidural analgesia was never perceived to be such an issue by the midwives or women in the study. Sitting down with the woman (albeit facing her back to insert the epidural catheter) compared to the obstetricians and paediatricians who always remained standing, the anaesthetists appeared in less of a hurry and spent considerably longer time in the labour room. They were observed to enquire about the extent of the woman's knowledge and understanding, using mainly open questions as well as inform them of specific details about the effects of anaesthesia prior to commencing such invasive procedures as inserting an epidural catheter or administering spinal anaesthesia. As a result, this encouraged the woman to seek further information if necessary, and so enhance the dialogue with the anaesthetist and ultimately give consent

that was informed. However, some women were too distressed to fully appreciate the explanations or enter into conversation with the anaesthetist. Nevertheless, the recall and understanding that the woman demonstrated during the follow-up interview concerning this type of pain relief was usually improved in comparison to their recall of other invasive obstetric procedures. This is highlighted in the following extracts from the observational field notes and interview transcripts concerning the labour of Case 46, a designer:

- 10:43: MIDWIFE 39 RETURNS WITH ANAESTHETIST 17.
Anaesthetist 17: *“Hello, I understand you want an epidural? Do you know anything about them?”*
Case 46: *“I’ve seen them on the video.”*
Anaesthetist 17: *“OK.....You’ll need an intravenous drip in the back of your hand first as your blood pressure can fall as well as cause some women to get a headache or feel nauseous.”*
Case 46: *“Is this the “mobile” epidural?”*
Anaesthetist 17: *“Yes. It’s not mobile in the sense of you walking around, but you’ll be able to move your legs around on the bed. I’ll get everything ready behind you first and explain things before I start..... There can be odd occasions where the epidural doesn’t work, or it works just on one side. There’s also a slight risk of backache or itchiness and a feeling of heaviness in your limbs: we can sort out those problems if they occur. The chances of any permanent damage are pretty slim.....”*
Case 46: *“Will I be able to feel the contractions with the epidural?”*
Anaesthetist 17: *“They’ll begin to feel less. You should still contract at the same rate as you’re doing now. Sometimes it doesn’t always take the pressure sensation away.....When the time comes to pushing you should still have some sensation to be able to feel where to push. OK, I’ll get the drip in first.”*
- Case 46** had requested an epidural and demonstrated a good understanding of its effects: *“I was aware that my blood pressure could fall so I had a drip to keep my fluid level and blood pressure up..... The anaesthetist (Anaesthetist 17) was the only doctor I saw. She explained the epidural very well and told me that it may not work, could make me feel nauseated and make me itch. She appeared very efficient.....I’d read about epidurals beforehand and felt well informed.”*

The role of the paediatrician in the study was observed as being much briefer, focusing on utilizing appropriate resuscitative skills on the baby in those cases where the midwife had recognised some degree of fetal distress. However, being summoned towards the end of labour when the birth was imminent considerably limited their opportunity to communicate with the woman and seek consent to attend to her baby. Even where the husband or partner was also present, there was seldom any attempt made by the paediatrician to initiate conversation.

As the paediatricians entered the room and headed straight for the resuscitaire avoiding any eye contact with the parents, the midwife always gave them a résumé of the woman's labour and the purpose for summoning their assistance. Once at the resuscitaire, they would check the apparatus was in working order, leaving the suction and oxygen on in readiness to attend to the baby as soon as it was born. Following the birth the midwife promptly clamped and cut the umbilical cord and handed the baby straight to the paediatrician. As soon as the paediatricians were satisfied with the baby's condition, they made an entry in the woman's records and swiftly left without any further communication, relying on the midwives to take on the role of explaining the purpose of their actions and outcome to the parents. The following example from Case 17, a retail trainee is a typical example of the extent and quality of the paediatricians' communication with the parents. Prior to the doctor's arrival, Midwife 22 explained that a paediatrician would be present at the baby's birth to ensure that any meconium in the amniotic fluid had not been inhaled into the lungs:

- 04:53: MIDWIFE 22 REQUESTS A PAEDIATRICIAN.
 04:54: PAEDIATRICIAN 5 ENTERS THE ROOM AND GOES OVER TO THE RESUSCITAIRE.
Midwife 22 to Paediatrician 5: *"T's (Case17) labour has been fine up to SRM (spontaneous rupture of the membranes) about ½ hour ago when there was meconium."*
 04:56: NORMAL BIRTH OF BABY BOY. MIDWIFE 22 SEPARATES THE UMBILICAL CORD AND HANDS HIM TO PAEDIATRICIAN 5.
Midwife 22: *"Well done: you have a boy."*
Midwife 32: *"Congratulations T..... The paediatrician's sucking the baby out....."*
 05:04: PAEDIATRICIAN 5 HANDS THE BABY TO MIDWIFE 32, COMPLETES THE RECORDS AND LEAVES. NO COMMUNICATION TO THE PARENTS.
Midwife 32: *"Do you want to hold your baby, O? (Case 17's partner) He's fine. He didn't swallow or breathe in any of the meconium."*
O: *"That's good."*
 MIDWIFE 32 HANDS THE BABY TO O.

There were a few paediatricians of which the majority were female, whose approach to the parents deviated from that of their colleagues. They were observed to actively communicate with the parents and play a more significant role in informing them about their intended actions. In so doing, these paediatricians, such as Paediatrician 3, encouraged the parents to seek further details about the baby's condition. The

comparison in the extent of Paediatrician 3's communication with that of Paediatrician 5 highlighted in the previous excerpt is reflected in Case 9, a hairdresser:

- 13:24: **Midwife 12:** *"This is Dr S (Paediatrician 3), S (Case 9) and G (Case 9's partner)."*
13:25: **Paediatrician 3:** *"Hello. As soon as the baby's head delivers I'll try and suck out his airways and then check him more thoroughly over here"* (resuscitaire).
13:28: NORMAL BIRTH OF BABY BOY.
Midwife 12: *"Well done, congratulations. I'll just hand the baby to Dr S now. He looks fine."*
MIDWIFE 12 CLAMPS AND CUTS THE UMBILICAL CORD AND HANDS THE BABY TO PAEDIATRICIAN 3.
G MOVES OVER TO THE RESUSCITAIRE TO OBSERVE HIS BABY.
G: *"What's that you're doing?"*
Paediatrician 3: *"I'm just looking down his windpipe to ensure he hasn't inhaled any meconium.No, that's good: all clear. Here's your baby."*
13:34: PAEDIATRICIAN 3 HANDS THE BABY TO G.
Paediatrician 3: *"The baby's absolutely fine: congratulations."*
G: *"Thank you."*
Case 9: *"Thank you."*
PAEDIATRICIAN 3 COMPLETES THE RECORDS AND LEAVES.

In the follow-up interviews, women usually commented on the paediatricians' ability to communicate with them about the health of their baby. Although it was important and reassuring to them to hear that *"the baby was fine"*, the general lack of communication and consent to allow such procedures to be undertaken on their baby by the paediatrician appeared irrelevant to the woman as long as the baby was all right. Women trusted the authoritative knowledge and skill of the doctor to ensure their baby was appropriately treated.

5.4.2. Womens' Ability to Communicate in Labour.

As health professionals have the authoritative knowledge that directs and controls the extent of information disclosed to women during labour, this ultimately affects the quality of communication when seeking and obtaining of informed consent. However, when observing communication from the woman's perspective, other issues emerged that influenced her ability to effectively communicate with the midwife and doctors. This category further explores the emerging themes of: *Acquisition of Authoritative*

Knowledge, Experiencing the Effects of Labour and Stereotypical Roles of the Woman in Labour.

5.4.2.1. Acquisition of Authoritative Knowledge.

In order for women to communicate effectively with health professionals and make intrapartum decisions concerning consent to procedures, not only did they need to acquire sufficient knowledge about the physiological process of labour and childbirth but also have some insight into the cultural environment in which they were to give birth. Health professionals appeared to assume that women who had experienced labour and childbirth previously had acquired adequate knowledge and understanding and as a result, their information disclosure to multigravidae was not always as extensive compared to that given to primigravidae. This in turn affected the extent some women were enabled to communicate in labour. Nevertheless, as midwives such as Midwife 11, questioned: *“it is debatable as to how much they really understand from previous experiences, isn't it?”*

None of the women expressed that they felt totally inadequately prepared for labour as collectively they had acquired information from a range of information sources as illustrated in Figure 5.3, (page 172) in order to enhance their ability to communicate with the midwife and consequently facilitate their experience of labour. However, during labour midwives only ever explored the woman's acquisition of knowledge from Preparation of Parenthood classes of which only 37 women in the study had accessed: 24 primigravidae and 13 multigravidae [12 having experienced labour before on one other occasion (P1) and the remaining woman had experienced labour twice (P2)]. This reflected that 69% of the total primigravidae population attended classes compared to 20% of the total multigravidae population. Even when women such as Case 65, an Office Administrator, mentioned they had read a number of books in preparation for labour or had attended their sister's labour, midwives did not readily give women opportunity to communicate how much they understood from these sources.

When a woman was first admitted to the labour ward, only 47 women were actually questioned by the midwife about how they had acquired information in preparation for their present labour: 29 primigravidae (83%) and 18 multigravidae (28%). It was

assumed that multigravidae had previously attended classes in other pregnancies, and so midwives did not pursue this line of enquiry any further with the woman regarding her current labour preparation. It was subsequently revealed when interviewing the women, that this was in fact sometimes an incorrect assumption. The interviews conducted with the women such as Case 27, a housewife / nursery nurse, therefore served to explore how these women had acquired their knowledge and understanding of intrapartum care within the context of a hospital labour ward, in preparation for their latest experience of labour and birth:

- **Case 27:** “.....I’d had the first baby in the old unit and my second one at the other hospital. It was N’s (partner) first baby. He was apprehensive so we came on the ‘tour night’, but there were too many people to get a real feel of the place.....I only went to classes in my first pregnancy, but I saw the same community midwife this time: she updated me about labour.....I don’t really think you can be totally prepared for how things will go though.”

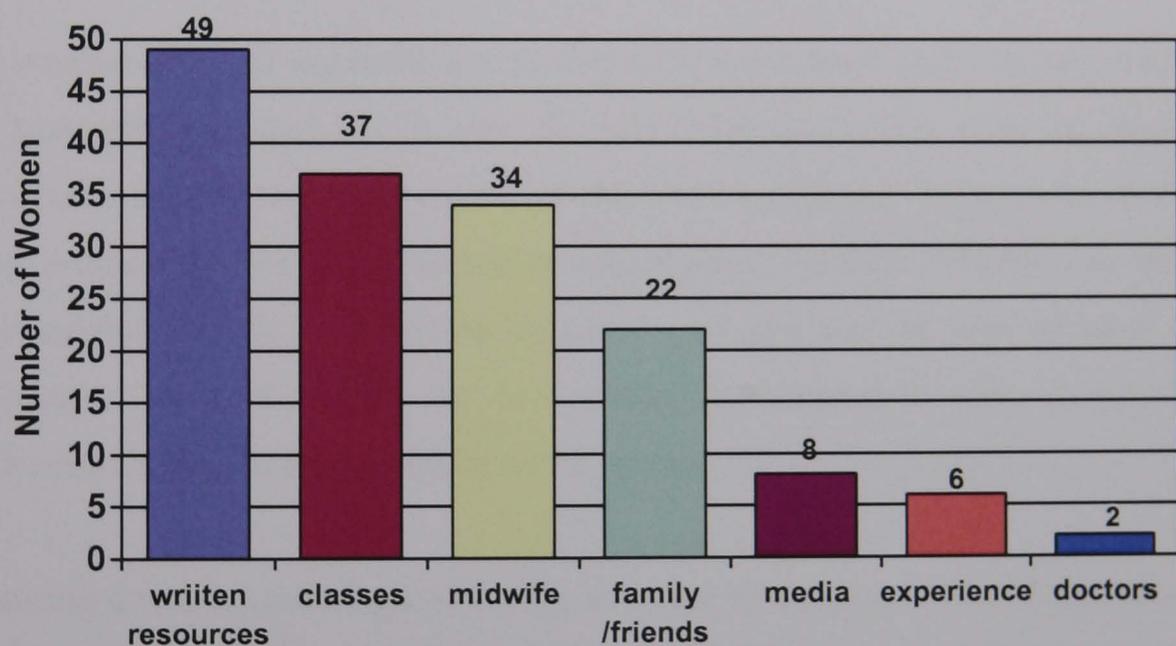


Figure 5.3. Sources of Information.

Regardless of parity and social class, the women in the study stated during the interviews that they needed information to help adjust to labour and the labour ward environment and looked to the midwife to “tell you exactly what to expect”, “inform you of your progress” and “keep you informed of what was going on”. To what extent information was disclosed and acquired in practice also depended on the extent that the women readily communicated with the midwife or doctor as well as the health professionals’ willingness to share their authoritative knowledge. However, there were

some women, such as Case 72 who did not want to know nor actively make decisions about their intrapartum care (page 159).

Those women who had experienced labour and childbirth previously had already acquired some familiarity with the routine practices and language of the labour ward and the type of information they needed to know to be able to play a part in making intrapartum decisions. However, as the maternity unit had only been open since 1994 (three years before the study commenced) the majority of women first acquired knowledge of the labour ward environment during labour and for some women, such as Case 13, a teacher, it was quite a shock:

- **Case 13:** *“I suppose I only became anxious when I saw the clinical delivery room with all the machinery for the first time as I’d had my two other children in the old maternity unit: it was quite frightening. I was hoping everything would be alright so the machines wouldn’t need to be used.”*

In contrast, women who had accessed antenatal classes were more likely to have had a tour of the maternity unit and labour ward to familiarise themselves with the labour ward environment and its technology prior to the onset of labour. These were in the main, primigravidae. As Case 5, a secretary, remarked about the tour: *“it helped to allay some of my anxieties about coming into hospital and give me an idea of what to expect”*. However, unlike Case 13, she had nothing to compare it with, so readily accepted her surroundings and its contents as the norm.

For the labouring woman, acquiring knowledge as to the likely time frame of her labour was important so that she was able to consider whether or not to request analgesia. Women who had been denied their choice of analgesia previously were aware that they needed to request their preference early on in labour so as not to be disappointed again. In order to determine the time scale of events, it was usual for the midwife to undertake a vaginal examination to assess cervical dilatation. Consequently cervical dilatation became the standard to which progress was assessed every four hours and decisions were made. No woman ever refused a vaginal examination if it was to provide her with information that would assist her in communicating her needs to the midwife, such as the need for analgesia. Although the extent of information given to the woman was usually sufficient to enable her to make decisions as shown in the example from Case

10, a housewife / baker, there were a few midwives who deviated from their colleagues and maintained control of the intrapartum decision making by denying the woman specific detail of her progress, as in Case 37, a chef:

- **Midwife 13:** *“.....My you’re doing well: you’re about 6cms dilated.....I don’t want to stop you having an epidural but at the rate you’re contracting I don’t think it will be too long before the baby is here.”*
(Case 10 chose to have pethidine instead of the epidural. The baby was born an hour after the vaginal examination).
- **Midwife 28:** *“..... I can get my fingers through your cervix, but can’t break the waters: the head’s too high..... I’ll put the monitor back on.....”*

In this second example, Case 37 did not respond and therefore never acquired any information of the cervical dilatation and whether it was appropriate to request analgesia at that point. It was not until some 4½ hours later when Midwife 31 took over the care and performed a further vaginal examination with an amniotomy was Case 37 informed the cervical dilatation was 4cms. She consequently received analgesia in the form of gas and air and the baby was born an hour later.

Women in the study, such as Case 98, a solicitor, who had previously experienced labour and childbirth commented during the interviews that they had received much more information from the midwives during this latest experience of labour than in the past and generally felt the better informed to make intrapartum decisions. This was in contrast to the midwives’ perception of their information disclosure to multigravidae being less than that to primigravidae.

- **Case 98:** *“I was very happy with the information given to me in labour.....C (Midwife 35) seemed to take time to explain more this time despite me having experienced labour before..... I suppose I did know more about things though..... They could have easily assumed I knew a lot more and not inform me so readily. Personally, I don’t think I could have coped with any more information as I was in advanced labour.”*

There was only one woman, Case 35, a housewife / childminder who felt that she had been denied information because of having experienced labour before. Although her labour progressed without any problems, the only involvement of medical staff was to site an intravenous infusion in readiness for an epidural, which she subsequently never

received as her labour promptly advanced with the baby's birth occurring 45 minutes later.

- **Case 35:** *"I don't think that the midwives (Midwife 44 and Midwife 45) and the doctor (SHO 12) gave me enough information about what they were doing to me. I wasn't told about the injection (syntometrine) at all. I just felt it being given.....I'd have liked more information about it and the mobile epidural. I'd got a lot of the information from before, but I think the midwives took it for granted that I knew about things as I'd already got a child."*

Where junior students (ranging from midwifery, nursing and medical students) had also been present at the labour, there was further opportunity for the woman to acquire knowledge from any teaching that the midwife undertook as well as contribute to the dialogue herself. Taking time to answer students' questions or seek their understanding of intrapartum care, the midwife was indirectly contributing to the woman's acquisition of authoritative knowledge. This is illustrated in Case 36, a teacher, where Student Midwife 8 relates her findings whilst undertaking a vaginal examination to Midwife 9:

- **Student Midwife 8:** *"The cervix is nice and soft and is fully effaced, thin and well applied to the presenting part: which is the baby's head. The os is about 2cms dilated and I can feel the membranes intact."*
Midwife 9: *"That's fine."* To Case 36 *"Do you mind if I examine you to check what C (Student Midwife 8) has found?"*
Case 36: *"No, that's fine."*
VAGINAL EXAMINATION UNDERTAKEN BY MIDWIFE 9.
Midwife 9: *"I agree with your findings C: well done. What do you think the plan should be now then?"*
Student Midwife 8: *"I'd suggest K (Case 36) gets up and mobilizes to get the contractions established. She could have a soak in the bath if she wants to ease the pain or we could give her a TENS unit to use as she's still in early labour."*
Midwife 9: *"How does that sound K?"*
Case 36: *"Fine. I'd be happy to have a walk around and use TENS".*

Unless they had a previous experience to guide them, during the interviews, women expressed their concern of being unable to cope with the effects of labour that would subsequently affect their ability to communicate effectively with the midwives and doctors and give their consent to intrapartum procedures. This aspect of women's ability to communicate in labour is explored in the next section.

5.4.2.2. Experiencing the Effects of Labour.

When women appeared very distressed and frightened upon admission to the labour ward or as labour advanced, their ability to communicate effectively was reduced. In addition, information disclosed by the midwife was not as extensive as when the woman was more questioning and communicative. This consequently affected the woman giving her consent to procedures. In these circumstances, the midwives' priority therefore became focused on offering appropriate pain relief or preparing for an imminent birth. During the interviews with the women, it was apparent that they were generally aware that their communication skills were dependent on the stage of labour they were at and their ability to cope with the physiological effects and pain of labour. Midwife 6 and Case 4, a civil servant acknowledge the difficulties experienced with communication in the following interview extracts, such that the woman became ambivalent as far as further intrapartum decision making was concerned:

- **Midwife 6:** *“C (Case 4) was 8 cms when she came in..... she was established in labour which made it difficult for me to communicate with her and get her consent. I felt I was competing against her pain all the time. She requested an epidural as soon as she came in.....it was too late for pethidine so the only thing I could offer her was gas and air.”*
- **Case 4:** *“L (Midwife 6) tried to give me information and explain things as best as she could, but I was in some oblivion as I was in so much pain.....L also tried to get me to make some of the decisions like breaking my waters, but to be quite honest I wasn't too bothered: I was too wound up with the pain. I left it to her: she's the expert.”*

In contrast, if the woman appeared to be tolerating labour, such that she had a higher pain threshold or was in early labour, she was observed to communicate more effectively. These women were more likely to seek further information from the midwife as and when necessary and consequently be involved in making decisions about their care that they felt they had some control of the situation. This observation was across the range of social class as highlighted in the extract from Case 70, a cleaner:

- **Case 70:** *“M (Midwife 2) talked things through with me all the time. I didn’t have that last time. Although I came in in early labour, I felt that I benefited from getting to know the midwife better as well as lots of information from her. I felt very much in control this time and that I made some of the decisions.”*

The difficulties that midwives expressed in respect of women who were in early labour or who did not appear distressed were in respect of assessing how far in advance of certain invasive procedures being undertaken, such as episiotomies and assisted deliveries, should they disclose information and also how much information to disclose to women. They were concerned that providing too much information, too soon, could provoke a degree of fear and anxiety in the woman as a possible consequence. Subsequently, as labour progressed and the woman became more distressed, the midwives’ concerns increased as they were aware that the woman’s ability to consider all the facts and give informed consent was considerably reduced. The excerpt from the interview with Midwife 64 concerning the communication she had with Case 57, a switchboard operator, illustrate some of the thoughts and concerns midwives had regarding the timing of information disclosure during labour:

- **Midwife 64:** *“I feel that I did not prepare C (Case 57) sufficiently for an ventouse delivery and manual removal. Everything seemed to happen so quickly in the end.....I wasn’t able to ask her if she understood what was happening or if she had any more questions. It was difficult to get true informed consent. These complications are never discussed in the first stage of labour when the woman is more likely to consider other options prior to giving / refusing consent.....but on the other hand you don’t want to frighten them, do you?”*

There was only one woman in the study Case 13, a teacher, who disclosed that she felt she had been given too much information to cope with during the latter stages of her labour and consequently found difficulty in making decisions about her care. She stated that she felt Student Midwife 5 *“needed to be more decisive.....regarding breaking my waters.”*

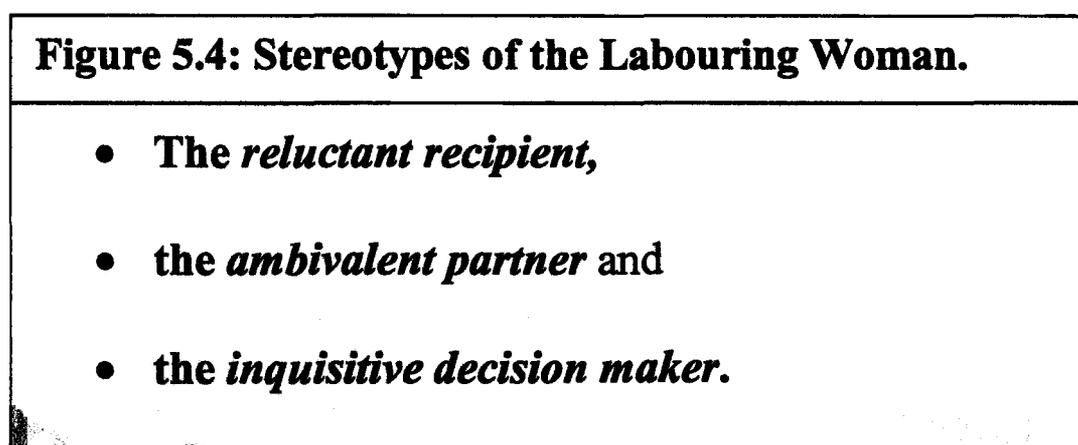
Of those labours where the woman had chosen to have an epidural for pain relief (31%), communication between the woman and midwife appeared to improve considerably, even as labour advanced. Midwives who cared for women in labour with epidurals viewed their use as positive as far as effecting communication was concerned so that women were able to contribute towards making decisions about their intrapartum care: a

typical response being from Midwife 90 in respect of the communication she had with Case 96, a dance teacher:

- **Midwife 90:** " I asked L (Case 96) if she wanted me to clarify things. She had an effective epidural and so I was able to have a lucid conversation with her than if she had inadequate pain relief, was distressed and unable to communicate."

5.4.2.3. Stereotypical Roles of the Woman in Labour.

The degree that women communicated and played an active role in making decisions about their intrapartum management in this study did not necessarily relate to social class status. How they were seen to deal with the information disclosed to them and subsequently make decisions about their intrapartum care is categorised as follows in Figure 5.4:



5.4.2.3 (i) The Reluctant Recipient.

It was observed that the woman who was a *reluctant recipient*, generally showed an unwillingness to enter a dialogue and develop a trusting relationship with the midwife. Such a woman saw labour as the means to an end and totally accepted the medico-technocratic model of birth, entrusting the midwife to make appropriate intrapartum decisions on her behalf. The reluctant recipient did not want to be fully informed as she believed that acquiring too much knowledge of intrapartum practices can cause unnecessary anxiety. Even when experiencing her first labour, any pre-labour preparation was of little importance to this woman. When caring for the reluctant recipient the midwife was therefore less able to fully assess the extent of the woman's knowledge and understanding which consequently makes obtaining consent to

procedures more difficult. An example of the *reluctant recipient* was Case 72 a Reprographics Administrator (page 159).

