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Supporting choice and control? Communication and interaction between midwives and women at the antenatal booking visit

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Abstract

This study focused on patterns of communication between midwives and pregnant women and their implications for information, choice and control as now advocated in UK government policy. An earlier casenote audit evaluation of a new organisation of maternity care where midwives carry a personal caseload indicated no difference in quality standards of midwifery care from conventional care, yet women using the service gave a different view. In order to understand whether this difference might be an artefact of the research, responses to change, or a reflection of the limitations of using casenotes for research, an observation-based study was conducted.

Forty interviews were observed in three UK settings: hospital clinic, GP clinic and women's homes. Interviews were tape-recorded and notes and drawings of interaction made. The transcripts were analysed using structured and qualitative approaches. The interactional patterns differed according to model of care i.e. conventional or caseload, and setting of care. Several key 'tasks' in the visits were noted, with risk screening and health education information being dominant in conventional care. A continuum of styles of communication was identified, with the prevalent styles also differing according to location and organisation of care. The hierarchical and formal styles discussed in earlier sociological work were the most common in conventional care, despite the focus of midwifery on being 'with-woman' and the recent policy emphasis on consumer choice. The caseload visits showed a less hierarchical and more conversational form and supported women's reports that this model of care offered them greater information, choice and control. The variation in patterns suggests that context is an important consideration in research of this type, with environment (both micro- and macro-level) and organisation of care influencing the ways in which the concepts of choice or consumerism operate in practice.

Keywords: Maternity services; Midwives; Antenatal care; Consumer choice; UK

Introduction

This study looks at interaction between midwives and women, through observing antenatal 'booking' visits, in different settings under two different models of midwifery care. It was originated as part of a larger research programme evaluating the implementation of a new model of midwifery care in the UK in the 1990s. In this model, midwives carried personal caseloads, with the aim of developing more woman-centred care, facilitating more choice, continuity and control for women, in line with UK government policy. Earlier parts of our research had suggested that women with caseload

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midwives were more satisfied with the care they received, and felt they had more choices in care (Beake, Page, & McCourt, 2001; McCourt, Page, Hewison, & Vail, 1998). However, an audit-based study of quality of care, using medical casenotes, had not indicated any significant differences in the quality of midwifery care provided, between the conventional and the new way of offering care (McCourt & Beake, 2001).

Our experience of conducting audit (using the validated midwifery audit tool Midwifery Monitor) to assess standards of practice revealed limitations linked to the nature and purposes of medical records. We were sensitised to the fact that casenote audit can only measure what is recorded in the notes, in line with the manner in which it is recorded. Medical records are constructed in particular contexts and for particular purposes and a direct, unmediated connection with practice cannot be assumed (Beake, McCourt, & Page, 1998; Berg, 1996). These methodological limitations were particularly pertinent for studying the so-called 'softer' measures such as quality of care.

Owing to this discrepancy in findings between different methods, we planned a small-scale, in-depth observational study of interaction between midwives and women. A series of visits were observed by a researcher, audio-taped and drawings made, and midwives were interviewed briefly after the visit to gain their perceptions. The booking visit was chosen as the focus, since this is the woman's first contact with the maternity service, early in pregnancy, during which a great deal of information is exchanged, initial expectations of the service and relationship with it, are likely to be formed.

Initially, the data were analysed in order to compare directly with the findings obtained by casenote audit. This explored whether there were aspects of the visit and the interaction, which would not be captured well by reliance on notes (Beake et al., 1998; McCourt & Beake, 2001). This article focuses in more depth on the analysis of the transcripts, both structured and qualitative, to explore the nature of information giving, choice and communication with pregnant women, in both conventional and caseload midwifery care.

Background to the study

During the late 20th century, as maternity care in the UK continued to shift towards the hospital and community-based domiciliary midwifery declined, concern about the quality of maternity care in the UK gathered pace (Lewis, 1990; Tew, 1995). Following the UK Health Select Committee enquiry on maternal and infant health (House of Commons, 1992), 'Changing Childbirth' (Department of Health, 1993) advocated a return to more woman-centred care, with choice, continuity and control for pregnant women seen as priorities. Since the turn of the century, concern has been expressed about the lack of progress of this policy, and the continuing rises in medical interventions in childbirth in the UK (Department of Health, 2004). This study sought to understand in greater depth the ways in which midwives work, their relationship with women and to explore the local manifestation of some of these wider issues.