5.4.2.3 (ii) The Ambivalent Partner.

In the study, although those women who possessed the attributes of the *ambivalent partner* appeared more eager to communicate with the midwife than the reluctant participant, they often seemed just as unwilling to take part in making decisions about their care. Women who demonstrated these attributes included Case 4, a civil servant (page 176) and Case 13, a teacher (pages 177, 202). Whilst this particular woman usually had acquired an amount of information about labour from a variety of sources prior to the onset of labour and was more appreciative of being informed, she appeared to lack confidence and certainty about making appropriate choices during labour. She believed that the health professional, be it the midwife, or doctor, was the expert who had the body of authoritative knowledge to make such decisions on her behalf. However, when caring for the ambivalent partner it was important that the midwife was never complacent as far as undertaking intrapartum procedures were concerned. Even when the midwife had fully informed the woman of all possible effects, indecision on the woman's part where consent was not formally expressed, did not determine the midwife's legal right to proceed.

5.4.2.3 (iii) The Inquisitive Decision Maker.

As with the ambivalent partner, this stereotype of labouring woman was enthusiastic to develop a good relationship with the midwife and to acquire as much information as possible about possible benefits and risks of intrapartum care and procedures. However, unlike other stereotypes, the *inquisitive decision maker* appeared confident to articulate her choices and make decisions in equal partnership with the midwife. She undertook extensive pre-labour preparation, which included attendance at antenatal classes, in order to be able to demonstrate her autonomy by taking an active part in making intrapartum decisions. Having contemplated issues in advance of labour, the inquisitive decision-maker usually constructed a birth plan, be it either in a mental or written format to discuss with the midwife when in labour. The enquiring nature of this particular woman not only encouraged the development of a good relationship with the

midwife, but also assisted in identifying the true extent of her knowledge and understanding and so any deficits or misunderstandings can be addressed. Obtaining consent from the inquisitive decision-maker was more likely to be informed. Examples of women displaying the attributes of the inquisitive decision maker were Case 70 (pages 176 / 177) a cleaner and Case 100, a library assistant (pages 185 / 186).

Unlike the midwife whose stereotype appeared constant throughout the observational stages of the data collection, the stereotype initially attributed to the woman was occasionally seen to change. This was more overt in the inquisitive decision maker where either as a result of labour advancing with increasing pain, or complications developing, the woman appeared to become a reluctant recipient, being more submissive and reluctant to communicate and voice her opinion to the midwife or doctor. This change in stereotype was evident in the annotated field notes and interview extracts from Case 95, a housewife / cleaner who initially demonstrated the stereotype of *inquisitive decision maker* until the obstetrician demanded that an epidural be organised totally disregarding her wishes, resulting in her becoming a *reluctant recipient*.

- 02:03: Case 95:** *“Will I need to have an epidural? Last time when they put the needle in my back the baby’s heartbeat went down and blood had to be taken from the baby’s scalp, it was quite worrying.”*

Midwife 55: *“The heart rate can go down with the epidural because it may cause the blood pressure to fall. It’s your choice to have an epidural anyway.”*

Case 95: *“No, I’m OK at the moment. I’ll just try the gas and air when I’m ready.....”*

04:37: REGISTRAR 20 HAS BEEN SUMMONED TO REVIEW THE FETAL BRADYCARDIA. HE UNDERTAKES A VAGINAL EXAMINATION AND AMNIOTOMY.

Registrar 20: *“Right, I’ve broken your waters: we need to get things going.”*

Midwife 55: *“Do you really need to put the drip up now?”*

Registrar 20: *“Yes, I think so, to get things going; it’s in the baby’s best interest. Have you thought about an epidural?”*

NO COMMENT FROM CASE 95 AS SHE IS CONTRACTING.

Midwife 55: *“She’s using gas and air.”*

Registrar 20: *“Have you had an epidural before?”*

Case 95: *“Yes, with the others.”*

Registrar 20: *“We’ll get the epidural in first and then put up the syntocinon.”*
- Midwife 55** was not happy about Registrar 20 authorising an epidural as Case had no choice. *“..... I gave S (Case 95) and M (Case 95’s partner) the opportunity to express their concerns to the doctors but they didn’t. It was then difficult to challenge Dr S’s management totally.....It’s very emotive when a*

doctor obtains agreement to undertake a procedure by stating “it will be in the baby’s best interest”: how could any woman refuse? It’s a form of coercion.”

- **Case 95**.....*I had no choice about the epidural. I was told by Dr S (Registrar 20) I had to have one as “it was in the baby’s best interest”. I’m not really sure why. I’d told C (Midwife 55) I was quite happy using the gas and air and didn’t want an epidural because of the problems last time.....The medical staff did not give me any choice: decisions were made for me, rather than with me.”*

5.5. HEALTH PROFESSIONALS’ AWARENESS OF THEIR PROFESSIONAL OBLIGATIONS REGARDING INFORMED CONSENT.

CORE - CATEGORY	CATEGORY	THEME
Health Professionals’ Awareness of their Professional Obligations regarding Informed Consent.	LEGAL ISSUES.	Duty of care to inform. Assessment of understanding. Consent or trespass to the person. Record keeping and the threat of litigation.
	ETHICAL ISSUES.	Respect for autonomy. Benefit or potential harm to the woman and baby. Standards of practice.

Table 5.4: Health Professionals’ Awareness of their Professional Obligations regarding Informed Consent: Its Categories and Themes.

5.5.1. Legal Issues.

As all health professionals are personally held accountable for their own practice, they each have a responsibility to be aware of their limitations in enabling women to make informed decisions to consent or decline procedures / treatment taking into account legal principles. However, the degree to which midwives demonstrated an understanding of the legalities surrounding informed consent through their intrapartum care practices was varied and often quite limited in the majority of cases observed. Conducting follow-up interviews with each midwife and woman involved in the study enabled further exploration of the extent of knowledge both these groups had of the law involving consent and the consequential effect this could have on the woman making decisions regarding intrapartum procedures. The next section presents the four themes that emerged from the data analysis of the study: *Duty of Care to Inform, Assessment of Understanding, Consent or Trespass to the Person and Record Keeping and the Threat of Litigation.*

5.5.1.1. Duty of Care to Inform.

It became apparent from the observation, that when midwives perceived certain procedures to be part of their own routine intrapartum care practice, information was more readily disclosed to the women about these procedures in order to get consent to proceed, than those procedures they practised less frequently: thus recognising their duty to inform. For example, it was evident that more midwives disclosed information concerning the management of the third stage of labour and the use of syntometrine, compared to the number of midwives who discussed the practice of episiotomy with the women. This is also reflected in the fact that whilst a total of 98% of the women received an injection of syntometrine to actively manage the third stage of labour, only 17% of the women experienced an episiotomy (four undertaken by midwives and 13 by obstetricians in conjunction with instrumental deliveries). The following annotated excerpts from both the observational field notes and interviews, serve to demonstrate the extent of information disclosed and the standard of detail provided by Midwife 9 and subsequently recalled by Case 45 a carer, in respect of the administration of syntometrine. This example also reflects one of the few instances where the midwife presented the risks as well as the benefits to the woman.

- **MIDWIFE 9 SCANS THROUGH CASE 45'S RECORDS.**
Midwife 9 confirms that Case 45 did have syntometrine with her two previous labours. *“There’s two ways your placenta can be delivered: the physiological way and then active management.....Physiological management means that you’d deliver the placenta without any drugs: it can take up to 20-30 minutes. Whereas with active management, the injection of syntometrine speeds it up, but can cause your blood pressure to rise.....and you may vomit. With the physiological method there is more risk of you bleeding..... We need your consent to give the injection. If you feel sick we can give you some medication to counterbalance the effects if need be. How do you feel about having syntometrine?”*
Case 45: *“That’s fine: I’m happy to have it.”*
- **Case 45** remembered being given the syntometrine this time *“to help the afterbirth come quicker. I was also told that it would make me feel a bit sick, but if I didn’t have it, the afterbirth would take longer to come and I may bleed more.....so I had it.”*

Comparing the above example to the practice of performing an episiotomy (a less frequently observed procedure), there was less variability in the extent and detail of information disclosed. During the labours observed such a practice was rarely discussed as the midwives never expected to undertake this procedure. The following excerpt from the interview with Midwife 51 concerning her care with Case 42 a Local Government Officer, is a typical response:

- **Midwife 51:** *“I didn’t mention the possibility of an episiotomy as I suppose I never expected R (Case 42) to deliver with me: the second stage was quite quick in the end. Anyway she didn’t need one (episiotomy) in the end.”*

During the interviews, the standard of the information disclosed in labour did cause the midwives some concern within the context of their professional and legal duty to always fully inform women about the risks associated with procedures regardless of their parity. The findings presented in the next section consider the many issues facing the midwife when attempting to assess the level of understanding that a woman in labour has, regarding procedures that may be undertaken.

5.5.1.2. Assessment of Understanding.

In addition to disclosing pertinent information to women concerning the management of their labours, it is of vital importance for all health professionals to ascertain the extent

of a woman's knowledge and understanding about intrapartum practices and procedures that have relevance to the woman's own situation, before obtaining consent and undertaking the procedure. It was observed during the study that the extent to which a woman's understanding was formally assessed by the midwife and the doctor during labour, varied considerably: from little or no exploration of the woman's knowledge of labour and birth to a more in depth investigation. If there are situations whereby the woman does not feel she was adequately informed or did not fully understand the consequences of a procedure, the health professional who carried out the procedure, could then face legal action.

It was observed that midwives did not demonstrate their ability to fully investigate to what extent a woman actually understood about labour and intrapartum practices. Instead of asking the woman to relate to them what she already knew and understood, midwives tended to use closed questions with little scope to explore in any depth the woman's level of understanding. It was also observed that midwives generally assumed that these women either had acquired some understanding from past experiences of labour and birth, from attending Preparation for Parenthood classes or by completing a birth plan before they went into labour. Very seldom did midwives actually pursue the woman's understanding from these sources as highlighted in the following annotated excerpts from the observational field notes and interview transcripts involving Case 57 a switchboard operator and Midwife 11:

- **Midwife 11** asks if **Case 57** has a birth plan.
D (C's husband) HANDS THE BIRTH PLAN TO MIDWIFE 11 WHO THEN PROCEEDS TO READ IT.
Midwife 11: *"That looks fine C. We'll need to look you over first and then look at getting you into the pool. Have you been in the bath at home?"*
Case 57: *"Yes."*
Midwife 11: *"Did it help?"*
Case 57: *"Not really!"*
Midwife 11: *".....Did you go to Parentcraft classes?"*
Case 57: *"Yes, we came here."*
CASE 57 EXPERIENCES ANOTHER CONTRACTION : SHE GRIMACES.
Midwife 11: *"Do you remember discussing the injection for the placenta at the classes? Syntometrine?"*
Case 57: *"Yes, we did."*
Midwife 11: *"Are you happy to have it? Do you understand what it is for?"*
Case 57: *"Yes."*
Midwife 11: *"OK. I'll stop the trace now: it's fine."*

- **Midwife 11** recalled that she had asked C (Case 57) about Preparation for Parenthood classes and *“both she and her husband D had attended the classes at the hospital. She had also written a birth plan..... She knew about the effects of syntometrine from the classes and she was happy to have it.....”* As Case 57 was in established labour when she was admitted to the labour ward Midwife 11 said it was difficult to really assess whether or not she had given her sufficient information. *“However, I did feel that she understood most things as she appeared fairly well read and had been to classes.”*

In those cases where women (and their partners) appeared genuinely interested in how the labour was progressing and continued to seek information for themselves from the midwives i.e. the inquisitive decision maker, their recall and understanding of intrapartum care and procedures as well as their involvement in decision making was greater than those women who had been less communicative. Where midwives had established a good relationship and there was generally a good dialogue with the woman, they appeared more able to assess the woman’s level of understanding based on the extent of her questioning and quality of responses. As a consequence, these midwives stated during the interviews that they felt more confident that the consent to procedures they had acquired from the women, was informed as highlighted in Case 100, a library assistant:

- **Midwife 8** asks **Case 100** what thoughts she has about pain relief.
Case 100: *“I’m not sure really.”*
Midwife 8: *“You had an epidural last time. Do you want an epidural this time? There’s also the pethidine injection.”*
Case 100: *“If I have pethidine, could I still have an epidural?”*
Midwife 8: *“Yes you can.....”*
CASE 100 EXPERIENCES ANOTHER CONTRACTION.
Case 100: *“What effect does the pethidine have?”*
Midwife 8: *“It relaxes you and takes about 20 minutes to work. It doesn’t take the pain away completely, but will relax you.”*
Case 100: *“Does it affect the baby?”*
Midwife 8: *“It depends on when the pethidine is given. If it’s given too late it can get through to the baby and make it a little sleepy at birth: nothing to get worried about though.”*
CASE 100 HAS ANOTHER CONTRACTION.
Case 100: *“Will I need to have another forceps delivery if I have an epidural?”*
Midwife 8: *“Not necessarily. It numbs you from the waist down, but shouldn’t really affect the actual delivery, as it’s your second. You’ll need a drip with the epidural as it can lower your blood pressure and your baby’s heart rate may fall. Anyway, see how you go: you seem to be coping quite well at the moment.”*
- **Midwife 8** thought she had given **Case 100** sufficient information about pain relief. She felt that *“A (Case 100) appeared to have a good understanding and*

asked relevant questions to clarify issues and confirm that she understood. She was an intelligent woman and I did get some response from her, unlike some clients, so I felt that the consent I obtained to any procedure I did, was informed."

- **Case 100** really wanted an epidural but by the time she requested it she was *"too advanced to have one, therefore I had to consider an alternative. I chose pethidine to relax me and ease the pain. I know that it can cause the baby to be drowsy as well..... I also know that epidurals can cause your blood pressure to fall as well as the baby's heart rate and increase forceps deliveries. I had a normal birth this time which was more painful, but I achieved it myself."*

During the interviews, the extent to which the midwives acknowledged that assessing a woman's understanding is a vital element in obtaining consent to intrapartum procedures was variable. In situations where labour had progressed without any difficulties, very few midwives actually demonstrated any awareness of this fact. In comparison, a proportionally increased number of midwives openly expressed their concern that assessing understanding and the mental capacity of a woman in labour is often difficult and very subjective. This was especially so if communication with the woman was limited. This could be for a variety of reasons such as labour advancing quickly and the woman being too distressed, or being affected by drugs, or merely reluctant to converse and labour developing complications. The following annotated excerpts from Case 14 a milk woman, highlight the difficulties with communication, assessing understanding and subsequent recall of information where the woman was particularly distressed and disorientated.

- **Midwife 18:** *"That's good you're about 5 cms dilated now and the head is well down. I think that if you need pethidine it's probably best to have it now. I think you're going to crack on."*
Case 14: *"Get it in now, then(!)"* (pethidine).
21:55: MIDWIFE 18 EXITS TO GET THE PETHIDINE. CASE 14 APPEARS DISORIENTATED AND RESTLESS. SHE CONTINUES TO INHALE THE GAS AND AIR.
21:58: MIDWIFE 18 RETURNS WITH AN INJECTION OF PETHIDINE.
Midwife 18 appears hesitant to give the injection as she states that it may make Case 14 more disorientated, however she continues: *"Do you want me to give the injection in you leg?"*
Case 14: *"Anywhere(!) Just put it in(!)"*
22:00: MIDWIFE 18 ADMINISTERS THE INJECTION OF PETHIDINE TO CASE 14.....
22:17: S (Case 14's husband): *"L says she wants to push."*
Case 14: *"Can I push?I want to push... don't let me split open. I feel really pissed(!)"*

22:20: MIDWIFE 18 UNDERTAKES A VAGINAL EXAMINATION.

Midwife 18: *“That’s fine, you’re ready now. You can push now.....”*

Case 14: *“My voice seems all funny. I feel I’m here, but can’t see what’s happening.”*

Midwife 18: *“It’s probably the combined effects of the gas and air and the pethidine, don’t worry.....Can you remember L, being given the syntometrine last time to help deliver the afterbirth? You probably can’t.”*

MIDWIFE 18 BEGINS TO DRAW UP THE SYNTOMETRINE INJECTION.

S: *“What’s that for?”*

Midwife 18: *“That’s the syntometrine. It’s an injection that we give to help get the afterbirth, the placenta, out. It also helps to control the bleeding.....”*

- **Midwife 18** said that although she tried to ask Case 14 for consent to undertake the procedures, *“it was hard to assess how much information to give and how much she understood. I didn’t have much time to explain things well in advance.....I tried to explain about the syntometrine but L (Case 14) was too spaced out to take it in. She’d had it before..... S (L’s husband) asked what it was, so I explained the effects to him..... L was so high on the gas and air that it was difficult to communicate with her at times.”*
- **Case 14** stated that as she was so disorientated with the gas and air she appreciated the difficulty Midwife 18 must have had trying to communicate with her. Whilst she remembered the internal examinations *“I think I was also given pethidine.....but to be quite honest I can’t remember that much..... I don’t even remember what K (Midwife 18) looked like.....I could only hear her voice being so high on the gas and air. It was like being in another world: totally drunk..... I don’t remember the syntometrine being given this time either. It’s oxytocin isn’t it? I know from helping S with the calves when we had the farm it’s to help the placenta deliver and stop bleeding. Cows have oxytocin when they give birth.”*

Regardless of how labour progressed, in the 11 cases where the midwife provided care for pregnant teenagers (15-19 years), the issue of assessing their understanding as being important to gaining consent was fully appreciated by each midwife, as was the difficulty this sometimes posed in practice. They also recognised the importance of keeping the girl’s birth companion, be it her mother or boyfriend, informed as a means of improving the discussions about intrapartum care and procedures, and ultimately the girl’s understanding. The midwives believed this to be vital if the girl was legally classified as a minor and she was not particularly communicative. However, not all of these midwives demonstrated they were aware of the legal precedent of Gillick competence for assessing the understanding of girls under the age of 16 years (Gillick v West Norfolk and Wisbech AHA 1985). The following excerpt from an interview

transcript with Midwife 36 is a typical response of the midwives' concerns when caring for minors in labour:

- **Midwife 36** felt that as T (Case 29) was only 15 years old she probably would not have been able to cope with any more information. *"I tried to get T involved in making some of the decisions, but this was limited.....She's technically still a child, but she didn't withhold her consent to anything. I do wonder about the level of her understanding as she hadn't been to any antenatal classes as the pregnancy had been concealed until 34 weeks....."* Midwife 36 was conscious that some of the explanations were given more for H's benefit (T's mother) benefit as she was there as her advocate and was more questioning.

Although in this particular case, it had been observed that the girl's dialogue with the three midwives involved in her care was limited, she was extremely communicative during the follow-up interviews. As the following excerpt illustrates, despite the girl demonstrating good recall of her labour, her understanding of certain intrapartum procedures was variable:

- **Case 29** expressed that she was quite scared as she did not know what to expect of labour having only found out that that she was pregnant a few weeks earlier and had no time to go to any classes. She said her mother and the community midwives informed her about labour. She was aware that the three midwives *"took my temperature, pulse and blood pressure, but I don't really know why. They also felt my stomach and listened to the baby's heartbeat to check how the baby was.....I had a number of internals to see how far dilated I was and R (Midwife 36) broke my waters to speed thing up. I didn't know it would be so painful afterwards though. I asked for an injection of pethidine to calm the pain, but it made me feel sick..... I would have liked more information about the breaking of the waters and the pain it was likely to cause me afterwards."*

Where midwives and student midwives stated that they had experienced some difficulty in assessing the woman's understanding during labour due to either labour progressing quickly or complications developing, some midwives suggested discussing complications and possible outcomes in early labour to overcome these concerns. Others such as Student Midwife 6, acknowledged that explaining events and procedures retrospectively could serve in improving the validity of the woman's consent where any deficits in the woman's knowledge and recall of events could then be assessed (and rectified if necessary), as shown in Case 23: a Senior Administrations Officer:

- **Student Midwife 6** felt that she had not fully explained the actions of syntometrine and was worried as to how much B (Case 23) knew about it from her previous labour. She recognised the importance of giving women as much information as possible: *"so they can choose whether to have them (injections) or not. However, when a woman is in established labour, seems distressed and is concentrating on her breathing, it can be more difficult to assess their level of understanding. I suppose how much they actually have understood can be assessed by the follow-up visit as in B's case?"*

The four community midwives in the study felt they were in a better position than the hospital midwives to further explore the woman's understanding and offer any debriefing regarding her labour and birth experience as they continued to care for the woman and her baby postnatally. This was especially in those cases where there had been fetal distress in the latter stages of labour / second stage of labour and the midwife found they could not fully explain to the woman the events as they developed because of *"the urgency of the situation"*.

5.5.1.3. Consent or Trespass to the Person.

It was observed that the type of consent obtained from the woman by the midwife or doctor to undertake intrapartum procedures varied according to certain factors concerning each labour: the range observed being from implied consent, to express consent / informed consent to finally obtaining written consent for emergency procedures. To what extent the midwives were aware of the type of consent they had acquired from the women was explored in the follow-up interviews, but this tended to be very limited. Where a procedure was perceived by the midwife as being part of the intrapartum routine or hospital policy, the woman was given little scope to refuse and as a result consent was merely implied.

On the other hand, should a proposed procedure carry some degree of risk it is always legally advisable to obtain written consent from the woman. In the study, a written consent form was signed in a minority of cases (7 cases), which either permitted the obstetrician to proceed with an emergency caesarean section (5 cases) or manual removal of the placenta (2 / 4 cases). As only one of these cases was conservatively managed, a manual removal of placenta was undertaken without any written consent being obtained in the 4th remaining case: Case 42: a Local Government Officer. This

practice could potentially have had major implications for the doctor concerned had any harm come to the woman. However, Midwife 51 never challenged the female obstetrician's authority to undertake the manual removal in the labour room without the woman's written consent nor offered any criticism of such practice during the follow-up interviews. She was more critical of her own lack of communication with the woman regarding the procedure.

It is legally expected that the person informing the woman of the procedure and all the potential risks that it involves prior to obtaining her written consent, should be the person who will then undertake the procedure. However, this was only observed on two occasions, as in five of the cases it was the less experienced SHO who obtained the woman's signature for the operative procedure, which the Obstetric Registrar subsequently carried out. The degree of information given by the SHO about the procedure and its risks was extremely variable, with only one woman being fully informed. Each woman was observed to sign the consent form without further questioning the obstetrician's decision. The following excerpts from the observational field notes and annotated interview transcripts of Case 38, a shop assistant and Case 91 a receptionist, compare the degree of detail given to the woman by medical colleagues prior to signing the consent form regardless of her social class, and the effect this had on her understanding of the operative procedure:

- **Registrar 11:** *"I think it's time to deliver you. We'll take you to Theatre, reassess you there and probably do a caesarean section."*
REGISTRAR 11 LEAVES.
SHO 15: *"I have a consent form for you to sign. We're going to do a trial of forceps and maybe proceed to a caesarean section, OK? Do you want to sign here?"*
CASE 38 SIGNS THE CONSENT FORM WITHOUT ANY QUESTION.
- **Case 38** knew that she had signed a consent form for a trial of forceps but stated that the doctor (SHO 15) never explained about it or the caesarean. It was L (Midwife 48) who did. She also mentioned that no one had talked to her about episiotomies. *"From what I had read I knew I had to have one because of the forceps deliverybut the doctors (Registrar 11 and SHO 15) didn't really explain things to me, particularly the delivery before I had to sign the consent form. I would have liked more information about the delivery."*

- **SHO 25:** *“J (Case 91), I’ve got a consent form here for you to sign. We’ll make sure that you are pain free first before starting. It involves doing an internal examination to try and peel it (the placenta) off the uterus. You may get a heavier blood loss initially, and there’s a slight risk of infection. Tell the midwives up on the ward if you have an excessive and smelly discharge.”*

Case 91: *“How long does the anaesthetic take?”*

SHO 25: *“About 10-15 minutes. The actual procedure itself lasts about 5 minutes. The anaesthetist will come and talk to you about the spinal. You had an epidural last time: it’s quite similar really.....Will you sign the consent form please?”*

CASE 91 SIGNS THE CONSENT FORM.