Relatively few studies of maternity care have used observation as well as interview reports by service providers or professionals. Although we identified work in relevant areas such as communication between doctors and patients, maternity care may not be typical of medical encounters: pregnant women are not ill but undergoing a social as well as physiological process; midwives are mostly female, and the issue of social hierarchy may be less prominent.

The earlier sociological work highlighted power relationships between doctors and patients, and features of interaction and communication which enabled the medical encounter to be managed in ritualised ways (Dingwall, 1980; Strong, 1979). In a review of studies, Hauser (1981, Chap. 5) noted gaps and inadequacies in information giving and exchange, with working class patients in particular tending to receive poorer information. This has also been found in studies of women's views of maternity care (Reid & Garcia, 1989). Physicians often failed to listen to patients' accounts, an issue which different studies have linked to cultural factors, including the training and socialisation of doctors, expected social roles, and the medical and organisational context, rather than simply lack of time. We might expect this early work to be less relevant today, with the impact of consumerism, plus greater levels of education and access to information and a decline in social deference. There have also been considerable changes in medical and nursing education. However, as we discuss, similar themes emerged in later studies, including our own.

Porter, in a study observing a large number of ante- and postnatal midwife visits, in hospitals and women's homes during the 1980s, found that little had changed from earlier work, in which staff tended to use stereotypes or 'ideal types' of women and women who asked lots of questions were labelled as neurotic or difficult. She found that women asked few questions and rarely questioned decisions, in an atmosphere which was not conducive to asking, and professionals tended to offer only limited information in most cases, sometimes withheld information and often ignored or dismissed concerns expressed by women (Porter, 1990). Similarly, a study by Lomax and Robinson (1996) used videotapes to record midwife–client interactions, and using conversational analysis, argued that interaction was highly asymmetric, with midwives generally assuming the right to open, direct and close interactions, and

women generally ceding that right, even during postnatal visits in women's homes.

Methven (1989) observed and recorded a number of booking visits in a hospital antenatal clinic, using structured and qualitative approaches to data analysis. She found that standards of communication were generally poor and that women were not treated as equal partners in the process of care. Awareness of women's information needs among doctors and midwives appeared to be very low. On a methodological note, she commented that this was the case, despite the likely observer effect, which might mean professionals will be attempting to conduct a model visit. Her findings suggested that the professionals involved did not regard communication or partnership with the woman as a priority, or that they were unreflectively unaware of the extent to which their conduct of the interviews disregarded the woman's perspective or wishes.

A number of studies focused on screening have been conducted more recently, since this forms a major aspect of modern maternity care. In a systematic review, Green, Hewison, Bekker, Bryant, and Cuckle (2004) concluded that information levels remain inadequate for fully informed choice. In a recent study observing 14 pre-screening consultations with community midwives, as part of a newly introduced nuchal translucency screening programme, Pilnick (2004) concluded 'whilst there is clear evidence that midwives are at pains to explicitly invoke the issue of choice, there are other more subtle factors in the interactional presentation of screening tests that serve to undermine this'. She found that with many areas being covered in this time-pressured visit and the presentation of screening tests which are perceived as mundane (such as blood tests) prior to the Downs screening, the approach tended to frame women's responses in such a way that agreement seemed a matter of course.

The existing literature offers a critique of the adequacy or equality of interactions in medical and midwifery encounters, and suggests that organisational and cultural issues are important in framing them. However, there has been considerable change in policy and acceptance of consumerist principles since much of this work took place. Our study aimed to explore whether, or how, the recent reforms to promote more women-centred care would have a positive impact on interaction between midwives and their clients, particularly regarding the areas of information and choice which have been so extensively critiqued. Although some recent research has studied midwives' communication around screening, these continue to raise concerns about the interactional environment in which women are expected to make an increasing number of 'consumer' choices. They suggest the issues are subtle and complex, and not easily unpicked through research methods which do not include observation. Our study sought to explore the subtle and complex areas of interaction which could not be fully explored through interview or survey techniques.