- **Case 91** realised that she had no choice but to sign a consent form to have her placenta removed in Theatre under a spinal anaesthetic as it had failed to deliver. *“I was aware that the side effects of the spinal were similar to those of the epidural: headache, shakiness, nausea and low blood pressure. I was also given some antibiotics in Theatre as a precaution against infection due to the retained placenta.....”*

However, in the remaining two cases where the Registrar not only informed the woman about the proposed operative procedure but also gained her written consent, there appeared no significant difference in the woman’s level of understanding of the procedure they had experienced than had different doctors undertaken the two activities. At the follow-up interview the women raised the fact that they were unaware of any risks the instrumental / operative delivery may have had on them and their baby as shown in Case 28: an accounts officer, where the woman also expressed her anxiety of not knowing the type of anaesthesia that may be used should a caesarean section be undertaken.

- **Registrar 7:** *“The problem is that the baby is facing the wrong way. I’ll try and deliver you by ventouse in Theatre. We’ll rotate the baby first and then deliver it. If we can’t manage that, then we need to do a caesarean section.”*

CASE 28 BEGINS TO CRY. HER PARTNER, J, CONSOLES HER.....

Registrar 7: *“I’ve got the consent form here T (Case 28), for you to sign. We will try and do a ventouse first and if there is no advancement, we will need to do a caesarean. Is that OK?”*

Case 28: *“Yes.”*

CASE 28 SIGNS THE CONSENT FORM AND THEN REGISTRAR 7 EXITS.

- **Case 28** was aware that the ventouse delivery was done to rotate the baby and then deliver it as it was facing the wrong way...*“When I signed the consent form the doctor (Registrar 7) told me that if the suction delivery was unsuccessful she would then do a caesarean section, but I wasn’t told of any risks of either. I was*

also frightened about having a general anaesthetic. I'd had my wisdom teeth out last year and it took me a while to come round after the anaesthetic."

Of the five women who gave their written permission for a caesarean section, only two of these actually had such an operation as the remaining three either experienced a forceps delivery (2) or ventouse delivery (1) However in one case, although Registrar 17 had discussed the possibilities concerning the mode of delivery, one woman Case 56: an Administrator, was particularly upset that she had signed a consent form expecting to have a caesarean section, and consequently experienced a forceps delivery. As this was not what she had anticipated, her distress was apparent during the follow-up interview. There was also detail on her birth plan that addressed the preferred mode of delivery should complications develop, but these had been disregarded. This issue is demonstrated in the following annotated excerpts from the observational field notes and interview transcripts with the Registrar 17 and the woman:

- **Registrar 17:** *"The baby's head is facing the right direction, so we're not sure why it's still quite high.....it may too big for your pelvis. If it was further down, we could safely deliver it with the suction cap or forceps. As you've been pushing for a while now, the only way to deliver the baby would be by caesarean.....We'll do the operation under a spinal injection, so you'll be awake throughout. I'll examine you in Theatre and if the head's come down, we'll try and deliver the baby by forceps. I need you to sign a consent form if you would?"*

CASE 56 SIGNS THE CONSENT FORM WITHOUT ANY QUESTION.

- **Case 56** explained that she had signed a consent form for a caesarean section with the doctor (Registrar 17) but had not been given time to read the small print She was also upset that she was not made aware until after the delivery that she had torn as well as had an episiotomy....." *I felt so disappointed and would have preferred a caesarean. I'd actually stated on my birth plan that should I need help to deliver the baby I would prefer a ventouse. I did not want an episiotomy: I know that with ventouse deliveries, episiotomies aren't usually performed.....I was expecting to have a caesarean: I'd consented to it in writing and was geared up to having one....."*

This last example not only highlights to the health professional the importance of ensuring that whatever is consented to is always carried out, but the woman fully understands that written consent may also involve "alternative" procedures. On those occasions where implied consent had been observed, midwives appeared to only carry out the procedure to which the implied consent referred. This therefore served in avoiding any misinterpretation on the woman's part as she only experienced the

procedure that the midwife had announced she was intending to do. In some instances it was observed that a health professional not only undertook the action for which consent had been implied, but also continued to undertake a further procedure without informing the woman of the potential consequences, or gaining consent, thus incurring trespass to the person. This was more apparent among the obstetricians than the midwives. It was generally assumed by the doctor that the woman and midwife would respect their authoritative knowledge without any challenge as the example of Case 95 a housewife / cleaner, illustrates where a fetal scalp electrode was applied following an amniotomy with no prior discussion or consent obtained from the woman:

- **Registrar 20:** *“Right, I’ll examine you and see what’s going on”.....*

CASE 95 EXPERIENCES A CONTRACTION.

Registrar 20: *“So how often are your pains coming?..... Right, I’ll examine you and break your waters, then get things moving. Do you want to start using the gas and air?”*

Student Midwife 19: *“Here you are S (Case 95) Do you remember how to use it? Nice deep breaths.”*

CASE 95 BEGINS BREATHING IN THE GAS AND AIR.

REGISTRAR 20 UNDERTAKES A VAGINAL EXAMINATION FOLLOWED BY AN AMNIOTOMY.

Registrar 20 to Midwife 55: *“Can you get me a scalp clip?”*

REGISTRAR 20 APPLIES AN ELECTRODE TO THE FETAL SCALP AND MIDWIFE 55 CONNECTS IT TO THE CARDIO TRANSDUCER, SECURING IT IN PLACE WITH A BELT AROUND CASE 95’S THIGH.

Although midwives tended to be self-critical of their ability to obtain consent and tried to justify their practice, it is worth noting that in the follow-up interviews very few of them were aware that failure to provide sufficient information and gain informed consent from the woman, not only would constitute a breach of the health professional’s duty of care to the woman, but also trespass to the person. As far as the legal implications are concerned, few midwives recognised that they could be held liable should any physical or psychological harm results for which women may be entitled to compensation. This tended to be regarding more invasive techniques such as an episiotomy that were perceived by the midwife to carry a significant risk compared to other procedures that had become part of routine intrapartum care, such as vaginal examinations. This is highlighted by the annotated extract from the interview with Midwife 27 who was concerned about having undertaken an episiotomy in Case 60 a

pharmacy technician, as discussion had been minimal such that she questioned the validity of the consent and was mindful of future litigation.

- **Midwife 27:** *“.....I don’t think I could have avoided doing an episiotomy.....but it wasn’t ideal to discuss it with S in the second stage. I didn’t get true informed consent. G (Case 60’s husband) actually questioned the need to perform an episiotomy as S (Case 60) wanted to avoid having one..... I tried to explain the reason, and documented it, in case there are any questions asked, or comeback in the future..... As a professional, the midwife has two lives to consider: the fetus and the morbidity of the mother, and litigation is something the midwife is constantly aware of.”*

A total of 98 women in the study received an oxytocic drug for the management of the third stage of labour, but the actual administration of such a drug was only observed in 93 cases. This was due to two women experiencing physiological management where no drug was administered, and as the remaining five cases resulted in an emergency delivery in the operating theatre, the administration of the oxytocic drug was not observed. In all but one of the 93 cases, an additional midwife was called into the room to administer the drug. The timing of her entry (second stage of labour) made it impossible for her to acquire express consent from the woman to administer the drug. This meant that this particular midwife was placed in a difficult position and, being unaware of what the woman actually understood about the drug, had to trust her colleague’s judgment that it was appropriate to proceed with the injection. At the follow-up interviews with the midwives, a number of them expressed their concern about this practice and the potential litigation that may ensue should a woman feel she had not given her consent for the drug as in Case 98: a solicitor.

- 03:15: MIDWIFE 44 ENTERS THE ROOM.
Midwife 44: *“Hello, I’m here to help C (Midwife 35) with the delivery.”*
Midwife 35: *“I’ve not had chance to get C’s (Case 98) consent for syntometrine yet.”*
Midwife 44: *“OK. C, are you happy for me to give you an injection of syntometrine to help get the placenta out?”*
CASE 98 IS IN THE MIDDLE OF A CONTRACTION AND DOES NOT RESPOND. MIDWIFE 44 DRAWS UP THE SYNTOMETRINE INJECTION.
03:25: BABY GIRL IS BORN.
MIDWIFE 44 ADMINISTERS THE INJECTION OF SYNTOMETRINE TO CASE 98: NO COMMUNICATION CONCERNING THE INJECTION.
- **Midwife 35** stated that she had no time to discuss syntometrine with C (Case 98), or get her consent and it was L (Midwife 44) who finally administered

it..... *“but no effects of the drug were ever discussed by myself or L which I am concerned about. C had syntometrine last time, so I assumed it was OK for her to have it this time. As L gave it, she was ultimately responsible as she is legally accountable for her action.”*

In comparison, when interviewing the women, although none of these women actually raised the issue of trespass to the person, they did state they were not certain that the syntometrine injection had been administered as they had neither seen it, nor felt it being given as highlighted in Case 70: a cleaner:

- **Case 70:** *“.....I also consented to have the injection to deliver the placenta quicker: syntometrine. However, I can't remember it being given as K (Midwife 94) never told me the injection was coming.”*

5.5.1.4. Record Keeping and the Threat of Litigation.

It is part of the midwife's legal responsibility to ensure that she maintains accurate, succinct and contemporaneous records of the events that take place during a woman's labour (NMC 2005, NMC 2004b). These may be used in defence of the midwife's actions or inactions where current practice may be challenged at a future date. As a result, record keeping was seen to be an important part of the midwife's intrapartum care practice, such that attending to the woman's physical and psychological comfort was sometimes left to her birth partners, the student midwife or even the researcher. Should the woman make a request whilst the midwife was completing her records, the midwife's priority was usually the documentation. Common responses given by midwives were: *“I'll just finish my notes first.....”* or *“can you hang on a moment I need to write this down before I forget”*. To the woman in labour, record keeping was perceived to be more important than the midwife attending to the needs of the labouring woman and as a result the woman was unlikely to trouble the midwife again whenever she was updating her records.

Although midwives' use of the birth plan to discuss intrapartum practices with women varied considerably in the labours observed, in the interviews, they acknowledged that whenever consent to undertake any procedures was obtained from the woman it was more likely to be informed if there was reference to it on her birth plan. However some midwives also recognised that an existing written record, such as the birth plan, was not

necessarily acceptable on its own as evidence of the woman's willingness to consent to procedures. They acknowledged that they had a personal responsibility to ensure that the woman fully understood the implications of each and every procedure before they were undertaken and as Midwife 89 confirmed: *“the accountability ultimately rests with those performing the procedure.....”*

Should there have been a change in carer before the woman gave birth or the labour became complicated, midwives and student midwives were also more likely to acknowledge the importance of recording accurate details from earlier discussions where consent to procedures had been raised with the woman Typical comments being from Student Midwife 8 and Midwife 51 in respect of Case 42: a Local Government Officer:

- **Student Midwife 8:** *“Record keeping is an important role and responsibility for the midwife. As B (Case 42) didn't deliver on my shift, my records needed to be accurate to inform the next shift of what B and I had discussed and to what she had consented to before they came on duty.”*
- **Midwife 51:** *“When you take over the care of a woman, you rely on the accurate record keeping of colleagues.....The hospital birth plan had been filled in and signed, stating B's (Case 42) preferences: she had consented to having syntometrine.....It's still important to go through the records / birth plan yourself with the woman, to satisfy yourself that they have an understanding before actually going ahead with any procedure.”*

Where continuity of care with the one midwife was not experienced, midwives expressed criticism of their colleagues' record keeping should specific detail be lacking when they took over the woman's care at a stage where labour was advanced. In such circumstances, they felt they were unable to satisfactorily assess the woman's understanding and consequently were concerned about the validity of the woman's consent to any procedure they subsequently undertook as well as the threat of litigation should anything adverse occur to the woman and / or the baby. This is reflected in the interview extract from Midwife 57 concerning the intrapartum care of Case 48: a secretary:

- **Midwife 57:** *“..... it was quite difficult having to go over the same ground to discuss A's (Case 48) wishes for the delivery and gain informed consent to procedures at the late stage I became involved. She was in established labour*

and there was no birth plan.....There was a tendency to assume that consent had already been obtained as I was the third midwife looking after A but there's still the threat of litigation if anything happened to her or the baby so I shouldn't be complacent."

In comparison, where the same midwife had provided continuity of care during labour, caring for the woman from admission to transfer to the postnatal areas, during the interviews, these midwives acknowledged that this had a positive effect on their documentation and ability to gain informed consent to procedures. One midwife giving the information, checking understanding and obtaining consent was seen as the ideal scenario, such that they were fully aware of what had been discussed with the woman and to what she had consented without having to read over colleagues' records or repeatedly question her. These issues are highlighted in the extract from the interview with Midwife 76 regarding her care to Case 78, a Communications Assistant:

- **Midwife 76** expressed that *"providing continuity of care in this case was ideal as far as documentation was concerned. I'd discussed D's (Case 78) birth plan and knew exactly her wishes for labour and delivery. I was in a better position to try and fulfil them than if a colleague had taken over, should she have not delivered before I went off duty."*

In those cases where either midwives or women chose not to comply with certain policies, midwives were fully aware of their professional accountability and the importance of documenting the details of the discussion and resulting decision in the woman's labour records. If it was felt that the woman's decision could compromise her own health and that of the fetus, the midwife was observed to seek support from colleagues as in Case 32: a bank clerk, who requested that she did not want a blood transfusion or episiotomy:

- **Midwife 40** asks **Case 32** about her previous labour **Case 32** states it was OK despite having an episiotomy and forceps delivery as the baby got distressed. She also added that she needed a blood transfusion. **Midwife 40** then asks if **Case 32** would consent to a blood transfusion if she bled again.
Case 32: *"I'm not that happy to, unless I really have to. They messed it up last time.....The blood was contaminated with antibodies. I didn't have them before."*
Midwife 40: *"Usually the lab has very strict screening procedures regarding blood, but sometimes antibodies do appear. If it's a matter of life and death, I would urge you to have a transfusion....."*

Case 32: *“I’d rather not. It was horrendous last time. I also had to be re-stitched three months later and had a catheter bag for a few days afterwards. I don’t want to have another episiotomy either.”*

Midwife 40: *“It sounds as though you really went through it last time.....I will speak to Dr R (SHO 11) about you not wanting an episiotomy this time.”*

- **Midwife 40** was aware that the doctors had also written on the partogram “for elective episiotomy” which she thought was inappropriate and did not adhere to. *“Possibly a more junior midwife may have done.....I discussed episiotomy and blood transfusion with J (Case 32) but these were never warranted..... It’s important with invasive procedures that benefits to mother and baby are explained and documented, especially if the woman doesn’t give consent and decides on an alternative to the written policy or the doctor’s instructions.”*

It was discovered during the interviews that midwives recognised the importance of maintaining accurate records when complications developed in labour should anything adversely affect the health of the woman or baby. Concern was also expressed if little or no consideration had been given to the woman taking part in the decision making process concerning the management of the complication and as a result, interventions had occurred without informed consent. The threat of litigation was more of an issue in such cases. However, midwives did not always fully appreciate the significance of the records reflecting the extent of the woman’s involvement in making decisions as well as how her choices were subsequently affected by the development of intrapartum complications. The following annotated extract from an interview transcript with Midwife 65 involving the intrapartum care of Case 80 (a ward manager) highlights the extent of one midwife’s appreciation of the value of her record keeping where the labour had become complicated and the woman was no longer able to play an active part in making intrapartum decisions:

- **Midwife 65:** *“S (Case 80) had made a birth plan but it had been disregarded because of the complexities that had developed..... I couldn’t give S any opportunity to be active in making decisions about her labour when I took over I feel that it was totally unnecessary for Dr W (SHO 22) to do the V.E after Consultant B (CO2) to reaffirm that S wasn’t fully dilated. S had no choice: she was just told by Consultant B that Dr W was going to check the examination.....This wasn’t a midwifery case, but I’m still accountable. It was important that records were maintained as accurately as possible because of litigation. My colleagues S (Midwife 78) and K (Midwife 79) had written informative recordsIt was important to write on the CTG paper events as they occurred such as, fetal blood sampling, vomiting etc., and to make sure that times coincided with the records that I and the doctors wrote should there be a case for litigation.”*

5.5.2. Ethical Issues.

In addition to legal issues, another category from the data analysis concerning health professionals' awareness of their professional obligations regarding informed consent, involved ethical considerations. The findings from the study showed that although midwives had some awareness of the legal implications of informed consent, their knowledge and understanding of ethical principles was quite limited. The themes making up this category include: *Respect for Autonomy, Benefit or Potential Harm to the Woman and Baby* and *Standards of Practice*.

5.5.2.1. *Respect for Autonomy.*

Whilst the interview data found that the majority of midwives in the study generally respected that the woman should be an equal partner in making decisions about intrapartum care and the various procedures that may be involved, this was not always observed in practice. To what degree midwives empowered women to make such decisions was determined by the extent they were seen to share their knowledge and experience of intrapartum management and care with the woman. The following examples concerning the decision to suture the perineum following the baby's birth, compare the dialogue of a policy following midwife in Case 15, a housewife / cleaner, where the woman was given no alternative but to consent to the procedure, with that of an informing, enabling midwife in Case 26, a kitchen assistant:

- **Midwife 19:** *"It looks like you have a small graze. It will need suturing. It's only a small one: it's not bleeding that much, it will only need a stitch or two. I'll give you a local anaesthetic to numb it first: like at the dentist, OK?"*
Case 15: *"Yes."*
- **16:56: Midwife 31:** *"Right L (Case 26).....another thing to talk to you about is an episiotomy. I won't be doing one unless the baby's heartbeat falls. Because you've delivered a big baby (9lbs 13oz) before, the size of the baby wouldn't be an indication for an episiotomy. Would you mind me giving you a cut if I need to?"*
Case 26: *"Only if you really have to: I don't really want to have any stitches"*
18:33 (following the birth of the baby weighing 12lbs 7oz / 5640g).....
Midwife 31: *"You've got a small graze at the top and at the bottom, but they're not really bleeding that much, so no need to stitch them unless you want me to?"*

Case 26: *“That’s good: can you leave them alone then? Thanks.”*

Although some midwives attempted to encourage women to make decisions about their intrapartum care, it was observed that regardless of their willingness to communicate with the midwife during labour, or social class, women who demonstrated the characteristics of the ambivalent partner or reluctant recipient were unwilling to make decisions freely, and entrusted the midwife to do so on their behalf. Some women also found making decisions less important when coping with increased pain as labour advanced and decisions were left to the midwife as already illustrated by Case 4, a civil servant (page 176).

At the follow-up interviews, midwives also raised concern about the vulnerability of the woman in advanced labour and her increasing inability to exercise personal autonomy and refuse procedures, such as vaginal examinations, especially when undertaken by the authoritative figure of the doctor. These midwives not only recognised the implications this may have for the woman, the woman’s partner and fetus, but also the effect it could have their own autonomy and professional accountability. This is shown in the following annotated interview extracts with Midwife 90 and Case 96: a dance teacher who perceived this procedure to be part of the normal routine intrapartum practice of which she had no choice but to accept, especially as the male doctor was considered to be *“quite forceful”*:

- **Midwife 90:** *“I feel that Dr S (Registrar 20) and Dr D (SHO 27) did far too many vaginal examinations and never got L’s (Case 96) consent. They seemed to be constantly examining L to find out the position to decide how to deliver her..... I’d consider it to be assault. L didn’t object as she had an effective epidural and was unaware of what was actually happening: it became very impersonalised.By not respecting the woman’s autonomy and ability to make decisions, I can’t say that I protected L’s interest at the time. I’m also concerned about the effect of all these examinations on P (L’s partner).”*
- **Case 96:** *“the internals were done to check how I’d progressed and what the position of the baby was, I wasn’t really given a choice. Internals are a matter of course aren’t they? I mean they’re part of the routine procedure. I feel that Dr S (Registrar 20) was quite forceful and that I couldn’t refuse to be examined.”*

5.5.2.2. Benefit or Potential Harm to the Woman and Baby.

Not only do midwives and doctors have a duty to inform women of the personal benefits of intrapartum procedures, they also have a duty to disclose details of any potential harm or health risks that could result, so that the woman can make an informed decision. However, women in the study tended to be guided into making decisions about their intrapartum management, by the ethical principle of beneficence. It was observed that the midwife or doctor tended to disclose to the woman how the intended procedure would generally benefit her or the baby without always informing her of any risks. As a result, every woman in the study accepted the reasons given by the health professional for the procedure to then be undertaken. The following example from Case 21 a nursery nurse, also highlights the perceived benefits of technology that midwives and women became reliant on within the labour ward of this study.

- **Midwife 18:** *“I can’t really get a very good trace of the baby’s heart at the moment. It’s probably because the head is so well down and the baby is very active. Can I re-examine you and break your waters so I can attach a fetal scalp electrode and get a better tracing?”*

Case 21: *“That’s OK..... Is the heart OK?”*

Midwife 18: *“Yes, I’ve been listening in to the heartbeat and it’s fine, but the tracing is not very good because of the way the baby is lying. It’s important with an epidural we know what the baby is doing. I’ll try and be as quick as I can...”*

Case 21: *“Alright.”*

MIDWIFE 18 UNDERTAKES A VAGINAL EXAMINATION AND THEN AN AMNIOTOMY.

Midwife 18: *“I’ll just put the clip on the baby’s head now. You’re doing very well. You’re a good 4 cms dilated now.”*

ELECTRODE APPLIED TO THE FETAL SCALP: MIDWIFE 18 CONNECTS THE LEADS TO THE CTG MACHINE.

- **Case 21:** *“I was examined internally on a number of occasions to see what progress I’d made and so that K (Midwife 18) could break my waters and put a clip on the baby’s head to get a better tracing of the heartbeat.....I needed to have the trace because of the epidural, but I couldn’t have done without the epidural: the pain was too much before.”*

Women never refused a procedure if there was some possibility that by refusing, they may be endangering the life of their baby. However, in some of the labours observed, midwives and student midwives demonstrated the characteristics of the informing, enabling midwife and attempted to inform the women of any potential harm they personally may experience from a procedure. In the interviews with the women, where a

balanced argument had been presented involving both benefits and risks, there was generally a better understanding demonstrated of the importance of this element of intrapartum informed consent. This is highlighted in Case 13: a teacher, where the findings further demonstrate that some women were ambivalent and still wanted midwives to make decisions for them, especially as labour advanced.

- **Case 13:** *“I’m quite happy for them to be broken if it speeds the labour up.”*
Student Midwife 5: *“It’s not always necessary to break the waters. The membranes help to dilate the cervix. Once they’re broken, it speeds up the labour but it can be more painful.....”*
Case 13: *“Do you think I should have the membranes broken? Will it help the head to come down?”*
Student Midwife 5: *“Ooh that’s a difficult one. I’ve never experienced them being intact at this point before, but they’ve done such a good job, so I would leave them alone.....The membranes also help to cushion the baby’s head against the contractions and protect against infection.”*
- **Case 13:** *“.....I feel that K (Student Midwife 5) needed to be more decisive regarding my waters though, I know it would have speeded things up. They’d been broken each time before. I was worried about meconium (I had it in my last labour), and hoped the baby was all right..... I wonder if I should have had my waters broken earlier than wait for them to go on their own, although the pain was bearable whilst they were still intact. I wasn’t aware that the membranes also protect the baby from the pressure of the contractions and infection, until K told me.”*

Comparing the various specialities of doctors involved in the study, it was the anaesthetists who usually informed women of both the benefits and potential harm and health risks that epidural analgesia entailed in advance of them commencing the procedure. Nevertheless, for some women experiencing a pain-free labour was the main priority and any risk involved with the epidural procedure was of little significance. Consequently having been informed of the risks involved, no woman ever changed her mind and declined this method of pain relief.

In comparison, the obstetricians rarely discussed the risks of any of the procedures they intended to undertake and even when a consent form was used for operative procedures, seldom did the doctors discuss the potential health risks to the woman. Midwives tended to inform the women on the doctor’s behalf. Where women had perceived that an intervention had mainly affected their own health and morbidity, such as an episiotomy as a consequence of an instrumental delivery, they were more critical of the

obstetricians' lack of consideration informing them and seeking their approval as highlighted by Case 57, a switchboard operator:

- **Case 57:** “.....I ended up having a suction delivery by Dr A (SHO 9).....It wasn't until the other doctor (SHO 19) told me that I'd be stitched in theatre as well as have the afterbirth removed, that I was aware that Dr A had done an episiotomy: she never informed me of this before or at the time of the baby's birth. I was really upset when I found out.”

5.5.2.3. Standards of Practice.

During the observational stage of the study there was only one instance where the standard of practice demonstrated by one health professional was of major concern to other members of staff present. This involved a male doctor proceeding to undertake a ventouse suction delivery before ensuring the woman (Case 5: a secretary) had acquired analgesia. He totally disregarded the details in the records as well as Midwife 7's constant reminding that the woman had no analgesia. Midwife 7 recognised the potential harm that such an experience may have on the physical and psychological health of Case 5 and her husband that she sought further assistance from the labour ward co-ordinator and the female on-call registrar. After the shift ended, Midwife 7 also sought support from her supervisor of midwives should the couple make a formal complaint against the doctor. However, when interviewing Case 5 within 24 hours of the baby's birth, she was so pleased that her baby was healthy regardless of the actual birth to which she referred as: “*the worst part*”.

06:55: SHO 2: “.....I'll just do an examination to assess you and see”.

SHO 2 UNDERTAKES A VAGINAL EXAMINATION.

SHO 2: “We'll prepare her for a ventouse delivery.”.....

07:05: SHO 2 PREPARES TO APPLY THE VENTOUSE CAP ON THE FETAL HEAD. CASE 5 BECOMES INCREASINGLY DISTRESSED.

Case 5: “You're hurting me, C, he's hurting me.”

Midwife 7: “S has no analgesia, you know. What about a pudendal block?”

07:10: SHO 2: “It's OK. I'm just checking the position of the cap again.”

Case 5: “Stop, you're hurting me.”

SHO 2: “I'm just assisting you: only push when you have a contraction.”

S IS EXTREMELY DISTRESSED. MIDWIFE 7 USES THE INTERCOM TO ASK THE LABOUR WARD CO-ORDINATOR TO ORGANISE A PAEDIATRICIAN.

07:12: PAEDIATRICIAN 1 ENTERS AND GOES OVER TO CHECK THE RESUSCITAIRE. SHO 2 CONTINUES TO ATTEMPT THE VENTOUSE DELIVERY.

Case 5: *“Tell him to stop. He’s hurting me.”*

Midwife 7: *“What about analgesia? S has no pain relief.”*

07:15: NO RESPONSE FROM SHO 2. HE CONTINUES TO APPLY THE VENTOUSE CAP.

SHO 2: *“Can you switch on the suction?”*

Midwife 7 (uses intercom): *“Can Dr A (Registrar 2) come in here please?”*

07:17: REGISTRAR 2 ENTERS.

Registrar 2: *“What’s the history here? Just hold off the delivery for the moment.....”*

SHO 2 STANDS ASIDE. REGISTRAR 2 WASHES HER HANDS AND PROCEEDS TOWARDS CASE 5.

Registrar 2: *“I’m going to take the cap off the baby’s head first and then re-examine you. I’ll numb the area before helping you to deliver your baby. Is that all right?”*

Case 5: *“Yes, that’s fine thanks.”*

CASE 5 LOOKS RELIEVED AND SMILES.

- **Midwife 7:** *“.....The way Dr R (SHO 2) went ahead with the ventouse was inexcusable ignoring the fact that S (Case 5) had no pain relief: his communication was non-existent. It was my responsibility and duty of care to S to call Dr A (Registrar 2) to intervene. S was distressed and climbing up the wall in agonyHowever, Dr A did seek permission and tried to explain to S and C (S’s husband) what she was intending to do.....It was important that any concerns over the management were documented should the records need to be reviewed. I’ve arranged to speak to my supervisor to discuss my actions in the second stage. I hope S isn’t too traumatised by her first experience of labour.”*
- **Case 5:** *“.....I wanted to have further pain relief, but it was too late, I’d progressed too far at that point.....At the delivery, I was out of control and very tearful: I just wanted to give up. I’m really cross with myself for getting in such a state..... the delivery was the worst part: it was so painful. The male doctor (SHO 2) didn’t tell me what he was doing, or explain things to me to reassure me, or ask me for permission.The female doctor (Registrar 2) did explain she was injecting the local anaesthetic before she used the forceps, which was reassuring..... I’ve got a lovely healthy baby at the end which I’m so grateful for.”*

Having presented the findings pertaining to all three core-categories with their respective categories and themes that developed from the data analysis, the main issues are presented in the final section of the chapter.

5.6. SUMMARY.

To seek and obtain informed consent from the labouring women regarding intrapartum procedures was observed to be a difficult, if not an impossible, task to achieve by the health professionals in the study, especially if the woman was in advanced labour or the birth imminent. The main issues to arise from the study that affected intrapartum informed consent related to the labour ward culture, the quality of communication and the health professionals' awareness of their professional obligations.

The cultural environment of the consultant-led labour ward in which the study was undertaken is based on a medico-technocratic model where health professionals have the power of authoritative knowledge over the labouring woman. Women looked to the midwife in particular, to acquire information that would enable them to adapt to their unfamiliar environment, its routines and professional language. Although women were low risk at the outset of their labour they were all taken through the routine list of procedures that constituted the admission procedure and socialised them into a patient role that encouraged powerlessness and compliance. Rarely did the midwife offer any alternatives to any of these procedures and neither did the women refuse.

The extent that midwives and doctors disclosed their authoritative knowledge to women about the labour ward culture and the various intrapartum procedures they were expected to experience, varied from there being a full explanation of the benefits and risks to virtually no communication at all. Spending considerably longer with the woman in labour, the midwives were in a better position to develop a trusting relationship with the woman and demonstrate more effective communication skills than their medical colleagues. As a group of doctors, the anaesthetists were observed to communicate more effectively with the women and not only disclosed the benefits, but also the risks of epidural analgesia prior to obtaining consent from the woman. In comparison, few obstetricians discussed with the women possible options or risks of procedures they intended to undertake, including those associated with instrumental / operative procedures, even prior to the woman signing a consent form. These observations were regardless of the doctors' gender. Where paediatricians had been called to the birth to undertake resuscitative measures, they rarely communicated with

the woman or her husband / partner to inform them of their baby's condition. It was often the midwife who explained medical decisions to the women on their behalf.

Although three stereotypical roles of midwife emerged from the data analysis, the constraints of working within the culture of a medico-technocratic labour ward environment affected the extent that midwives were able to demonstrate the attributes of an informing, enabling midwife. This type of midwife appeared confident and more autonomous and was less likely to follow maternity unit policy and give women biased information based only on benefits as did midwives with the attributes of the policy following midwife or the biased informing midwife.

The degree that women communicated, dealt with information disclosed to them and played an active role in making decisions about their intrapartum management in this study did not necessarily relate to social class status. There were some women, such as the reluctant recipient who did not want to be empowered to make intrapartum decisions and looked to the midwife to do this on her behalf. In comparison to the stereotypical roles of the midwife that appeared to remain constant, the three stereotypical roles attributed to the labouring woman were observed to change as labour advanced and the woman became more distressed or when complications developed and medical intervention followed. Women who had originally demonstrated the attributes of an inquisitive decision-maker subsequently became either an ambivalent partner or a reluctant recipient.

A total of 51 birth plans were constructed among the women in the study who were mainly from social classes I, II and III. The extent they were used effectively to explore the woman's knowledge of intrapartum procedures and enable her to make decisions regarding giving / refusing consent varied and was dependent on the stereotype of the midwife and the stage of labour the woman was at. As the birth plan provided evidence regarding the discussions that had taken place and to which procedures women had already given consent, midwives and women recognised it had a value should there be a change of shift or the woman unable to articulate her wishes as labour advanced.

All midwives offered women some form of analgesia, but these were mainly pharmacological. Some women, regardless of social class, wanted a pain free and easy

labour that a medico-technocratic model of birth would offer and requested epidural analgesia. Although epidurals were perceived to have a positive effect on facilitating communication between the woman and midwife, they were also observed to be a controlling agent where the woman was more likely to experience further interventions.

Although midwives had some knowledge of the legalities of intrapartum informed consent that was mainly in respect of record keeping and litigation, their knowledge and understanding of ethical principles was less evident. As women never challenged the authority of medical decisions, for fear of endangering the life of their baby, obstetricians usually undertook procedures by implied consent. Furthermore, they sometimes continued with further procedures without informing the woman of the potential risks or gaining her consent and in so doing were causing trespass to the person. Midwives recognised the increasing vulnerability of the woman to exercise personal autonomy and decline procedures as labour advanced or when complications developed: in such situations the midwife often took on the role of the woman's advocate with medical colleagues.

Having provided a summary of the main findings from the study, the following chapter will discuss the study in the wider context, including the implications that the findings have for practice and the obtaining of intrapartum informed consent.

CHAPTER 6: DISCUSSION: THE DILEMMAS OF INTRAPARTUM INFORMED CONSENT.

6.1. INTRODUCTION.

In the light of the many publications produced over the past decade by the government and other agencies, that have been aimed at improving communication between health professionals and clients including gaining consent to procedures, and encouraging a multi-disciplinary collaborative team approach in the working and learning environment, it would therefore appear both timely and appropriate to have undertaken this particular study into intrapartum informed consent (DH 2003a, Universities UK 2003, DH 2001a, DH 2001b, DH 2001c, DH 2001d, DH 2001e DH 2000, DoH 1999, DoH 1998, DoH 1993).

Having already summarised the main findings pertaining to these core-categories in the previous chapter, this chapter will therefore discuss in more depth the key issues that have arisen and the possible implications they have on developing theory and practice in this area. Furthermore, an attempt will also be made to determine to what extent the aims (page 49) have been met by the study design. However, as the aims are interlinked into more than one of the key issues that have arisen from the analysis of the data, it is difficult to discuss them separately. The five key issues that have arisen and will be discussed in detail concern: *Culture, Authoritative Knowledge and Power, The Quality of Intrapartum Communication, Woman-Centred Care, Legal Perspectives of Intrapartum Informed Consent, and Ethical Perspectives of Intrapartum Informed Consent.*

6.2. CULTURE, AUTHORITATIVE KNOWLEDGE AND POWER.

This first section examines to what extent the culture of the labour ward environment affected the seeking and gaining of informed consent to intrapartum procedures and the empowerment of women to make their own decisions. Such detail will serve in addressing the first aim of the study.

6.2.1. Influences of Culture on Intrapartum Informed Consent.

The women in the study had very little experience, if any at all, of the hospital labour ward environment in which they were to give birth. There were some women, including middle class women, who expected that with the help of science and technology, they would have a pain free and easy labour. The degree to which they were already influenced by the western culture of a medico-technocratic birth that was evident in the labour ward of the study, could therefore have been a major contributory factor towards them giving their consent and generally accepting what was offered / done to them by the health professionals without question. Furthermore, women were neither familiar with, nor offered any alternative cultural model of birth.

The existence of policies and procedures set by the dominant group (predominantly medical) where doctors and midwives are seen to have the power to make decisions that others are expected to follow, reflect Lukes' (1974) first dimension of power. Such policies are generally imposed at a time when the labouring woman is at her most vulnerable and she is less able to exercise control and challenge such practices. When admitted to the labour ward, it was observed that every woman in the study complied with the midwife's expectations to undertake routine intrapartum procedures, such as electronic fetal monitoring and vaginal examinations. This observation supports the work of Machin and Scamell (1997) and Davis-Floyd (1990) where the hospital is seen as a socialising agent promoting patient conformity. For some women, this meant suppressing their own opinions and needs, as they did not want to cause any conflict in developing a good relationship with their midwife. Similar findings were also apparent in Edwards (2000) study of women planning homebirths. In those cases where the midwife felt bound by unit policy to refer the intrapartum management to the obstetrician because of a possible complication, the woman was even less likely to challenge the midwife's decision, or any further interventions that were undertaken by the doctor. Consequently these women became powerless.

Despite the DoH (1993) recommending that at least 75% women should know the person who cares for them in labour, in this study there were only two women who were cared for by their familiar community midwife. It could be assumed that the experience

of an unfamiliar carer may affect the development of a trusting relationship between midwife and woman. However, the midwives attempted to develop a trusting relationship with the women during labour and empower them to make intrapartum decisions (Yearley 1997), but the constraints of the labour ward environment often limited their ability to do so and practise autonomously. As a result, the midwives generally followed rules and routines that were common to the processing of patients in hospital, such as undertaking the rituals of the admission procedure and vaginal examinations every four hours (Bergstrom et al 1992). Rarely was Leap's (2000) approach of "the less we do, the more we give", adopted by the midwives in the study as they, and the obstetricians, were more inclined towards their societal imperative to always be doing something as recognised by Anderson (2002) and Enkin (1992). Midwives who attempted to offer a more holistic approach, involving the woman in making her own intrapartum decisions, such as Midwife 2, or women who wanted to give birth without intervention, such as Case 2 and Case 41 (who were the only two women to experience a physiological third stage of labour), could be considered deviants in terms of not conforming to the accepted norms of the labour ward being studied (Sookhou 2003).

6.2.2. Power and the Gate Keeping of Information.

In order for women to adjust to the labour ward environment they looked to the health professional, who was mainly the midwife, to acquire information about what to expect and how their labour was progressing, especially in relation to knowing when to request analgesia. However, the processes that are involved when women make decisions regarding their intrapartum care are complex with the midwife being in a powerful position to influence the decisions that women make (Levy 1999).

The second dimension of power according to Lukes (1974) concerns the control of the agenda of what may be discussed and consequently what decisions may or may not be made. Edwards (2000) recognises that midwives may be perceived to possess power by the virtue of their authoritative knowledge of childbirth as well as their status as practitioners within the health services' hierarchy, with the underlying assumption that they know best. Although Lazarus (1997) claims that medical knowledge is unequally distributed and connected to matters of power and control, midwives in the study

appeared more willing to share their knowledge with women regardless of the woman's social class, than did their medical colleagues. As far as the situation allowed and whilst they perceived they had some control, women felt they had received sufficient information to contribute to the decisions made about intrapartum care and procedures and generally stated that they could not have coped with any more information. Should this control be reduced along with their ability to make decisions when labour advanced quickly or developed complications, a trusting relationship where there was a good understanding of the woman's choices and preferences enabled the midwife to more easily take on the role of advocate. However not all women wanted to be empowered to make their own intrapartum decisions and looked to the midwife / doctor to do this on their behalf. This finding was evident among women of different social class status, including those from the middle to upper classes, in contrast to what others studies, such as those by Green et al (1998) and McIntosh (1986) had previously found.

Language is recognised as the filter through which experiences are interpreted and expressed (Davis-Floyd and Sargent 1997). To the labouring woman giving birth within a hospital labour ward where the language is hegemonically technomedical that only the health professionals understand and control can further reinforce the inequalities of power. Where professional discourse existed in the study this was usually between the obstetrician and midwife when management of complications were being discussed, often at the exclusion of the woman. Consequently, it was either left to the midwife to offer an explanation or the woman to seek further information herself. Although the dialogue that midwives had with women appeared to be less technical than that of the doctors, there appeared to be limited opportunities for women to be encouraged to talk about their birth in any other terms but medical. Information disclosure and the seeking of consent to intrapartum procedures further emphasised the professional discourse women were likely to experience in the hospital setting.

In many instances, as Fraser 2002, Kirkham and Stapleton (2001) and Levy (1998) had also discovered, information was given in such a way as to steer women into making decisions that were more in line with the midwives' views, such as choice of pain relief or amniotomy. However, women recognised the midwife as having the expert knowledge, skill and judgement in making appropriate intrapartum decisions, those women who appeared to have developed a trusting relationship with the midwife were

more inclined to openly ask the midwife for her own opinion: “*What would you do?*” “*What do you think: you’re the expert?*” As a result, this opened the gate to more dialogue with the midwife and increased information disclosure.

The midwives’ gate keeping of information was sometimes seen as benevolent, intending to protect the woman from unnecessary worry or distress when complications developed during labour. Despite readily informing the woman of their intention to summon medical assistance, they did not always fully inform the woman of their concerns and the potential implications it could have for her, her labour and her baby.

Where obstetricians became involved in intrapartum management, very few were observed to fully explain the true extent of the situation to the woman, nor give her any opportunity to discuss possible options and seek her opinion in making decisions. Similarly, paediatricians appeared to generally ignore the parents when attending to the baby at the time of birth and neither explained their function or the subsequent condition of the baby, to the parents. This supported the claim by CESDI (2003) and Dyas and Burr (2003) that medical staff generally possess poor communication skills due to limited training in communication skills development. It was therefore left to the midwife when faced with these situations to decide whether or not she should inform the woman of the doctors’ decisions / actions.

In comparison, anaesthetists attempted to communicate and explain the epidural procedure to the woman themselves. They enquired more about the woman’s knowledge and understanding and gave specific detail of the effects of epidural analgesia prior to commencing the procedure that also encouraged the woman to seek further information if necessary. At the follow-up interview, the majority of women who had chosen to have an epidural for pain relief demonstrated a good level of understanding of the possible effects they may have experienced as a consequence. The study by Swan and Borshoff (1994) also found that a number of women had acquired some knowledge of epidurals prior to labour from various sources, including Preparation for Parenthood classes, which may have contributed to improving their overall level of understanding. In addition, Kirkham and Stapleton’s (2001) study found that women who had accessed the *Informed Choice Leaflet on Epidurals* (that included the possible side effects and problems of epidurals), felt it was a valuable source to

increase their knowledge and enable them to make informed decisions about this type of analgesia, especially in situations where health professionals omitted to give such detail.

In those cases where medical intervention became necessary, some midwives expressed that they felt personally disempowered by the attitude of their medical colleagues, especially male doctors. As a consequence, these midwives were less able to empower women to exercise choice and control: an observation supported by Jamieson (1994). This also reinforces the work undertaken on the power relations between doctor and nurse in the hospital setting (Stein 1967, Stein et al 1990, Porter 1991), of male dominance over female passivity. Although the doctors in this study were predominantly male, the gender distribution of the obstetricians was more evenly spread. Having been socialised through their training into the traditionally male-dominated medical profession where the culture is one of technology and intervention, the female obstetricians appeared to exert the same dominance as their male counterparts over the labouring woman when undertaking intrapartum procedures.

6.3. THE QUALITY OF INTRAPARTUM COMMUNICATION.

One of the key issues surrounding informed consent as Ralston (1994) purports, is the effectiveness of communication between health professionals and the labouring woman. This fact would also endorse the high priority given to good communication skills by other authors such as Dyas and Burr (2003), Fraser et al (1996), Kirkham (1989), McIntosh (1988), Kirkham (1987) and MacIntyre (1982). Consequently, the study aimed to determine the factors that influenced midwives' and doctors' communication with women during labour and to explore how consent to intrapartum procedures was obtained. It was therefore essential that in order to be part of the study, the woman was able to speak English. In the one case where Punjabi was the first language, the woman had demonstrated during the antenatal period that she had the ability to converse in English sufficiently to not require the assistance of an interpreter, and so was included in the study.

6.3.1. Midwives' Communication Abilities and Stereotypes.

For all but two midwives in the study, the first encounter with the woman was during labour. As Kirkham (2000) claims it is difficult for a relationship to develop between the midwife and woman when maternity care becomes fragmented, this was also observed within this study. It is therefore important that midwives possess good communication skills and make the best they can of their usually brief relationship with the labouring woman in order to seek and obtain informed consent to intrapartum procedures. In comparison, to their medical colleagues, midwives demonstrated better communication skills which was to be expected as it is usual for there to be continual presence of a midwife for the entirety of labour to assist in putting the woman at ease and develop a trusting relationship.

Few midwives used open questions to investigate how much the women actually understood about labour and intrapartum practices. Furthermore, the majority of midwives lost valuable opportunities to explore the woman's knowledge and understanding as only a few recognised the non-verbal cues and body language of the woman as a need for more detail or clarification. However, although Leap (2000) also recognises the importance of midwives recognising the overt and covert clues from women in order to relate appropriately to them (i.e. 'cluefulness'), Kirkham (2000) suggests that professional pressures can often prevent midwives who have these skills from being 'cluefull'.

Three stereotypes of midwives were observed throughout the course of the study in terms of how midwives communicated with the woman in labour: *the policy following midwife*, *the biased informing midwife* and *the informing, enabling midwife*. Where midwives had been observed in providing intrapartum care to more than one woman in the study the stereotype that was attributed to them with the initial case, was rarely seen to change in subsequent cases.

The culture of the labour ward supported the policy following midwife, although midwives tended to possess the attributes of the biased informing midwife. To a degree there were some similarities of this stereotype with Fraser's (2002) work that explored the learning environment for students on the labour ward. She had also found

that some midwives disclosed information in such a way so the woman was likely to choose the midwife's preferred option. In comparison, although there were some midwives who demonstrated the attributes of the informing, enabling midwife, the constraints of the hospital labour ward with its overarching expectation of compliance to routines, affected the extent that these midwives were observed. These midwives however, displayed some flexibility in the language they used in order to empower women regardless of their social background in contrast to the findings of other studies in this area, for example those conducted by Hunt (2004), Green et al (1998) and Kirkham (1987).

In those labours where student midwives were observed, the type of stereotype they demonstrated tended to reflect the attributes of their midwife mentor. This observation supports much of the work undertaken by other authors on role models such as Bluff (2003), Chartres (2000), Spouse (1998) and McLeod et al (1997) regarding students emulating their mentors, including both positive and negative traits.

6.3.2. Limitations of the Doctors' Intrapartum Communication.

Within the context of this study the situations in which obstetricians and paediatricians were faced with, were with a clientele that was essentially low risk and not the high risk pregnancies and sick neonates to which they are usually accustomed. These doctors were therefore expected to make clinical decisions where any previous contact with the woman was either very limited or non-existent. Furthermore, their involvement with the woman's management and care was often at a time when labour was advanced, and so it could be expected that communication with the woman and obtaining informed consent may prove difficult.

6.3.3. Woman's Intellect, Communication Ability and Stereotypes.

Perceiving the woman's intellect and assessing her communication ability was not only difficult for the midwife to do when first encountering the woman in labour on the labour ward, it was also very subjective. Midwives tended to assume that a woman who had experienced childbirth previously was more knowledgeable than a primigravida and

as a result, the extent of information disclosed to the multigravida was often reduced. This was also an observation made by Kirkham and Stapleton (2001) in their study of the Informed Choice leaflets. Although Garcia et al's (1998) study into women's views of maternity care had found that staff limited their explanations to women from lower classes or different ethnic groups as they perceived they would have difficulty in understanding, this was not the case in this study. However, midwives expressed that they had difficulty in assessing the extent of a woman's understanding should she become less communicative as labour advanced. This subsequently led to information disclosure and explanations of procedures sometimes being reduced to women across the range of social classes and the development of the three stereotypes of the labouring woman that emerged from the study.

The three stereotypes: *the reluctant recipient*, *the ambivalent partner* and *the inquisitive decision maker*, related to how women were observed to deal with the information disclosed to them and subsequently make decisions about their intrapartum care. The stereotypes appeared to also have some correlation to three distinct presentations of the midwife. However, unlike other studies that have examined stereotypes, such as Green et al (1998), McIntosh (1986), Nelson (1983), and Ounstead and Simons (1979), the degree that women communicated and played an active role in making decisions about their intrapartum management in this study did not necessarily relate to social class. As labour progressed or developed complications and consequently affected the woman's ability to make decisions, her initial stereotype was observed to change, such that had she initially demonstrated the attributes of the inquisitive decision maker, she then took on the stereotypical role of either the ambivalent partner or the reluctant recipient.

Where women appeared reluctant to enter a dialogue with midwives and ask questions about their care and management, midwives expressed concern regarding the impact this could have on them obtaining consent that was informed. Midwives did not always appreciate that this reluctance may be due to their own communication ability and attitude, and not necessarily the woman's. It was found that a woman was less likely to initiate any conversation or ask questions if the midwife appeared unfriendly or pre-occupied with other things, such as her record keeping, and unreceptive to questions. These findings would also concur with the studies undertaken by McKay and Smith (1993) and Kirkham (1987) in which they discovered that the woman was less likely to

initiate any dialogue or ask any questions if she perceived the midwife to be too busy and unwelcoming. Whenever medical staff became involved in intrapartum care, the woman's reluctance to engage in conversation with the doctors became even more evident.

In keeping with the medico-technocratic model of birth, 31 women in the study chose to have epidural analgesia for pain relief during labour. Although midwives providing the intrapartum care for these women recognised that this form of pain relief had a positive effect on facilitating communication between the woman and midwife, it could also be perceived as a further technological means of ensuring women are "controlled" in labour and "*more easy to manage / look after*". Should midwives promote epidural analgesia as a means of improving communication with the woman, as Walters and Kirkham (1997) also warn, there is a danger that they will eventually lose the ability to empower women to acknowledge that their bodies are capable of experiencing labour without using such invasive means as an epidural. While women continue to believe they are incapable of experiencing labour and birth without the aid of medicine and technology, epidurals will remain at the forefront of their childbirth requests.

6.4. WOMAN-CENTRED CARE IN A MEDICAL MODEL OF BIRTH.

Despite the study being undertaken on a labour ward whose culture was essentially based on a medical model, midwives were observed in attempting to provide woman-centred care as best as they could within such limitations. Fundamental to providing intrapartum care that is woman-centred is the expectation that the woman is respected as an equal partner in making the decisions about her care as identified by the Report of the Expert Maternity Group: Changing Childbirth Part 2 (DoH 1993). In order to achieve this, the woman should be given unbiased information so as to be fully informed about the procedures she is likely to experience in order to either express her consent, or refuse them. These elements are consequently reflected in the aims of the study. To some extent the fulfilling of these aims was assisted by the use of birth plans and the consideration given by midwives to their content as far as focussing on the woman's needs and respecting her choice and subsequent decisions as far as intrapartum informed consent was concerned.

6.4.1. Facilitating Information Disclosure.

Midwives in the study recognised that it was not an ideal time to disclose information and seek consent to procedures when women were in labour and consequently this aspect of their role was affected. Leap (2000) also realised that there are situations in which no amount of information will clarify the decision process for women. As found in the study, and concurring with Kirkham (2000), midwives appreciated that for some women, (such as the ambivalent partner) to weigh up the options and make informed decisions may be extremely difficult, especially if this is not apparent in the rest of their lives. It is therefore a challenge for the midwife to enable women to face such dilemmas.

Very few midwives in the study appeared complacent with their current practice, as the majority recognised there was a need to further improve their information disclosure, particularly in giving non-biased information. As the study progressed an increasing number of midwives disclosed that by taking part in the study they had begun to critically assess their communication skills in labour and their practice of obtaining consent to procedures that could be considered an unexpected positive outcome of the overall study. If midwives and other health professionals are to improve information disclosure to women as recommended by DH (2000) and DoH (1999, 1998) then they need to be more questioning of all pregnant women regardless of parity and previous experience, in order to evaluate existing sources of pre-labour information, such as the “Informed Choice Leaflets” (Kirkham and Stapleton 2001). They would then be in a better position to develop appropriate information and educational strategies to meet the needs of the local population that in turn could assist in obtaining consent to procedures (DH 2001c).

6.4.2. The Value of Birth Plans.

The introduction mid-way through the study, of a standard labour ward birth plan along with client-held antenatal records that contained a birth plan on the back cover, may have been an influence on the number of birth plans subsequently completed either prior to, or during labour. However, midwives believed the labour ward environment was not

the ideal place to discuss labour options and formulate a birth plan as there is a limit on time available to discuss issues fully: as also found by Too (1996). As a consequence, in the study, a birth plan was completed in a total of 51% cases with very few (17%) being undertaken in labour. Although these findings were an improvement on those acquired by Jones et al's (1998) study, they did not match those of Whitford and Hillan's (1998) study where a total of 77% women had completed a birth plan prior to labour. However, the latter results reflect a sample that consisted mainly of older and more affluent women. Whitford and Hillan (1998) also suggested that another explanation for the high completion rate of birth plans is that some midwives perceive it as a tool for obtaining consent to procedures. The attitudes that some women had towards birth plans which ultimately affected their decision to formulate one, were similar to what Green et al's (1998) study had also discovered, for example the birth plan being totally ignored by the staff and therefore deemed pointless or "*going to pot*" by the turn of events and the development of complications in labour.

Whilst an existing birth plan would indicate that the woman had some understanding of the birth process and had considered some of the issues pertaining to intrapartum care and management prior to the onset of labour, the extent that the woman's birth plan was discussed in labour was variable. In part this depended on the stage of labour the woman was at when first admitted to the labour ward. However as Green et al (1998) and Whitford and Hillan (1998) had also found, not all midwives in the study effectively used the birth plan to explore the full extent of the woman's knowledge and understanding, with some midwives simply reading it and then filing it in the labour records with little / no discussion at all. In comparison, when a birth plan was formulated in labour, providing there was adequate time, there appeared to be improved communication between midwife and woman and more discussion of options available. As a result these women felt valued by the midwife in that they had been able to take an active part in making decisions about their care. Furthermore, when complications developed, or decisions had to be made in a hurry, providing the woman was still considered central and kept informed of any decisions that were subsequently made, the majority still felt valued by the midwife even though their birth plan was unable to be fulfilled by the turn of events.

When there was a shift change during the labour, midwives taking over the woman's care valued the birth plan as a means of not only identifying which procedures had already been discussed but also to which procedures consent had been obtained from the woman by colleagues (Nolan 2001, RCM 1997). Some midwives recognised that a birth plan was not sufficient on its own and that they had a personal responsibility to ensure the woman fully understood the implications of each and every procedure before they were undertaken. This could sometimes prove difficult for the midwife should the woman be in advanced labour when the care was taken over.

In some instances, the use of the birth plan in labour served in improving communication between midwife and woman and to some degree enhanced choice and control (Green et al 1998, Whitford and Hillan 1998, Kitzinger 1987 and Jackson 1986). The format of the two birth plans introduced in the locality however, were completely different. Whilst the birth plan on the back of the client-held records was originally left blank for the woman to complete upon discussion with her community midwife, the labour ward birth plan consisted of a menu of options including the current labour ward practices / routines. Although the latter style of birth plan has been viewed in the literature as another form of coercion in the guise of choice, Price (1998) has suggested that using a pre-set format could offer a more realistic approach to planning a woman's birth where the labour ward culture, such as the one in this study, is based on a medico-technocratic model and true choice is not available to women. Until there are real maternity care options available for women in this area, as requested by the DH (2003b), women are unlikely to be able to plan anything other than a medical birth.

The third aim of the study intended to investigate midwives' and doctors' knowledge and understanding of informed consent from a professional perspective, including medico-legal and ethical issues and will be examined in the light of the findings within the following two sections.

6.5. MEDICO-LEGAL PERSPECTIVES OF INTRAPARTUM INFORMED CONSENT.

Throughout the study, the extent that health professionals demonstrated knowledge and understanding of the legal principles surrounding intrapartum consent in their clinical practice was particularly variable and limited in the majority of cases. This was also reflected in practice when the midwife or doctor undertook procedures on the labouring woman and is discussed through the following sections.

6.5.1. Trespass to the Person.

When routine intrapartum procedures, such as vaginal examinations, or procedures that were considered familiar to the woman as they were also part of antenatal care, such as abdominal examination, were contemplated, the midwife and obstetrician, undertook the procedure with little or no discussion with the woman. The study found that the procedure was simply announced and then carried out, with the health professional assuming that the woman's silence implied her consent. These findings would also concur with those of Bergstrom et al's (1992) observational study of vaginal examinations that was undertaken during the second stage of labour. In comparison, where a procedure was not considered part of the routine intrapartum care, such as amniotomy (Henderson 1991, NCT 1989) and the even less frequently practised episiotomy (Barwise 1998, Way 1996, Kitzinger 1986, Sleep et al 1984) midwives appeared to disclose more information to the woman before obtaining her express consent. However, the occasions when discussion took place concerning episitomes were rare, as midwives perceived this procedure as an emergency and mainly in the context of assisted deliveries. As a consequence the practice of midwives undertaking episiotomy was seldom observed. They also raised the issue of litigation more readily during the follow-up interviews. However, very few midwives had any appreciation of the legal principle pertaining to trespass should they have not fully informed the woman of the procedure they intended to undertake or gained her prior consent. They neither recognised that a woman would be entitled to compensation should any physical or psychological harm result and she had not given her consent to the procedure (MDU 1996, Clement 1994, Menage 1993).

Some health professionals (mainly obstetricians), not only undertook the procedure for which consent had been implied, but also continued to undertake further procedures without fully informing the woman of the possible consequences or gaining her consent: for example, vaginal examinations followed by an amniotomy / application of a fetal scalp electrode. To a certain extent, these observations reflect similarities to the results of Coldicott et al's (2003) study concerning medical students, awareness of their legal and ethical responsibilities when undertaking intimate examinations, such as vaginal examinations.

In this particular study, permission to undertake a procedure by a student was always obtained in advance, be it by the supervising midwife or the student themselves, as the need for students to learn skills in undertaking clinical examinations is well recognised (Hennigan et al 1991). The more knowledgeable and experienced the student midwife, the more she personally sought the woman's consent. In comparison, the few medical students (7) and student nurses (2) who were involved in the study, sought consent from the woman to attend the labour and birth, but the extent to which they participated and undertook procedures was very limited, consisting mainly of assessing the woman's temperature, pulse and blood pressure.

Regardless of using their own professional judgment and assessing the individual woman's risk for haemorrhage, midwives tended to follow the maternity unit policy and administer syntometrine in 93% cases in the study (in a further 5% the administration was not observed as these women gave birth in the operating theatre). This demonstrates the restrictive influence policies and procedures can have on both inhibiting the woman's choice as well as limiting the midwife's autonomy (Marshall and Kirkwood 2000, Garcia and Garforth 1989). Although midwives expressed anxiety about giving women biased information regarding the administration of syntometrine, they were more concerned about the actual practice of obtaining the woman's consent should they be the one administering the drug. It was common practice within the maternity unit for a second midwife to be called during the second stage of labour to administer the injection. Consequently, they were unable to gain the woman's consent themselves at such a late stage and had to trust their colleague's integrity that it was appropriate to proceed with the injection. During the follow-up interviews, although the majority of

women felt that they had been given some choice by the midwife regarding syntometrine, they were not always fully aware of any side effects nor were they always able to recall the drug being administered, which also bears similarities to Green et al's (1998) findings. Nevertheless, although the women raised no issues concerning trespass to the person as far as the midwife's intrapartum care was concerned, the administration of syntometrine and gaining consent does require review. It is important that the vulnerability of the midwife administering the drug where consent may not have been overtly expressed by the woman, be reduced particularly should an adverse reaction consequently occur and trespass to the person be challenged.

6.5.2. Written Consent.

A written consent form was signed by a minority of seven women in the study for the obstetrician to proceed with operative procedures such as caesarean section or manual removal of placenta. The extent that the doctors informed women of such procedures, including the risks, was extremely variable and reflected to a certain degree Coldicott et al's (2003) investigation of medical students seeking and gaining of consent to intimate examinations. By failing to provide sufficient information, the doctor would be seen to be in breach of his / her duty of care to the woman (Dimond 2003).

Since the data collection was completed there have been new consent forms issued within the local hospital that comply with the government guidelines as defined by DH (2001c, 2001d, 2001e) that further endorse the professional guidelines issued by the BMA (2001) and MDU (1996). Such forms should not only help doctors in improving standards by eliminating any misinterpretation and ambiguity concerning more invasive procedures that carry a degree of risk, but also define alternative procedures to that which the written consent is obtained. Had the new consent forms been available at the time of the data collection, there would have been less risk of one woman consequently being upset that she had not had the caesarean section to which she had given her written consent (page 192). Applying the "reasonable patient test" (Heneghan 1996) and the Bolam principle (Bolam v. Friern Hospital Management Committee 1957) alternative methods of delivery should have been disclosed and discussed with the woman at the time the consent form was signed in order to avoid such an experience.

6.5.3. Teenagers.

As identified in the Social Exclusion Unit Report (1999), the UK has the highest rate of teenage pregnancy in Europe, which consequently has implications for all midwives in terms of them providing maternity care within the legal parameters, especially in the context of informed consent. Although the midwives who provided intrapartum care for the 11 pregnant teenagers (15-19 years) in the study appreciated the difficulty in assessing the girl's level of understanding, not all were fully conversant with the legal precedent of "Gillick competence" for assessing the understanding of girls under the age of 16 years (Gillick v West Norfolk and Wisbech AHA 1985). However, they did identify that those teenagers aged 18 years and over are legally considered to be competent adults and capable of giving consent.

Midwives were sometimes faced with teenagers who had acquired very little knowledge of childbirth (if any at all) in advance of labour, especially if the pregnancy was concealed, which further affected obtaining the girl's informed consent to undertake intrapartum procedures. They therefore felt it was important to keep the girl's birth companion informed about intrapartum care and procedures, be it her mother or boyfriend, and document their discussions in the labour records especially if the girl was reluctant to communicate. As Dimond (2002) stresses, all health professionals have a duty of care to the child and decisions concerning intrapartum management and care should always be made in the child's best interest.

The introduction of the Sure Start initiative in 1999 has meant that there are now specific midwives identified to work with pregnant teenagers in order to educate them about childbirth and develop their confidence and skills to become a competent mother (Sure Start Unit 1999). However, as this scheme was not in operation at the time the study was undertaken, none of the teenagers were able to gain information about labour from such a source that could have assisted health professionals in the process of obtaining intrapartum informed consent.

6.5.4. Record Keeping.

Working within the consultant-led labour ward, with its medico-technocratic model of care, (Machin and Scamell 1997, Davis-Floyd 1990), midwives recognised their responsibility in relation to intrapartum record keeping according to the NMC (2005, 2004b), Dimond (2002), RCM (1997). However, this was within the context of it being used in defence of a midwife's or doctor's actions / omissions in cases of litigation. Midwives also appreciated the importance of the labour records reflecting management decisions whenever faced with challenging situations that could consequently affect the health of the woman and / baby and were particularly concerned if obstetricians had made decisions and interventions had occurred without the woman's consent.

Record keeping was often observed to become the midwife's priority over attending to the woman's needs in labour and was another factor affecting intrapartum communication. As women perceived the midwife to be too busy, they were less inclined to initiate conversation or ask her any questions which further supports the studies of intrapartum communication by McKay and Smith (1993 and Kirkham (1987). When labour was less challenging and progressed without any problem the significance of the records showing to what extent the woman had been involved in making decisions about her care was not as evident.

6.6. ETHICAL PERSPECTIVES OF INTRAPARTUM INFORMED CONSENT.

From the data obtained, it would appear that the midwives were even less knowledgeable of the ethical implications of informed consent than the legal issues. In order to address this particular aim of the study, the level of knowledge and understanding that the health professionals demonstrated in respect of intrapartum informed consent from an ethical perspective, will be discussed in the following section.

6.6.1. Respect for Autonomy.

The majority of midwives recognised that the woman should be an equal partner in making decisions about her intrapartum care and management (DoH 1993). The degree that midwives empowered women to be autonomous was dependent on their conformity to a medico-technocratic model of birth that subsequently had some effect on the extent that authoritative knowledge was disclosed and the willingness of women to actively participate in making decisions. As labour progressed, some midwives were aware of the woman's increased vulnerability to exercise personal autonomy and refuse a procedure, such that they became more cautious and concerned regarding consent issues. This was even more apparent when obstetricians were involved in decision making.

The more autonomous and assertive the midwife was to challenge obstetric practice, such as vaginal examinations, the more successful she believed she was in being a true advocate for the woman. The way in which midwives attempted to achieve their aims for the woman sometimes emulated the much documented work of Stein (1967), Stein et al (1990), where the midwife made the obstetrician believe the decision was his idea. Where midwives felt unable to take on such a role, or the doctor ignored their request, they believed that as their own autonomy had not been respected, they had failed the woman, her fetus and her partner. Lazarus (1997) suggests that some women may in fact welcome medical intervention and want all the technology made available to them and thus their acceptance is based on a cultural need rather than submitting to physical pressures. It is therefore important that midwives also recognise this fact whenever they are contemplating undertaking the role of the woman's advocate as their intervention may be inappropriate to what the woman actually wants.

6.6.2. Beneficence and Non-Maleficence.

In addition to some women in the study being influenced by the western culture of a medico-technocratic model of childbirth, such that they accepted what was offered / done to them, they were also guided by the ethical principle of beneficence when making decisions in labour. This was because health professionals tended to disclose

more openly how a procedure would benefit the woman or her baby, and as a result the woman accepted such reasons and consented to the procedure. There appeared less likelihood of a woman refusing a procedure if there was any possibility she may be endangering the life of her baby, even if it could ultimately affect her own health and well-being, such as an episiotomy. Very few midwives and obstetricians were observed to also inform women of potential risks involved with a procedure and consequently offered the woman other options. Thus, women in the study were not always in a position to give valid informed consent. In comparison, anaesthetists were generally observed to inform women of possible risks of epidural analgesia prior to commencing the procedure, according to “the reasonable patient test” (Heneghan 1996) and the Bolam principle (Bolam v Friern Hospital Management Committee 1957). Given this information, and being influenced by medical ideology, not one woman in the study, was seen to change her mind from choosing such pain relief as all they wanted was their pain suppressed.

6.6.3. Intrapartum Complications.

In those cases where complications developed and the midwife sought assistance from the obstetrician, women appeared to trust the judgment of the midwife and doctor and providing their baby’s interest remained paramount, they were not unduly worried. Riley’s (1977) study had also found that women felt relieved, grateful and generally positive after the safe birth of a healthy baby. However, this finding should not make health professionals complacent about their intrapartum care practices as obstetricians in particular, were seen to abuse this trust by undertaking invasive procedures without informing the woman and seeking her consent. In those cases where this occurred and both the woman and midwife appeared reluctant to challenge obstetric decisions, should any harm result, the doctor could potentially face both the legal and ethical consequences of such actions (Dimond 2003).

6.6.4. Standards of Practice.

Whilst it was never intended that the observational stage of the data collection would serve as a means of critically assessing standards of intrapartum care of all those health

professionals who participated in the study, as a professional (and a midwife) having a duty of care towards others (NMC 2004a, 2004b, Estroff and Churchill 1984), this was sometimes hard to avoid (Rees 2003). There was only one instance where there was such an ethical dilemma. This involved the doctor attempting to undertake a ventouse suction delivery without addressing the woman's lack of pain relief beforehand. In such situations such as this, the midwife has a duty of care towards the woman and her baby and appropriately summoned further medical assistance in order to prevent any further harm (NMC 2004a, NMC 2004b). When interviewing the woman within 24 hours of the baby's birth, there was little mention of the actual birth, apart from her referring to it as "*the worst part*". The woman was so overjoyed that her baby was healthy regardless of the birth. This would further support the findings from Riley's (1977) work regarding women's experience of childbirth and that of Fleissig (1993) where women were less critical of the overall care they received if their baby's health was not affected. Where there has been a difficult birth, it is important for midwives to offer women the opportunity to talk over their experience at a later date should they wish, in order to reduce any psychological trauma that could exist as a result of such an experience.

6.7 SUMMARY.

This chapter has considered the findings from the study and discussed them within the context of five key issues that consequently developed and have significance to the practice of intrapartum informed consent. Through the discussion, there has also been reflection on the study's initial three aims to ensure that an ethnographic approach was appropriate in fulfilling their intent.

CHAPTER 7: THE WAY FORWARD.

7.1 INTRODUCTION.

Having discussed the findings of the research study, this final chapter will present the conclusions by first of all assessing the strengths and limitations of the research methodology, bearing in mind that no study whether qualitative or quantitative in approach is without limitations (Rees 2003). Through the theoretical perspectives that have developed from the analysis of the observational field notes and interviews, the implications that these have for practice will then be discussed. Appropriate recommendations are finally made that could improve the process of obtaining informed consent to intrapartum procedures by all health professionals concerned. These recommendations will be disseminated to both maternity service and education providers at local and national level through subsequent publications and oral presentations generated from the findings of the study.

7.2. STRENGTHS AND LIMITATIONS OF THE STUDY.

7.2.1. Choice of Methodology.

To undertake this study into intrapartum informed consent, an ethnographic approach using elements of both interpretive ethnography and critical / feminist ethnography was adopted (Muecke 1994). This was in order to discover the meaning of social interactions between health professionals and women whilst focussing on the power distribution within the culture of a hospital labour ward. Such an approach can be considered appropriate as all but one aim have been fully met: investigating the doctors' knowledge and understanding of informed consent from a legal, ethical and professional perspective. As the findings that have been presented could consequently enhance the social interaction and communication and foster emancipation and empowerment of women and midwives within the labour ward setting, to have used a classical ethnographic approach as defined by Melia (1982) that never intends to improve, challenge, change, question or criticise what is observed, would have therefore been unsuitable.

Through adopting an ethnographic approach using participant observation and interviews, it has been argued that a more accurate account of intrapartum communication and consent to procedures was obtained than undertaking a quantitative survey as it was experienced “as it happens, in the field” by all participants. This has also been found in previous studies such as those conducted by Hunt (2004, 1989), Machin and Scamell (1997), Kirkham (1987) and Henderson (1984). Compared to the survey technique where there is relative ease in recruiting a large sample and obtain data at a relatively low cost, Polit et al (2001) discuss that ethnography is both demanding and time consuming. However, as Rees (2003) claims, with a large survey there is always the risk that respondents may misinterpret questions or fail to complete / return the questionnaire and as a consequence, the overall response rate can be affected, such that the responses could be considered biased and not truly representative of the study sample. Had a quantitative survey approach been chosen via questionnaires for this particular study, the wealth and richness of data collected, particularly through observation and being immersed in the actual setting, would never have been achieved to the same extent, e.g. the effect that body language and non-verbal cues had on communication. These findings were also similar to what Machin and Scamell (1997) had discovered in their ethnographic study comparing the power that certain childbirth cultures conveyed to women from both the NHS and NCT.

Principles of grounded theory analysis were used to constantly compare data as they were collected, in order that original coding and grouping of data into categories were regularly reviewed until the three core-categories affecting intrapartum informed consent were eventually identified. Although there has been much criticism of its use in qualitative studies, a triangulation approach, as described by Denzin (1978), was also used as a means of assessing the authenticity and credibility of the data collected by comparing the observational data with the perceptions of the midwives and the women during the follow-up interviews (Mason 2002, Patton 2002, Silverman 2000, Seale 1999, Miles and Huberman 1994, and Fielding and Fielding 1986). Recognising that the purpose of triangulation is not necessarily for the findings from these different sources of data to tally, all were considered to be just as important and illuminating. Consequently, these alternative perspectives contributed to a broader and richer account of intrapartum informed consent within the study setting, rather than one definitive account (Hammersley and Atkinson 1995). In order to determine that the data collection

was rigorous, opportunities were given at the end of each interview for the women and midwives to check that the data collected were authentic and accurately reflected their responses. The majority of participants did read through the interview transcripts which Rees (2003) refers to as a "member's check" and which Spencer et al's (2003) study revealed can further improve the credibility of qualitative data.

7.2.2. Appropriateness of Interviewing Doctors.

As the entry criteria to the study focused on low risk pregnancies, the main intrapartum carer was the midwife, and the involvement of the doctor only occurred when a complication arose. A decision therefore was made not to interview this group of health professionals due to their often fleeting and limited involvement that could be considered a limitation of the study's design. As a consequence, the only aim that was not entirely fulfilled involved investigating the doctors' level of knowledge and understanding of informed consent from a legal, ethical and professional perspective. Conducting interviews with the doctors would have provided additional data to compare their perceptions of obtaining intrapartum informed consent with what had been observed. Had a quantitative survey been employed in the study's methodology to compare the doctors' perceptions with that of the qualitative observational data, such a method could only have been effective if a good response rate of questionnaires was achieved in order to claim an unbiased sample.

7.2.3. Researcher Bias and Reflexivity.

Whilst to some it may be considered there could be some bias in the fact that the same person undertook all the observation and interviews, this was considered an essential element when deciding on the study design and the data collection stage. This was so that whilst all the data were being collected, they could also be continually compared in order to assess when the saturation point had finally been reached: when no more new data emerged (Strauss and Corbin 1998). Because of the nature of ethnographic studies, it is expected for there to be a degree of bias, but rather than champion the underdog as Dingwall (1980) warns, it is anticipated that the findings from this study have presented a 'reasonable' level of objectivity and discussed the perspectives of all participants in the study regardless of their position (Spencer et al 2003).

Throughout the data collection, the work of Meyer (2001), Cutcliffe and Mckenna (1999), Murphy et al (1998), Lipson (1991), Sandelowski (1986), Lincoln and Guba (1985) and Becker (1958), that recognize the importance of reflexivity on the part of the researcher, was always borne in mind. The researcher's professional status of being not only a midwife, but also a senior midwife teacher known to many of the midwives and student midwives, may have accounted for them never refusing to participate in the study. Whilst this may be perceived by some as a limitation of the study in terms of researcher influence, others may see it as a strength as some midwives readily sought to recruit women to the study on behalf of the researcher. However, there were three midwives who appeared reluctant to recruit women to the study and stated that they had "*forgot to ask the woman*" for her consent to take part. It was possible that these midwives perceived the presence of a midwife teacher to be a threat to them personally and did not want their clinical practice to be observed and scrutinised just as those midwives did in Adams (1989) study.

Where student midwives had provided the majority of intrapartum care with indirect supervision from their midwife mentor, it was observed that they attempted to fully inform women of the benefits and risks of procedures as far as their knowledge allowed. It was recognised that the researcher's existing relationship with the student midwives in the study as a midwife teacher could have affected the data that were gathered in such cases to the extent that women were more likely to be given non-biased information in order that they were enabled to make their own intrapartum decisions. In this context, the presence of the researcher therefore could be seen as a strength of the study design in terms of benefit for the participants: namely the women.

Assisting with simple tasks on the labour ward whilst waiting to recruit suitable women to the study rather than being a hindrance to the staff and sharing the midwives' coffee room, were an attempt for the researcher to become part of the labour ward scene such that the influence of her presence during the observational stage became less obtrusive as the study progressed (Stoddart 1986, Posner 1980). However these activities, as well as making the decision to always accompany the last midwife out of the labour room and undertake the follow-up interviews in the hospital environment, could be considered to be a limitation of the study as they clearly identified the researcher with the labour ward staff.

Where midwives had been observed in providing intrapartum care to more than one woman in the study the stereotype that had been attributed to them with the initial case, was rarely seen to change in subsequent cases. This would suggest that the presence of the researcher as participant observer did little to affect the behaviour of these midwives, which can be a major criticism of observational studies (Rees 2003, Maykut and Morehouse 1994, Berg 1989, Stoddart 1986, Foucault 1977).

As Hammersley and Atkinson (1995) have recognised that although it is impossible to achieve a position of genderless neutrality, being female enabled the researcher relative easy access to the labour ward and its participants to undertake the study using both observational and interviewing techniques, as childbirth is essentially women's work. In addition, it was found during the interviews that some women had only given their consent to taking part in the study having been informed by the midwife that the researcher was both a woman and a midwife, as they "*did not want just anyone seeing them in labour.*" Within this context, although the researcher's status was perceived to be a further strength in terms of gaining access to this particular group of participants, their responses may have also been influenced by these facts and the extent to which trust had already been built with the researcher during the course of the study. Despite effort on behalf of the researcher to ensure her dress code was always compatible to the individual being interviewed, women appeared generally willing to converse and articulate their birth experiences regardless of their age and social class. This also may have been as a result of the researcher's continued presence throughout their labour and the degree to which the relationship had developed prior to the interviews.

Being privy to unacceptable and unethical conduct by staff has been claimed by Estroff and Churchill (1984) to be one of the most problematic situations for the researcher in the clinical setting, especially when they are familiar with the accepted standard of practice. In this study this only occurred on the one occasion. Observing the male obstetrician attempting to undertake a ventouse delivery without the woman having any analgesia, the researcher became fully aware of her moral obligations to the woman, such that no harm should befall her and her baby, as well as to her husband. As the midwife involved in the case eventually intervened and prevented the doctor from proceeding with the delivery, the researcher did not have to personally act and consequently step out of the role of researcher. Whilst attempting to report the findings

of this case in an objective way however, there may be some personal bias reflected against the offending doctor.

7.2.4. The Use of NUD*IST and the Analysis of the Data.

It had been decided at the outset to enter all the data into the NUD*IST computer software package that would assist with coding and retrieving the data. Being aware of the reports from Fielding and Lee (1995) and Weitzman and Miles (1995) that the extensive amount of data collected would be particularly challenging to sort and analyse manually, it seemed more appropriate to use computer software. It could be argued that a clerical officer could have entered the data as this stage of the research process proved to be extremely time-consuming. By personally entering the data provided valuable opportunities to revisit the data and assisted in identifying emerging themes and the development of subsequent theory. Upon reflection, despite the many challenges faced with using NUD*IST for the first time to support the data processing and analysis, a sound appreciation of this particular form of qualitative data analysis software package was personally achieved.

7.2.5. Representativeness and Transferability of the Findings.

Rees (2003) and Mitchell (1983) discuss that it is not an intention of qualitative research to achieve generalisation, based on statistical representativeness and sampling theory as with quantitative research. It is therefore not be assumed that the findings from this study could be extrapolated in totality to all childbearing women, midwives, doctors and birth environments, such as midwife-led units or the woman's home (Schofield 1993, Delamont and Hamilton 1976). However, whilst similarities may be found in labour wards in other such large maternity units where the culture is based on a medico-technocratic model, the degree to which they can be extended to midwives will depend on how stable that population actually is.

Undertaking statistical analysis using cross-tabulation and chi-squared tests from SPSS (Puri 2002) revealed no significant difference in respect of age, parity and ethnicity. Whilst these findings confirm that the sampling method had not resulted in a skewed / biased group of participants (Rees 2003, Hammersley 1992, Polit et al 2001) the study

sample could only be considered representative in these particular attributes as far as the local childbearing population who gave birth at the study hospital was concerned. As there were no data available pertaining to the total population of women who gave birth at the hospital during the time of the data collection, comparisons could not be made with the study sample regarding the social class status of the women. Consequently this could also be perceived to be a limitation of the study.

7.2.6. Ethnic Minority Groups and Non-English Speaking Women.

Whilst it may be considered a criticism of the study that only a limited range of ethnic minority groups were included compared to a more diverse range in the total population, this was to be expected with a study sample of 100, especially as these additional groups only constituted 0.9% of the total childbearing population from the study hospital. This difference therefore could be considered to having little effect, if any, on the study's overall findings.

As informed consent involves the assessment of understanding as well as information disclosure, it was established at the outset that only English speaking women would be included in the study. In cases where the woman is unable to communicate in English and is assisted to make decisions by an interpreter, it is difficult to assess the quality of the interpretation, the influence the interpreter may have on any decisions made and consequently, the effect this would have on the whole data collection. To have excluded non-English speaking women could also be considered a limitation of the study. Some critics of the study may further argue that assessment of understanding in such a group of women is especially important as far as obtaining consent to intrapartum procedures is concerned to ensure these women do not experience trespass to the person by the health professional.

7.3. THEORETICAL PERSPECTIVES.

When reflecting on the observational field notes and interview transcripts, it became increasingly apparent that the main issues for both the midwives and women in relation to intrapartum informed consent, centred on the quality of intrapartum communication and interactions between health professionals and women in labour within the culture of

a labour ward that was essentially based on a medico-technocratic model. Consequently, developing from the findings, are three main theories for those involved in providing intrapartum care to consider: *three stereotypical models of midwives, three stereotypical models of labouring women and the doctors' role in labour.*

7.3.1. Stereotypes of Midwife.

Whilst it is recognised that is not an ideal time for midwives to develop a relationship with women in labour, it was apparent that the midwives generally communicated well, with some, being more effective than others. As presented in Section 5.4.1.1. (page 161), the three stereotypes of midwives observed during the study were the *policy following midwife, the biased informing midwife and the informing enabling midwife.* As midwives in the study tended to possess the attributes associated with the *biased informing midwife*, (which bore some similarities with the findings of Fraser [2002]), all midwives should be encouraged to re-examine to what extent they inform women about the risks of intrapartum procedures to enable them to make informed decisions and subsequently give their consent. This would also ensure that Articles contained in the Human Rights Act 1998 (HMSO 2000) are not breached.

Although the constraints of working within the culture of a medico-technocratic environment of a consultant-led labour ward limited the extent to which the *informing, enabling midwife* was observed it still remains a challenge for midwives to aspire to this stereotype rather than possess the attributes of the *policy following midwife.* Knowing that students emulate some of the attributes of their mentors, education and service providers should be aiming to prepare the midwives of the future to be autonomous, accountable practitioners who are confident in their role and capable of informing and enabling women to make intrapartum decisions within whichever environment they practise (Bluff 2003, Chartres 2000, Spouse 1998, McLeod et al 1997).

The ultimate challenge lies with changing the culture of the birth environment. While ever midwives demonstrate the attributes of a policy following midwife or a biased informing midwife they are contributing to the reinforcement of western culture's perspective of childbirth. Until this culture is changed such that birth is viewed through a holistic birthing model that gives authority of knowing to the labouring woman, health

professionals will continue to control the birth experience where women are expected to consent to all available medical interventions. However, as not all women may want this power and authority to control their birthing experience, it is important for midwives to also recognise the different ways in which women may respond to information disclosure at different stages in their labour so as to ensure that communication is always effective as far as informed consent is concerned.

7.3.2. Stereotypes of the Labouring Women.

The three stereotypes of women presented in Section 5.4.2.3 (page 178) related to how women were seen to deal with information disclosed to them and subsequently make decisions about their intrapartum care. They did not always correlate with social class status as previous studies by Green et al (1998), McIntosh (1986), Nelson (1983) and Ounstead and Simons (1979) had found, but they did occasionally change according to how their experiences in labour affected their ability to communicate. This was particularly apparent in some women seen to be an *inquisitive decision-maker* at the outset of their labour. As a result of labour advancing, pain increasing or complications developing, the inquisitive decision-maker became a *reluctant recipient*.

Although observed less frequently in the study, the *reluctant recipient* remains the most challenging for midwives as far as obtaining consent to undertake procedures during labour is concerned, due to the difficulty in ensuring that the woman has been given information and fully understands the benefits and risks involved. It is therefore important that intrapartum records accurately reflect the discussions that take place and that the woman has chosen to entrust the midwife to make appropriate decisions on her behalf (NMC 2005, 2004b, Dimond 2002).

Where the *ambivalent partner* was observed, this type of woman appeared eager to communicate with the midwife and acquire information, but seemed just as unwilling to take part in making decisions as the reluctant recipient. This therefore implies that when providing care to the ambivalent partner, the midwife should never be complacent as far as undertaking intrapartum procedures even when all possible effects have been

disclosed to the woman. Indecision on the woman's part where consent is not formally expressed, does not determine the midwife's right to proceed.

Whilst it may be considered by some authors that midwives should be empowering all women to be inquisitive decision-makers (Levy 1999, Yearley 1997, DoH 1993), it was found that women in the study sample did not necessarily want to be empowered. As Kirkham (2000) states that if women are not used to considering the options and making decisions in the rest of their lives, it becomes even more difficult for midwives to enable these women to do the same in labour. Regardless of their stereotype, however, as Fleissig (1993) had also found, the majority of women in the study considered they were given sufficient information by the midwives to enable them to contribute and make decisions about their intrapartum care and consent to procedures, to the extent they were willing to do so.

7.3.3. The Doctors' Role in Labour.

Although the doctors observed in this study were predominantly male, the gender distribution of the obstetricians was more evenly spread. Having been socialised into the traditionally male-dominated medical profession where the culture is one of technology and intervention, the female obstetricians appeared to exert the same dominance as their male counterparts over the labouring woman when undertaking intrapartum procedures. The urgency of dealing with the development of complications in labours that were considered to be low risk at the outset, often made it difficult for obstetricians and paediatricians to effectively communicate with women and their husbands / partners at this first meeting. To some extent, although this observation maybe was to be expected, it does not endorse that the doctors' ineffective communication should be acceptable.

In comparison, the study found that the anaesthetists appeared to communicate more effectively than obstetricians and paediatricians. When the anaesthetist became involved it was usually as a result of the woman already having made a decision with the midwife to have an epidural for pain relief. As this usually occurred when labour was progressing normally, there generally appeared to be ample time for the anaesthetist to inform the woman of benefits and risks of epidural analgesia before finally undertaking the procedure.

As the main intrapartum carer, midwives are in the best position to be proactive in informing women of the exact reasons for obstetricians and paediatricians becoming involved in their care, as well as what they are likely to expect from them. This did occur in the study to some extent, but could be further improved. However, where obstetricians (and to a lesser degree paediatricians) were seen to communicate directly with the woman, they attempted to inform her of recent developments and the purpose of their involvement, whilst also involving her in making decisions about the intrapartum management as far as the situation allowed. When this is put into perspective, it could be argued that the obstetricians in the study were seen out of their usual context and consequently had difficulty in obtaining informed consent from the woman. It is recognised that the obstetrician dealing with high risk pregnancies will have usually developed a relationship with the woman, having had the opportunity to discuss the options available to her and involve her in making decisions about the intrapartum management during the antenatal period. This model could therefore be more formally adopted by midwives for women with low risk pregnancies and will be discussed further in this final chapter.

7.3.4. Significance of the Theoretical Perspectives.

It is envisaged that taking these perspectives into consideration could have a positive effect on how health professionals communicate with women in labour and obtain consent to procedures, as well as contributing to further improving the overall intrapartum experience for all concerned. Midwives should therefore be encouraged to reflect on their practice to determine which stereotype they belong to and if necessary, effect a change in their practice: this will depend to some extent on the culture and model of care adopted within the birth environment they practise. If the midwives' personal reflection is used in conjunction with them also being aware of which stereotype of labouring woman they are caring for (recognising that this stereotype may change during the course of the woman's labour), the process of obtaining intrapartum informed consent may be further improved. Whilst some midwives may recognise that doctors have a limited role in low risk labours, all midwives need to support their medical colleagues in communicating more effectively with women when complications develop.

7.4. RECOMMENDATIONS.

7.4.1. Media Influence and Consumer Involvement.

It has been recognised that the media and advances in information technologies continually contribute to reinforcing birth as a medical event that is dependent on science and technology. As a result, women are more likely to perceive this as the norm when experiencing childbirth themselves and readily accept all available interventions (Henley-Einion 2003, Davis-Floyd 1992). In order for there to be a cultural change in public opinion that embraces a holistic model of childbirth, it is recommended that there needs to be more emphasis placed on educating the media about the normal physiological processes of birth so that women may be offered a true choice of an alternative birth option to the medico-technocratic model.

Within the professional press, awareness has been raised about recent innovative developments in maternity care, such as team midwifery, midwife-led units and the re-introduction of birth centres that support women to give birth with minimal, if any, medical intervention (Kirkham 2003, Saunders et al 2000, Flint et al 1989), but never to the same extent in the general media. Midwives working in such environments, providing intrapartum care outside of the hospital labour ward, are ideal ambassadors to promote childbirth as a natural event that the majority of women could successfully experience with the support of their midwife. The challenge however lies in getting access to those individuals who control media coverage in order to influence them that birth outside of the hospital can be a viable and safe alternative and should therefore be incorporated through their various sources. Until this is achieved consumer opinion of childbirth will remain influenced by a medico-technocratic model. Midwives have a responsibility to ensure that birth is portrayed as a normal physiological event through a holistic birthing model in their own clinical practice as well as in the media in order for women to be empowered.

The Changing Childbirth Report from the Expert Maternity Group (DoH 1993) was the first major study into the maternity services that incorporated the opinion of its consumers. The recommendations from this earlier report have presented those health professionals working in the maternity services with a number of standards to work

towards achieving in practice: e.g. that all women should be equal partners in making decisions about their childbirth experiences. However, such findings did not fully represent the opinion of all socio-economic and ethnic backgrounds, and could therefore be considered inappropriate to implement with every childbearing woman. As it was discovered in this study into intrapartum informed consent, regardless of their social class, not all women want to be part of the decision-making process or to give birth without any analgesia / medical intervention and will trust the expert opinion of their carers (the midwife / doctor). Recently, the House of Commons Health Committee has further reviewed opinion of professionals and consumers regarding maternity services for the 21st century and has called for more Trusts to reverse the medicalisation of childbirth with a shift to developing midwifery units and greater autonomy of the midwife (House of Commons Health Committee 2003). To what extent these reflect specific local opinion and needs should however be determined before any changes to maternity service provision are considered and finally made.

7.4.2. Antenatal Consent to Intrapartum Procedures.

It was acknowledged at the beginning of the study that during labour was not the most ideal time to inform women about procedures they were likely to experience. The findings from the study clearly demonstrated that obtaining consent in labour was often fraught with practical difficulties as well as ethical and legal dilemmas for the midwife involved in providing the intrapartum care. Consequently this consent could rarely be considered informed. It is therefore recommended that when birth is likely to take place within a consultant-led labour ward as in this study, where the woman does not know the midwife who will be providing the intrapartum care, obtaining consent for intrapartum procedures should be undertaken in a more structured way during the antenatal period, and in advance of the onset of labour. This would give women time to acquire knowledge and understanding of such procedures and make informed decisions to either give / refuse consent during labour (Dimond 2003, BMA 2001). As the majority of women are considered to be low risk during pregnancy, midwives predominantly undertake their antenatal care. This places the midwife in an ideal position to inform women during the antenatal period of those procedures considered to be routine and part of the midwife's role in intrapartum care. However, it would be inappropriate to recommend that all women should give consent to intrapartum

procedures in this way. Where women experience their intrapartum care in alternative birth environments to an consultant-led unit, such as in the home or in a birth centre, the care is fundamentally woman-centred / midwife-led by the same midwife or small group of midwives and consequently should not be influenced by medicalisation and its routine procedures. However, as highlighted in the East Hertfordshire home water birth scenario (Richards 1997), the clinical practice of midwives working in such settings might still be influenced by acute Trust policies in some areas

It is suggested that a leaflet outlining the reasons for each procedure, including the benefits and risks to both mother and fetus, be given to the woman when she is 28-30 weeks pregnant. Such a leaflet may be based on the current *Informed Choice* leaflet series produced by MIDIRS (2003). Once the woman has had chance to read the leaflet at her own pace, understand / clarify its contents, discuss it with her husband / partner and consider her options prior to the onset of labour, the midwife would then discuss it with her at around 36 weeks gestation. At the same time, a checklist is completed and signed by both parties detailing those procedures that the woman has given her consent to at that time. Both the woman and midwife will retain a record of the check-list: the formatting of which would depend on the type of records used by the individual Trust e.g. hand written notes or computerised records. Such a process not only would be formalising / extending the current birth plan for all pregnant women, but would also be in keeping with the guidelines on consent to examination and treatment (DH 2001c) that Trusts are now expected to adopt: e.g. consent for elective caesarean sections. Having documentation that verifies information has been disclosed about a procedure, retained, understood and that a decision has been made to either consent to, or refuse, that procedure, could be a means of improving the woman's awareness and involvement in decision making as well as ensuring there is less risk of litigation occurring.

This checklist would consequently provide evidence for the midwife undertaking intrapartum care as to which procedures the woman has consented to (should they be warranted), and that the woman is more fully aware of the implications of such procedures. These details however, should only be used to support decisions that are made in labour, and not as a substitute for midwives utilising their own communication skills to check the extent of the woman's knowledge and understanding of a procedure before obtaining consent to proceed. In those cases where there is limited time to

discuss procedures e.g. when the woman presents in advanced labour, a check list for the midwife to refer to would provide the midwife with a better insight to what the woman had consented to in advance of labour. It would also give the midwife some reassurance as far as the legal and ethical considerations of consent are concerned, knowing that not only had the woman been given unbiased information, but also had the time to understand it and consider her options before finally making an informed decision.

7.4.3. Curriculum Issues.

Of those women who had given birth on a previous occasion, such as Case 98, a solicitor (page 174) and Case 70, a cleaner (pages 176 / 177), some commented that they had noticed improved communication and interpersonal qualities as well as a greater amount of information disclosed during their recent experience of labour. This was mainly from the midwives, although some women acknowledged that certain anaesthetists also communicated well with them. The midwife is particularly important during complicated labours where she needs to ensure the woman is kept informed and doctors talk to, and not over the woman. There were, however, sufficient instances of poor interpersonal interactions to suggest that there is no room to be complacent. The study also found that in particular, the midwives did not always recognise the woman's non-verbal cues or effectively interpret her body language during labour. It is therefore imperative that pre-registration curricula continue to emphasise the development of personal qualities and communication skills among its students, alongside the continuing professional development strategies adopted by each individual professional group.

On occasion there had been a few incidents of interprofessional tensions observed (page 203 / 204), and as Fraser (1999) had also found in her study, there would appear to be room for improvement in respecting, complementing and supporting each other's roles. As more emphasis is currently being placed on interprofessional education, (Universities UK 2003, DH 2001a) it is an ideal opportunity for midwives to share learning with doctors and other allied professionals from pre-registration to post-graduate level, to not only acquire knowledge and skills, particularly in relation to improving communication skills, but also learn about the values, attitudes and roles

each professional group possess. Innovations such as Interprofessional Team Objective Structured Clinical examinations (ITOSCEs) can assist student midwives and medical students in making decisions together as a team whilst at the same time recognising the full extent of each other's role (Symonds et al 2003). As discussed elsewhere, the real change that must occur among those providing maternity care, is in attitude: i.e. in the midwives' determination to be considered autonomous practitioners and in their medical colleagues decrease in resistance to allow them to practise autonomously (Marshall and Kirkwood 2000).

The study revealed that although midwives were aware of the impact of litigation on their midwifery practice, their understanding of legal and ethical issues in respect of obtaining informed consent for intrapartum care was particularly limited. Whilst legal and ethical issues may be incorporated into pre-registration curricula, it is recommended that they have a much higher profile whereby either a specific module is developed or such issues are integrated throughout the curriculum with the use of legal and ethical Enquiry / Problem Based Learning (EBL / PBL) scenarios, to challenge the student into considering practice related issues. Should a modular approach be adopted, it could be further developed for qualified staff, including medical colleagues, to access as part of their continuing professional development.

All student midwives in the study acquired their intrapartum skills through exposure to the labour ward of the hospital in the study where they were also exposed to obstetric interventions. It is therefore a challenge for the educationalists and maternity service providers in this locality to rise to the RCM's (2003) recommendations concerning the clinical experience of student midwives. They need to seriously consider how the clinical environment can enable future midwives to develop into autonomous practitioners who are confident in their abilities to provide women with genuine choice rather than a menu of options dominated by a medical model of care in order to empower them into making appropriate childbirth decisions. Although at the current time there are resource implications in this area to provide students with experience in midwifery based practices such as home births, a birth centre or group practice midwifery, a possibility would be to convert part of the labour ward / maternity ward into a midwife-led unit. Another means would be for each student to be provided with a placement in an alternative location where such midwifery based practices exist. This

however, could have practical and financial implications for those students who have family commitments.

7.4.4. Further Research.

There are number of areas identified from the study that indicate scope for future development and research, many of which have arisen from considering the limitations of the study. As the study was conducted within the environment of a consultant-led labour ward it would be inappropriate to speculate that the findings can be extrapolated in totality to all populations and birth environments. Further studies could be undertaken to explore how the culture of alternative birth environments such as a midwifery-led unit, a birth centre, and the woman's home, may influence the quality of communication and interaction between midwife and woman with regard to consent to intrapartum procedures. These studies could then be compared with the findings from this study.

As the medical staff who took part in the study were not interviewed, their knowledge and understanding of legal and ethical issues in respect of intrapartum informed consent were never explored. It is therefore suggested that a more appropriate follow-up study examining medical staff's practice of obtaining informed consent to intrapartum procedures be undertaken in those labours where they would have significantly more contact with the women than they did in this study: i.e. in pregnancies / labours that carry a certain degree of risk.

With the increase in the number of refugee and asylum seekers in the United Kingdom, it could also be seen to be both timely and appropriate to consider undertaking a collaborative study with trained interpreters to examine the intrapartum experiences of non-English speaking women. Women who are less able to articulate their wishes because of language barriers might have more needs as far as informed consent to intrapartum procedures is concerned. Similarly, health professionals providing care to these women may also have increased educational needs relating to cultural awareness issues. Such a study would therefore attempt to explore these issues.

The findings of the research and the above suggestions for future research so far have only focused on the perspective of the labouring woman and those health professionals

providing the intrapartum care. In the majority of cases, the woman was accompanied in labour by her husband / partner / friend, who tended to support any decisions that she made about her care, and on occasion influenced her choice. However, at the follow-up interviews the woman was often alone. As the data collection progressed, some midwives raised their concern about the psychological effect on the woman's husband / partner of attending the labour particularly when medical intervention was experienced. The partner's perspective and influence on intrapartum care and informed consent needs to be explored if midwives and doctors providing the care in labour are to ensure they not only understand the woman's perspective, but also the perspective of the person who is supporting her during and after labour.

7.5. CONCLUSION.

Whilst this study has identified that it is difficult to obtain informed consent during labour, it has also revealed that contrary to professional belief, not all women want to be fully informed about intrapartum care and procedures or wanted anything other than a pain free and easy labour based on the western medico-technocratic model. Not only has the study highlighted the implications that the findings have for clinical practice, it has also created more issues where further research could be undertaken. However, it is envisaged that midwives in particular, will consider the stereotypical models presented from the study in order to develop their communication and interpersonal skills and consequently their practice of obtaining intrapartum informed consent within the culture of whatever the type of birthing environment they practice, be it within the hospital or the community setting. In the wider context, it is anticipated that the findings from the study can be used in partnership between maternity service and education providers to ensure that health professionals have not only effective communication and interpersonal skills, but also are more conversant with the legal and ethical implications of consent. However, it must also be recognised that it is important to establish that what is provided in practice, is congruent with the needs and expectations of the childbearing woman.

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APPENDICES.

1. Research Ethics Committee Approval.
2. Client Information Sheet.
3. Poster Information (Antenatal Clinic).
4. Client Consent Form.
5. Total Time spent on Labour Ward during Data Collection.
6. Observation Time per Case.
7. Observation Time: Median.
8. Number of Episodes Midwives were Observed / Interviewed.
9. Number of Episodes Student Midwives were Observed / Interviewed.
10. Number of Episodes Obstetricians were Observed.
11. Number of Episodes Anaesthetists were Observed.
12. Number of Episodes Paediatricians were Observed.
13. Number of Episodes Other Personnel were Observed.
14. Extract from the Observational Field Notes divided into Text Units with Coding.
15. The NUD*IST Index System and Initial Codes used in the Analysis.
15. Comparative Age of the Women.
16. Comparative Parity of the Women.
17. Comparative Ethnic Origin of the Women.

Medical Administration Department.

Ext: 45678

Fax No:

0115 9627788 46788

Our Ref: **When replying please
quote: EC96/207d)**

Your Ref:

Please ask for:

10 December 1996

Miss J E Marshall
Midwife Teacher
School of Nursing and Midwifery
Midwifery Education
Postgraduate Education Centre
Local Hospital

Dear Miss Marshall,

**An observational study of the interactions between health professionals and women
in labour involving consent to procedures**

Thank you for your letter of 29th November, in response to mine of 29th October. I am now able to grant officer approval to this study which will be reported to our next meeting. You may proceed with the study, and I will be pleased to receive a copy of the information you will be giving to women in advance of their confinement, for our records.

Yours sincerely



Honorary Secretary
Local Hospital Research Ethics Committee

cc: Mr P Baker

INFORMED CONSENT IN LABOUR

CLIENT INFORMATION LEAFLET

I am a student registered with the University of Nottingham, Faculty of Medicine and Health Sciences for a Higher Degree / Doctorate studies, who is considering a research study that examines the ACT OF INFORMED CONSENT during LABOUR, in order to suggest recommendations for the improvement of maternity care in the future.

It has been well publicised that health professionals are expected to supply women with sufficient unbiased information in order for them to make informed choices about their care throughout the whole childbearing process (Department of Health {DoH} 1993).

You are invited to participate in this study by allowing me to OBSERVE the communication, conversations and interactions that take place during your labour between the health professionals involved (e.g. the midwife, doctor, students etc) and yourself, in relation to decisions made about your care.

Please discuss your participation in the study with your partner and the midwife whilst you are being admitted to the Labour ward, and should you have any concerns about the study and its implications, I would only be too pleased to discuss them further.

Your involvement in the study should not have any effect on how your labour is managed, nor the standard of care you receive whilst in the maternity unit. You are free to decline to participate or to withdraw from the study at any stage should you wish to do so.

Should you decide to participate, please complete the attached consent form (*Appendix 4*) and I will then follow your labour through to the point when you are ready to transfer to the postnatal ward / Patient's Hotel with your baby.

Thank you for taking time to consider contributing to this important research.

Jayne E Marshall
University of Nottingham, Academic Division of Midwifery

Reference :
Department of Health (1993) *Changing Childbirth: Report of the Expert Maternity Group*, London, HMSO.

INFORMED CONSENT IN LABOUR

AN OBSERVATIONAL STUDY CONDUCTED BY A MIDWIFE

I have been granted approval by the **local Hospital** Research Ethics Committee and the Maternity Unit to undertake a study examining the extent pregnant women are involved in making informed decisions about their care in labour.

From **APRIL 1997**, I will be spending **ONE DAY** each week on the labour ward **OBSERVING** the communication and conversation between you and the health professional involved (e.g. the midwife, doctor, student etc.), throughout your labour.

Within **24 hours** of your baby's birth, I would also like to conduct a short interview with you in order to discuss your labour and the part you played in the decisions made about your care.

If you feel that you do **NOT** wish to take part in the study, please inform one of the midwives in the **Antenatal Clinic** and they will record your decision in your Notes.

**THANK YOU FOR TAKING TIME TO CONSIDER
TAKING PART IN THIS IMPORTANT RESEARCH
STUDY.**

Jayne E Marshall

Midwife Teacher: University of Nottingham, Academic Division of Midwifery.

JANUARY 1997.

CLIENT CONSENT FORM

TITLE OF RESEARCH: INFORMED CONSENT DURING THE INTRAPARTUM PERIOD: An Observational Study of the Interactions between Health Professionals and Women in Labour.

SITE: Local Hospital – Labour Ward and Postnatal Ward areas.

INVESTIGATOR: Jayne E Marshall – Midwife Teacher
(MA RGN RM ADM PGCEA)

The client should complete the whole of this sheet herself.

Please circle your answer

- **Have you read and understood the client information leaflet?** YES / NO
- **Have you had an opportunity to ask questions and discuss the study?** YES / NO
- **Have all your questions been answered satisfactorily?** YES / NO
- **Have you received enough information about the study?** YES / NO
- **Who have you spoken to?** YES / NO
Name.....
- **Do you understand that you are free to withdraw from the study?** YES / NO
 - At any time?** YES / NO
 - Without having to give a reason?** YES / NO
 - Without affecting your future maternity care?** YES / NO
- **Are you aware that the results of the study may be published?** YES / NO
- **Do you understand that all the information obtained will be treated in confidence and that you will not be mentioned by name in the final report?** YES / NO
- **Do you agree to take part in the study?** YES / NO

Signature (Client)..... Date.....

NAME (in block capitals).....

I have explained the study to the above client and she has indicated her willingness to take part.

Signature (Midwife)..... Date.....

NAME (in block capitals).....

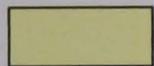
TOTAL TIME SPENT ON LABOUR WARD DURING DATA COLLECTION.

Case	Time from:	Time to:	Total Time (in minutes)
1	07:15	21:00	825
2	07:15	17:00	585
3	21:15	02:30	315
4	07:15	13:00	345
5	21:15	08:30	675
	07:15	12:00	285
6	21:15	02:15	300
7	07:15	13:45	390
	07:15	12:00	285
8	07:15	00:10	1015
9	07:15	15:00	465
10/11	07:15	02:00	1125
	07:15	21:30	855
12	07:15	18:00	645
13	07:15	15:00	465
14	21:15	02:30	315
15	07:15	15:00	465
16	21:15	13:15	960
	10:00	12:45	165
	07:15	12:00	285
17	21:15	07:00	585
18	21:00	11:00	840
19	21:00	08:30	690
20	07:15	14:30	435
	21:15	03:30	375
	07:15	12:00	285
21	21:15	11:15	840
22	07:15	17:15	600
23	07:15	16:00	525
24	07:15	20:30	795
	08:00	16:30	510
	07:15	19:15	720
	07:15	12:30	315
	07:15	12:00	285
25	07:15	15:00	465
26	07:15	19:15	720
27	07:15	13:30	375
28	21:15	08:30	675
	07:15	15:30	495
29	13:30	02:30	780
30	07:15	15:00	465
31	07:15	19:15	720
	07:15	13:15	360
	07:15	12:45	330
32	07:15	12:30	315
	07:15	12:45	330
33	07:15	18:30	675
34	07:15	21:30	855

Case	Time from:	Time to:	Total Time (in minutes)
	07:15	16:00	525
	07:15	12:30	315
35	09:00	17:00	480
	13:30	22:00	510
36	07:15	21:45	870
37	07:15	19:15	720
38	11:00	06:30	1170
39	07:30	13:30	360
	07:15	13:00	345
40	07:30	14:00	390
41	09:30	22:00	750
	07:30	13:30	360
	07:30	14:30	420
42	07:30	22:30	900
	07:30	14:30	420
	07:30	12:30	300
43	07:30	15:30	480
44	07:30	16:00	510
	07:30	15:00	450
	07:30	13:00	330
45	21:15	06:15	540
46	07:30	17:30	600
47	21:15	02:45	330
48	21:15	18:00	1245
49	21:15	04:00	405
50	07:15	14:00	405
	21:15	06:00	525
51	21:15	01:45	270
	07:15	12:15	300
52	21:15	06:15	540
	21:15	06:15	540
53	21:30	02:00	270
54	07:15	16:00	525
	21:15	04:15	420
	07:15	12:00	285
55	21:15	07:15	600
56	07:15	15:00	465
57	21:15	10:00	765
	07:15	12:00	285
58	07:15	17:30	615
	07:15	17:15	600
59	13:30	22:30	540
60	22:15	04:00	345
61	21:15	03:45	390
62	21:15	05:15	480
63	21:15	06:15	540
64	21:15	06:45	570
	21:15	12:00	885

Case	Time from:	Time to:	Total Time (in minutes)
65	21:15	12:30	915
66	07:00	19:00	720
67	21:15	02:00	285
68	21:15	04:30	435
69	21:15	12:00	885
70	21:15	04:30	435
71	21:15	13:30	975
72	21:15	15:30	1095
73	21:15	05:00	465
74	21:15	06:00	525
75	21:15	01:45	270
76	07:15	15:45	510
77	21:15	09:00	705
78	21:15	04:00	405
79	21:15	09:15	720
80	21:15	17:45	1230
	07:15	17:00	585
81	21:15	22:15	1500
82	21:15	05:30	495
	07:15	12:30	315
83	21:15	09:00	705

Case	Time from:	Time to:	Total Time (in minutes)
84	21:15	12:15	900
85	21:15	04:45	450
86	21:15	07:30	615
87	07:15	11:30	255
88	07:15	10:30	195
89	21:15	07:45	630
90	21:15	00:15	180
91	21:15	02:00	285
92	07:15	18:30	675
	21:15	03:15	360
93	07:30	15:45	495
94	21:15	06:30	555
95	21:15	10:30	795
96	21:15	13:30	975
	17:30	23:30	360
97	21:15	07:45	630
98	21:15	05:15	480
99	21:15	08:30	675
	07:30	20:30	780
100	21:15	10:00	765



Indicates those **38** occasions where no “suitable” subject was recruited to the study (includes the 22 abandoned cases and the 6 women who opted not to participate in the study).

TOTAL length of time spent on labour ward over the 137 visits: **76240 minutes**
(1270 hours 40 minutes).

AVERAGE length of time taken on labour ward per visit: **556 minutes**
(9 hours 16 minutes).

i.e. total time / number of visits = 76240 / 137.

AVERAGE length of time taken to recruit / observe a “suitable” case: **762 minutes**
(12 hours 42 minutes).

i.e. total time / number of cases in study = 76240 / 100.

TIME SPENT UNDERTAKING THE OBSERVATIONAL COMPONENT

Case	Time from:	Time to:	Total Time (in minutes)
1	10:00	20:25	625
2	09:25	16:15	410
3	23:00	01:45	105
4	07:40	11:00	200
5	01:00	08:00	420
6	00:10	02:15	125
7	08:45	12:00	195
8	11:00	23:30	750
9	09:50	15:00	310
10	08:30	11:00	150
11	15:00	02:00	660
12	09:50	18:00	490
13	08:10	13:15	305
14	21:45	00:30	165
15	11:15	14:00	165
16	00:00	12:15	735
17	23:25	06:00	395
18	00:00	10:30	630
19	00:30	07:30	420
20	09:20	14:00	280
21	02:15	10:45	510
22	08:20	16:30	490
23	11:20	16:00	280
24	13:20	20:00	400
25	10:45	14:30	225
26	11:45	19:00	435
27	07:55	12:25	270
28	01:10	06:45	335
29	16:10	01:35	565
30	07:55	14:00	365
31	13:15	19:15	360
32	08:00	11:15	195
33	08:00	10:30	150) 450
	12:30	17:30	300)
34	11:20	21:00	580
35	13:00	16:45	225
36	08:15	21:45	810
37	11:20	18:00	400
38	14:10	06:10	960
39	08:20	13:20	300
40	10:55	13:55	180
41	10:15	21:45	690
42	08:15	22:30	855
43	09:30	14:30	300
44	09:00	15:30	390

Case	Time from:	Time to:	Total Time (in minutes)
45	01:00	05:30	270
46	10:15	17:30	435
47	22:00	02:30	270
48	23:45	18:00	1095
49	23:30	03:00	210
50	07:45	13:30	345
51	22:00	00:45	165
52	00:35	04:00	205
53	21:45	00:30	165
54	07:30	15:15	465
55	01:00	06:00	300
56	08:30	14:00	330
57	04:00	09:30	330
58	13:15	16:30	195
59	17:00	22:00	300
60	22:25	02:05	210
61	21:15	00:30	195
62	23:30	02:45	195
63	22:00	05:30	450
64	00:00	04:30	270
65	03:00	12:00	540
66	10:45	17:15	390
67	22:10	01:25	195
68	00:00	04:00	240
69	02:15	10:15	480
70	22:30	03:00	270
71	04:00	12:30	510
72	02:15	15:30	795
73	01:45	05:00	195
74	23:45	05:00	315
75	21:30	00:30	180
76	08:00	14:00	360
77	01:45	08:30	405
78	22:00	01:30	210
79	01:30	09:00	450
80	01:00	17:30	990
81	06:15	21:30	915
82	01:00	04:00	180
83	03:45	09:00	315
84	00:00	12:00	720
85	21:15	03:30	375
86	02:15	07:00	285
87	08:00	11:30	210
88	07:30	10:00	150

Case	Time from:	Time to :	Total Time (in minutes)
89	23:15	07:30	495
90	21:45	23:45	120
91	21:30	23:30	120
92	09:45	18:15	510
93	08:15	15:45	450
94	23:30	02:00	150

Case	Time from:	Time to:	Total Time (in minutes)
95	01:30	09:30	480
96	01:30	13:30	720
97	02:15	07:45	330
98	03:00	04:30	90
99	03:30	07:45	255
100	05:45	09:30	225

Total LENGTH OF TIME: 38195 minutes (100 cases).

Average LENGTH OF TIME PER CASE: 382 minutes (6 hours 22 minutes).

The **5 cases** that have *no colour shading* are those in which the woman gave birth within 30 minutes of arrival on the labour ward.

MEDIAN LENGTH OF TIME SPENT UNDERTAKING THE OBSERVATIONAL COMPONENT.

Number	Case Number	Total Time (in minutes)	Number	Case Number	Total Time (in minutes)	Number	Case Number	Total Time (in minutes)
	98	90	29	27	270	62	19	420
	3	105	30	45	270	63	26	435
1	90	120	31	47	270	64	46	435
	91	120	32	64	270	65	33	450
	6	125	33	70	270	66	63	450
2	10	150	34	20	280	67	79	450
3	88	150	35	23	280	68	93	450
4	94	150	36	86	285	69	54	465
5	14	165	37	39	300	70	69	480
6	15	165	38	43	300	71	95	480
	51	165	39	55	300	72	12	490
7	53	165	40	59	300	73	22	490
8	40	180	41	13	305	74	89	495
9	75	180	42	9	310	75	21	510
10	82	180	43	74	315	76	71	510
11	7	195	44	83	315	77	92	510
12	32	195	45	56	330	78	65	540
13	58	195	46	57	330	79	29	565
14	61	195	47	97	330	80	34	580
15	62	195	48	28	335	81	1	625
16	67	195	49	50	345	82	18	630
17	73	195	50	31	360	83	11	660
18	4	200	51	76	360	84	41	690
19	52	205	52	30	365	85	84	720
20	49	210	53	85	375	86	96	720
21	60	210	54	44	390	87	16	735
22	78	210	55	66	390	88	8	750
23	87	210	56	17	395	89	72	795
24	25	225	57	24	400	90	36	810
25	35	225	58	37	400	91	42	855
26	100	225	59	77	405	92	81	915
27	68	240	60	2	410	93	38	960
28	99	255	61	5	420	94	80	990
						95	48	1095

The *Median* Time spent *observing* the 95 labours is 335 minutes (5 hours 35 minutes), as shown in the Table above.

The 5 cases that are left *unshaded* are those in which the woman gave birth within 30 minutes of arrival on the labour ward, and are thus excluded from the assessment of the median time.

NUMBER OF EPISODES MIDWIVES WERE OBSERVED.

Number of Episodes	1	2	3	4	5	6	7	8	9
Midwife /									
Student Midwife (SM)									
Community Midwife (CM)									

** = known to woman antenatally

Midwife	Case Number
1	1
2	1, 6, (8), (56) 70, 71, (80)
3	2, (25), 33, 65
4	2, 19, 52, (68), 77
5	3, 41, 47, 64, (70), 74, (75), 81, 99
6	4, 89
7	5, (7)
8	(8), 34, 100
9	8, 24, 36, 45, (94)
10	8, (30)
11	9, 57
12	9, (20), (24)
13	10, 90
14	11, 72, (94)
15	11, (92)
16	12
17	12, 21
18	14, 21
19	15, 29
20	16, (33), (38), (53), (61), 67, 68, (87)
21	16
CM22	17
23	18
24	18, 50
25	19, (35), (43), (96)
26	(12), 20, (41)
27	(17), 22, 55, 60
28	(12), 22, 23, (28), (37), (42), (48)
29	(5), (13), (24), 25, (48)
30	26, 54
31	26, 37, 39
32	(17), 27, 81, 97
33	28
34	(28), (33), (58), (96)
35	(23), 29, 48, (66), 98
36	29, (72)
37	30, (55), 94
38	(31)
39	31, (37), 46, 66
40	32, 33
41	(15), 33, 42, (50), 92, 96
42	(21), 34
43	34, (38), (40)
44	(10), 35, (91), (98)
45	35
46	36, (44), (61)
47	(34), 38

Midwife	Case Number
48	38, (63)
CM49	40
50	41, (62), 87
51	42
52	43
53	(22), (43), 44, (81), (83), (89)
54	44, (95)
55	46, 72, (84), 92, 95
56	48, (83)
57	48
58	49
59	51, 66, 71, (73), (83)
CM60**	53
61	54
62	(54)
63 / SM5	56, 75 / 13, 25
64	57
65 / SM6	58, 80 / (22), 23
66	(59)
67 / SM7	59, (70) / (31)
68	61
69	(34), 62
CM70**	63, (90)
71	65
72	(27), (42), 69
73	69, 82
74	(5), (42), (49), (59), 73, 79, (83)
75	76, 85
76	78, 81
77	(79)
78	80
79	80
80	(81)
81	(82)
82 / SM10	83 / 44
83	84
84	(77), 84
85	86
86	88
87 / SM8	91 / 36, 42
88	(28), (51), 93
89	93
90	(4), (8), 96
CM91	99
92	100
93	(41)
94	(9), (36), (81), (95)

(bold type = observation and interviews: () = observation only).

NUMBER OF EPISODES MIDWIVES WERE OBSERVED / INTERVIEWED.

Community Midwife (CM) ** = known to woman antenatally	Student Midwife (SM) (specific episodes <i>excluded from Midwives</i> totals)
--	---

Midwife	Observed	Interviewed
1	1	1
2	7	4
3	4	3
4	5	4
5	9	7
6	2	2
7	2	1
8	3	2
9	5	4
10	2	1
11	2	2
12	3	1
13	2	2
14	3	2
15	2	1
16	1	1
17	2	2
18	2	2
19	2	2
20	8	3
21	1	1
CM22	1	1
23	1	1
24	2	2
25	4	1
26	3	1
27	4	3
28	7	2
29	5	1
30	2	2
31	3	3
32	4	3
33	1	1
34	4	0
35	5	3
36	2	1
37	3	2
38	1	0
39	4	3
40	2	2
41	6	4
42	2	1
43	3	1
44	4	1
45	1	1
46	3	1
47	2	1

Midwife	Observed	Interviewed
48	2	1
CM49	1	1
50	3	2
51	1	1
52	1	1
53	6	1
54	2	1
55	5	4
56	2	1
57	1	1
58	1	1
59	5	3
CM60**	1	1
61	1	1
62	1	0
63 / SM5	2 / 2	2 / 2
64	1	1
65 / SM6	2 / 2	2 / 1
66	1	0
67 / SM7	2 / 1	1 / 0
68	1	1
69	2	1
CM70**	2	1
71	1	1
72	3	1
73	2	2
74	7	2
75	2	2
76	2	2
77	1	0
78	1	1
79	1	1
80	1	0
81	1	0
82 / SM10	1 / 1	1 / 1
83	1	1
84	2	1
85	1	1
86	1	1
87 / SM8	1 / 2	1 / 2
88	3	1
89	1	1
90	3	1
CM91	1	1
92	1	1
93	1	0
94	4	0

The total number of observations involving *Midwives* was: 236.
 The total number of interviews conducted with *Midwives* was: 143.

NUMBER OF EPISODES STUDENT MIDWIVES WERE OBSERVED / INTERVIEWED.

Student Midwife	Case Number	Observed	Interviewed
1	5	1	1
2	7 (25)	2	1
3	8	1	1
4	(12)	1	0
5 / M63	13, 25 / 56, 75	2 / 2	2 / 2
6 / M65	(22), 23 / 58, 80	2 / 2	1 / 2
7 / M67	(31) / 59, (70)	1 / 2	0 / 1
8 / M87	36, 42 / 91	2 / 1	2 / 1
9	(43), 44, (60)	3	1
10 / M82	44 / 83	1 / 1	1 / 1
11	48, (56)	2	1
12	58	1	1
13	62, (65)	2	1
14	(69)	1	0
15	(82)	1	0
16	86	1	1
17	(88), 94	2	1
18	(36), (93)	2	0
19	(95)	1	0
20	95	1	1

(bold type = observation *and* interviews : () = observation only).

The total number of observations involving *Student Midwives* was: 30.

The total number of interviews conducted with *Student Midwives* was: 16.

5 student midwives were also observed / interviewed as midwives (M): these episodes have been **excluded** from the final totals above, but included in the final totals for **midwives** (previous page).

NUMBER OF EPISODES OBSTETRICIANS WERE OBSERVED.

Obstetrician Grade / Number	Case Number	Observed
Consultant 1	80	1
Consultant 2	80	1
Registrar 1	1, 12	2
Registrar 2	1, 5	2
Registrar 3	16, 22	2
Registrar 4	4, 19	2
Registrar 5	22, 26	2
Registrar 6	26	1
Registrar 7	28	1
Registrar 8	30, 32	2
Registrar 9	36	1
Registrar 10	36	1
Registrar 11	38, 39, 66, 80, 81	5
Registrar 12	39, 57, 68, 72	4
Registrar 13	39, 72, 84	3
Registrar 14	40, 81	2
Registrar 15	42, 48, 67, 80, 83	5
Registrar 16	48	1
Registrar 17	54, 56, 63, 74, 80	5
Registrar 18	79, 81, 82	3
Registrar 19	91	1
Registrar 20	95, 96	2
SHO 1	1	1
SHO 2	5	1
SHO 3	9	1
SHO 4	16	1
SHO 5 / Paediatrician 13	19 / 57, 74, 75	1 / 3
SHO 6	22	1
SHO 7	22	1
SHO 8	26	1
SHO 9	28, 30, 57, 68	4
SHO 10	31	1
SHO 11	32	1
SHO 12	35	1
SHO 13 / Paediatrician 5	36 / 16, 17, 22	1 / 3
SHO 14	36	1
SHO 15	38	1
SHO 16	40, 52	2
SHO 17	42, 63	2
SHO 18	48, 71, 74, 75	4
SHO 19	57, 60, 72	3
SHO 20	66, 72	2
SHO 21	80	1
SHO 22	80	1
SHO 23	81, 95	2
SHO 24	81	1
SHO 25	81, 82, 83, 91	4
SHO 26	84, 97, 98	3
SHO 27	96	1

(bold type = intrapartum procedures undertaken by doctor
light type = minimal role / no physical contact with woman).

The total number of observations involving *Obstetricians* was: **93**.
i.e. Consultant Obstetricians = 2, Registrars = 47 and SHOs = 44.
(excludes those observations when SHOs were working as a *Paediatrician*).

NUMBER OF EPISODES ANAESTHETISTS WERE OBSERVED.

Anaesthetist Grade / Number	Case Number	Observed
Consultant 1	22, 39, 42	3
Consultant 2	24, 56	2
Anaesthetist 1	1	1
Anaesthetist 2	12	1
Anaesthetist 3	16	1
Anaesthetist 4	17	1
Anaesthetist 5	18	1
Anaesthetist 6	21	1
Anaesthetist 7	28	1
Anaesthetist 8	31	1
Anaesthetist 9	33, 34	2
Anaesthetist 10	36	1
Anaesthetist 11	36	1
Anaesthetist 12	38	1
Anaesthetist 13	38	1
Anaesthetist 14	41, 67, 71, 83, 84	5
Anaesthetist 15	42	1
Anaesthetist 16	43, 48	2
Anaesthetist 17	46, 80	2
Anaesthetist 18	55	1
Anaesthetist 19	57	1
Anaesthetist 20	66, 72	2
Anaesthetist 21	72	1
Anaesthetist 22	80	1
Anaesthetist 23	81	1
Anaesthetist 24	89	1
Anaesthetist 25	91	1
Anaesthetist 26	95	1
Anaesthetist 27	96	1

(bold type = epidural / spinal anaesthetic procedures undertaken
light type = minimal role / no physical contact with woman).

The total number of observations involving *Anaesthetists* was: 40.
i.e. Consultant Anaesthetists = 5, Registrars = 35.

NUMBER OF EPISODES PAEDIATRICIANS WERE OBSERVED.

Paediatrician Number	Case Number	Observed
1	3, 5	2
2	4	1
3	9	1
4	13	1
5 / SHO13	16, 17, 22 / 36	3 / 1
6	26	1
7	33, 37	2
8	34	1
9	35	1
10	39	1
11	40	1
12	53	1
13 / SHO 5	57, 74, 75 / 19	3 / 1
14	61, 63, 80	3
15	67, 72, 79	3
16	76	1
17	78	1
18	81, 84, 88, 96	4
19	82	1

(**bold type** = neonatal resuscitation procedures undertaken
light type = minimal role / no physical contact with baby)

The **total number of observations** involving *Paediatricians* was: **32**.
(excludes those observations when Paediatricians were working as *Obstetric SHOs*).

NUMBER OF EPISODES OTHER PERSONNEL WERE OBSERVED.

Grade / Number	Case Number	Observed
Neonatal Nurse Practitioner 1 (NNP)	39	1
Student Nurse 1 (SN)	4	1
Student Nurse 2	21	1
Medical Student 1 (MS)	1	1
Medical Student 2	2	1
Medical Student 3	11	1
Medical Student 4	24	1
Medical Student 5	26	1
Medical Student 6	42	1
Medical Student 7	52	1

(**bold type** = neonatal resuscitation procedures undertaken
light type = minimal role / observational role only).

The **total number of observations** involving *Other Personnel* was: **10**.
i.e. Neonatal Nurse Practitioner = 1, Student Nurses = 2 and Medical Students = 7.

Appendix 14.

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PROJECT: PhD, User Jayne Marshall.

++++
++++
+++ ON-LINE DOCUMENT: CASE15 (OBSERVATION).
+ CASE STUDY 15 (SW1): 20:10:97.

26 year old Caucasian, Single, Housewife.
Gravida 2 Para 1.
EDD: 21:10:97.
A Rhesus Positive.
Hb: 9.8g/dl (20:9:97) 12.0g/dl (24:9:97).
(Treatment: Hydroxycobalamin IM x 5).
Vegetarian.

PERSONNEL INVOLVED:
Midwife 19.
The Partner: C (Unemployed Cleaner).

+++ Retrieval for this document: 155 units out of 155, = 100%
++ Text units 1-155:

.....31
11:38: Midwife 19: 'I'm going to examine you in a minute to see how you're getting on. It won't hurt, OK?'
32
(1 5)
SW1: 'That's fine'.
33
(1 5)
C GETS UP FROM HIS CHAIR TO HELP SW1 GET MORE COMFORTABLE. HE SUPPORTS HER BY HOLDING HER HAND.
34
11:40: Midwife 19: 'I'll just put the head of the bed down. Can you draw your knees up and let your legs flop apart. I'll be as gentle as possible..... VAGINAL EXAMINATION UNDERTAKEN..... the waters are intact, you're a good 4cms dilated. Do you want me to break your waters and get on with it? It is very favourable!'
35
(1 5) (11 2) (11 3)
SW1: 'They broke my waters last time. It's OK'.
36
(11 2) (11 3)
Midwife 19: 'I'll break your waters then and we'll think about pain relief next'.
37
(11 2) (11 3)
SW1: 'I had an epidural last time'.
38
(1 4)
ARTIFICIAL RUPTURE OF MEMBRANES UNDERTAKEN BY MIDWIFE 19: CLEAR LIQUOR.
39
Midwife 19: 'With 2nd babies you may get away with some pethidine. The contractions will get a bit stronger now. When you need something for the pain let me know and I'll get you the pethidine. There's also gas and

air'.

40

(1 4)

SW1: 'I had some of that last time'.....

.....44

11:45: SW1: 'What's pethidine anyway? Is it the injection in the leg?'

45

(2 6)

Midwife 19: 'Yes. It's an injection. It won't take the pain away like an epidural, but it will take the edge off it. It will also make you feel as though you've had too much to drink and a bit sleepy. The baby is fine. As it's your second baby, you may get away with just the pethidine'.

46

(2 6)

(2 7)

11:48: SW1: 'I think I'll have the pethidine now'.

47

(2 6)

Midwife 19: 'OK, I'll go and get you some'.

48

(2 6)

Midwife 19 and I exit.

49.....

Appendix 15.

Q.S.R. NUD.IST Power version, revision 4.0.
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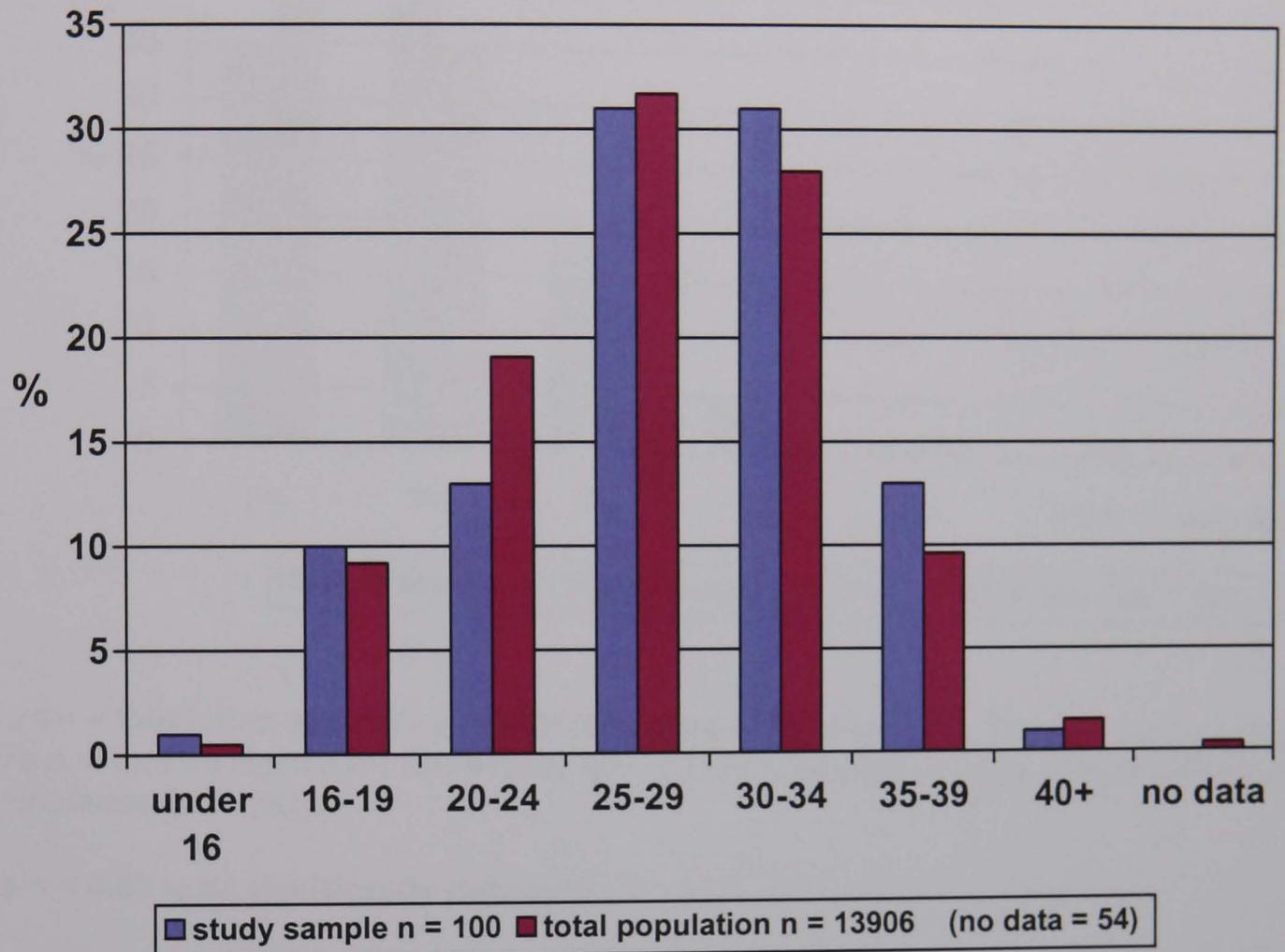
PROJECT: PhD, User Jayne Marshall.

Denotes CATEGORY (INITIAL)

(1 1) /admission/basic observations
(1 2) /admission/abdominal examination
(1 3) /admission/fetal heart monitoring
(1 4) /admission/pain relief
(1 5) /admission/vaginal examination
(1 6) /admission/condition
(1 7) /admission/privacy
(1 8) /admission/birth plan
(2 1) /pain relief/midwife
(2 2) /pain relief/anaesthetist
(2 3) /pain relief/student midwife
(2 4) /pain relief/SHO
(2 5) /pain relief/registrar
(2 6) /pain relief/woman's questions/choice
(2 7) /pain relief/effects of
(2 8) /pain relief/partner's questions
(3 1) /fetal monitoring/woman's choice
(3 2) /fetal monitoring/reasons for CTG
(3 3) /fetal monitoring/reasons to discontinue CTG
(3 4) /fetal monitoring/intermittent
(3 5) /fetal monitoring/scalp electrode
(3 6) /fetal monitoring/fetal blood sampling
(4) /maternal observations
(5 1) /interventions interruptions by staff/midwife coordinator
(5 2) /interventions interruptions by staff/obstetrician
(5 3) /interventions interruptions by staff/anaesthetist
(5 4) /interventions interruptions by staff/medical student
(5 5) /interventions interruptions by staff/midwife
(5 6) /interventions interruptions by staff/domestic staff
(5 7) /interventions interruptions by staff/change of shift
(5 8) /interventions interruptions by staff/paediatrician
(5 9) /interventions interruptions by staff/student nurse
(5 10) /interventions interruptions by staff/student midwife
(6 1) /vaginal examination/reasons
(6 2) /vaginal examination/woman's choice and lack of
(6 3) /vaginal examination/findings
(7 1) /venepuncture/reasons
(7 2) /venepuncture/woman's choice
(7 3) /venepuncture/information sought given
(7 4) /venepuncture/procedure
(7 5) /venepuncture/admin of drugs
(8 1) /syntometrine/information
(8 2) /syntometrine/woman's choice
(8 3) /syntometrine/administration
(8 4) /syntometrine/woman's knowledge
(9 1) /equipment/information
(9 2) /equipment/question by woman/partner
(10 1) /cutting the cord/partner's questions request
(10 2) /cutting the cord/woman's request
(10 3) /cutting the cord/midwife prompt
(10 4) /cutting the cord/no choice

(11 1) /membranes/reasons to leave intact
 (11 2) /membranes/reasons for ARM
 (11 3) /membranes/woman's questions choice
 (11 4) /membranes/partner's questions choice
 (11 5) /membranes/spontaneous rupture
 (12 1) /episiotomy/woman's/partner's concerns
 (12 2) /episiotomy/reasons for
 (12 3) /episiotomy/woman's choice
 (12 4) /episiotomy/procedure
 (12 5) /episiotomy/perineal trauma
 (12 5 1) /episiotomy/perineal trauma/woman's choice
 (12 5 2) /episiotomy/perineal trauma/procedure
 (12 5 3) /episiotomy/perineal trauma/perineal repair
 (12 5 3 1) /episiotomy/perineal trauma/perineal repair/woman's choice
 (12 5 3 2) /episiotomy/perineal trauma/perineal repair/procedure
 (12 5 4) /episiotomy/perineal trauma/perineal care
 (13 1) /bladder catheterisation/reasons for
 (13 2) /bladder catheterisation/woman's choice
 (14 1) /abdominal examination/fetal position
 (14 2) /abdominal examination/contractions
 (14 3) /abdominal examination/post delivery
 (14 4) /abdominal examination/bladder
 (15 1) /breastfeeding/initiated by woman
 (15 2) /breastfeeding/initiated by midwife
 (15 3) /breastfeeding/information given
 (15 4) /breastfeeding/information sought
 (16 1) /mode of delivery/reason for instrumental operative
 (16 2) /mode of delivery/woman's questions choice
 (16 3) /mode of delivery/procedure
 (16 4) /mode of delivery/consent form
 (16 5) /mode of delivery/manual removal
 (17 1) /placenta exam/parental choice
 (18 1) /neonatal exam/permission sought
 (18 2) /neonatal exam/vitamin K
 (18 3) /neonatal exam/security
 (18 4) /neonatal exam/presence of paediatrician
 (F 1 1) //Free Nodes/communication ability/intellect
 (F 1 2) //Free Nodes/communication ability/part in decision making
 (F 2 1) //Free Nodes/woman's knowledge/PFP classes
 (F 2 2) //Free Nodes/woman's knowledge/read books
 (F 2 3) //Free Nodes/woman's knowledge/previous experience
 (F 3 1) //Free Nodes/professional issues/records
 (F 3 2) //Free Nodes/professional issues/litigation
 (F 3 3) //Free Nodes/professional issues/policies procedures
 (F 3 4) //Free Nodes/professional issues/duty of care
 (F 3 5) //Free Nodes/professional issues/ethical principles
 (F 3 6) //Free Nodes/professional issues/standard of care
 (F 3 7) //Free Nodes/professional issues/standard of information

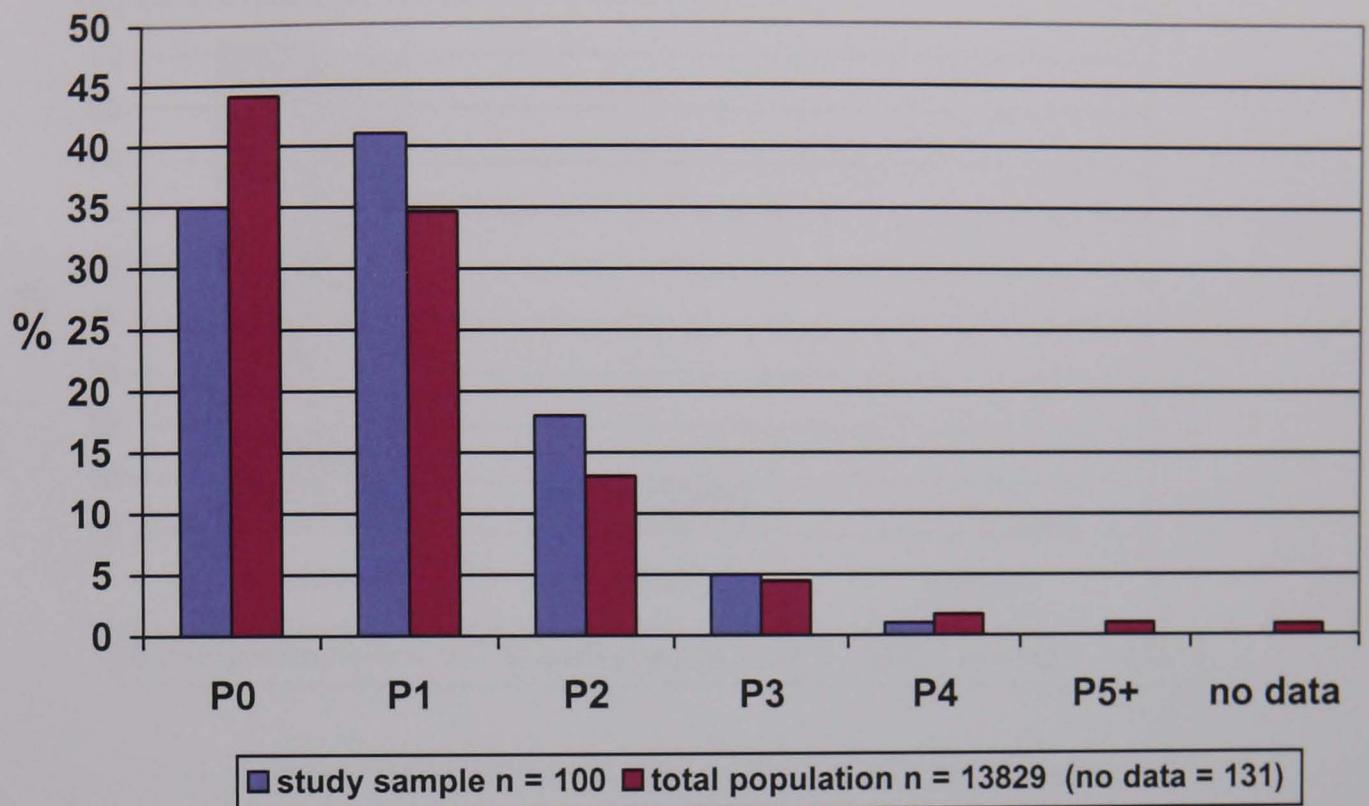
Chart 5(a): Age of the Women.



Cross – tabulation and chi – squared tests were carried out with SPSS on *Age of the Women* and no significant differences were found between the study sample and total population ($p = .972$).

($p = < 0.05$ to be significantly different)

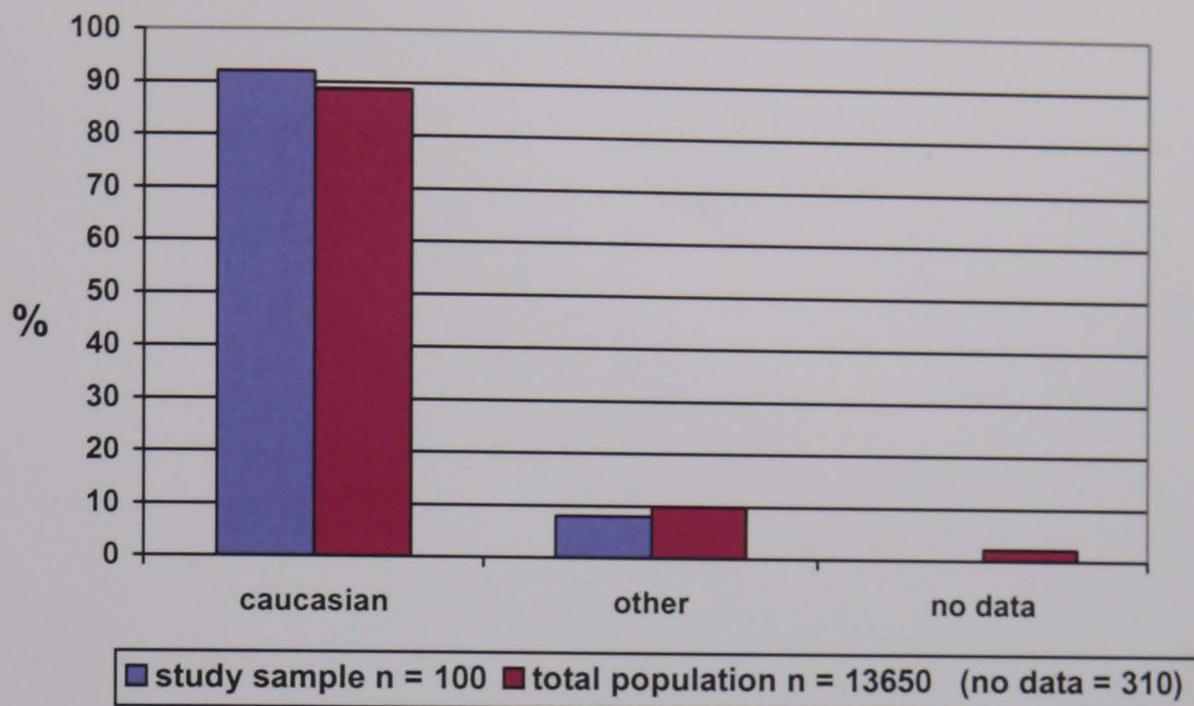
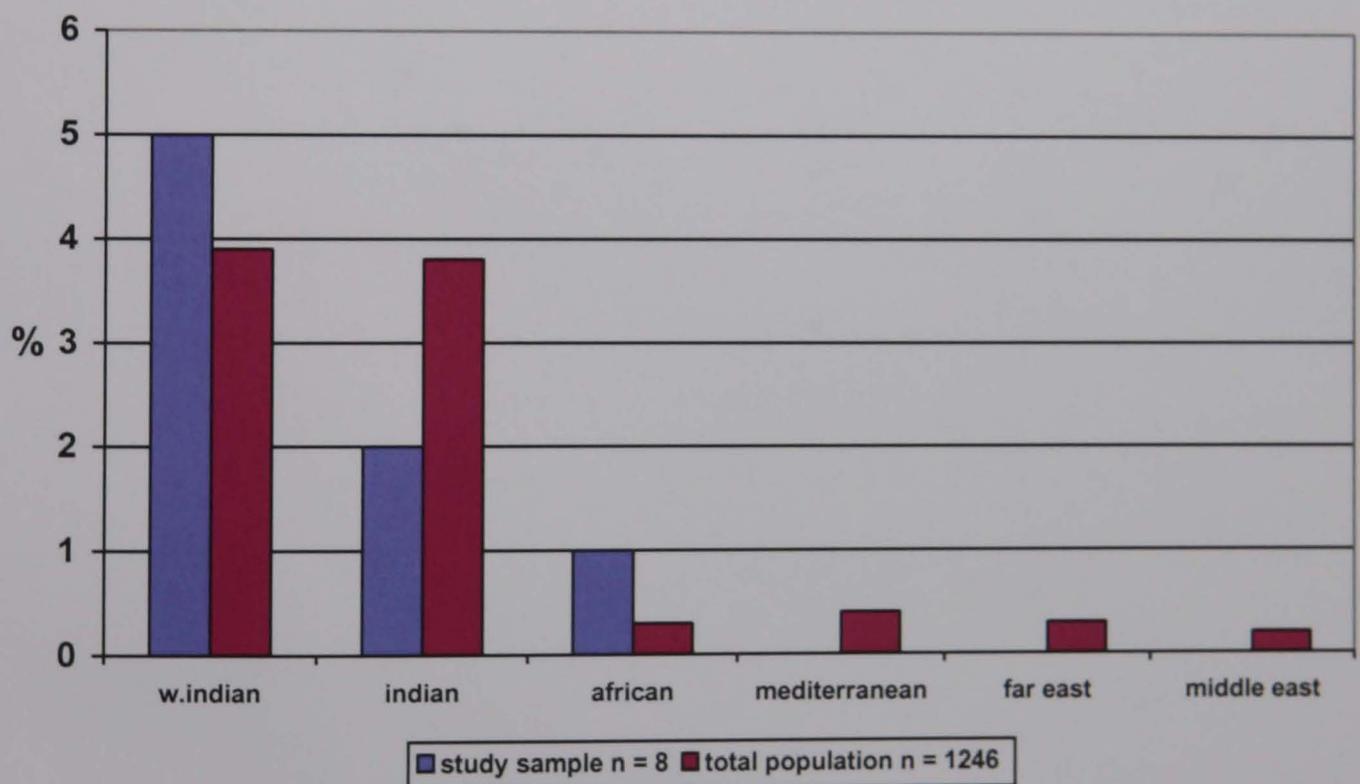
Chart 5(b): Parity (P) of the Women.



Cross – tabulation and chi – squared tests were carried out with SPSS on *Parity of the Women* and no significant differences were found between the study sample and total population ($p = .782$).

($p = < 0.05$ to be significantly different)

Chart 5(c): Ethnic Origin of the Women.

Chart 5(d): *Other* Ethnic Origin of the Women.

Cross – tabulation and chi – squared tests were carried out with SPSS on *Ethnic Origin of the Women* and a significant difference was found between the study sample and total population ($p = .000$).

The difference can be attributed to the total population classifying women in a wider range of other ethnic groups than the study sample, despite there being no significant difference between the two groups for caucasian and other.

($p < 0.05$ to be significantly different)