Methods

The study was conducted in the UK, from 1998 to 1999. An observational approach was used, including non-participant observation of 'booking' visits and brief interviews with midwives directly following the visit. Women were not interviewed, since a longitudinal survey and in-depth postnatal interviews were being conducted to explore women's views and experiences in another part of the research programme (Beake et al., 2001). Forty visit observations were conducted, divided equally between women receiving caseload care and those receiving conventional care, the numbers included being based on the desire to balance depth of work, requiring a small sample, and reasonable diversity of women and midwives.

The models of care operated on a neighbourhood basis, each serving a very socially and ethnically diverse urban population, and women could not self-select into one or the other type of care. Conventional care in this context usually meant 'shared care' for low risk women: care officially shared between the general practitioner and obstetric consultant. Women would have most of their visits with midwives in a community setting, such as a GP surgery, attending hospital for key visits. Women classified as high-risk would be under the care of an obstetric consultant, but would still have many of their visits in a community setting, and with midwives. In caseload care, midwives, instead of being based in either hospital or community teams, carried a personal caseload of 40 women per year (a mix of high and low risk) providing care around the women's needs, in hospital, at home or other settings, from booking through to postnatal care (NCT, 1995). They worked in partnerships to provide cover for women on their caseloads, within group practices that provided peer support and back-up cover.

The caseload midwives had all volunteered to work in this way. At the outset of the scheme, all transferred from existing roles within this NHS Trust, 3 having been community midwives and 17 having worked on hospital wards. By the time this study took place, most had at least a year's experience of caseload practice but several were recent recruits, from within the local service and externally, or were seconded internally to cover maternity leave for an existing caseload midwife. This meant they had limited experience of caseload practice, but all the midwives had at least 1 year's experience since qualification. A linked ethnographic study of the midwives' perspectives showed that most had volunteered because they were frustrated with their conditions of

practice, and several had been considering leaving midwifery (Stevens & McCourt, 2002). Such dissatisfaction with midwifery work was a widespread pattern around the turn of the century (Ball, Curtis, & Kirkham, 2002).

In conventional care, all booking visits took place in either a hospital or a GP surgery clinic (the latter being followed up with a hospital visit for scan and blood tests). The study was conducted, therefore, to observe 10 visits in each setting. Women were approached consecutively in the clinic and informed about the study. Few women declined, possibly reflecting the nature of the setting as well as the study approach. In the hospital clinic, only one midwife did not agree to be observed. In the community clinics, two midwives declined, but as community midwives had more opportunity to avoid participation, it is likely that the rate declining was effectively higher. In both cases, precise numbers of potential midwives cannot be given, since the organisation of these services was highly fragmented, with number of midwives and where they worked on particular days often being unpredictable. It is possible that only the more confident midwives made themselves available to participate. However, as in Methven's (1989) study, we felt that this should not prejudice our findings, since the midwives needed to feel reasonably relaxed and comfortable with our presence.

In caseload care, since all 20 midwives practising in this way in the Trust were willing to participate, a random sample of 10 midwives was drawn and these were asked to explain the study to the next women they were due to 'book' and ask if they would be willing to participate, until two observations had been conducted for each midwife. We were aware that professionals, if not the women themselves, might feel uncomfortable in being observed and recorded or may feel self-conscious and try to present an ideal 'face' to the researcher. Hence, researchers who were not health professionals undertook the observation. Since the research team had already undertaken research locally, they had been able to establish a reasonable level of trust with regular members of staff.

In addition to audio-taping the visits, the observers made brief notes and drawings of the interview room and participants' use of space within it. Interviews with the midwives were brief and informal, and in some cases were conducted in the car en route from a community visit. We asked about their view of the visit and whether it was typical or not, any particular issues the researcher needed to understand, and their own aims and impressions of the visit. This article does not focus on the midwives' views, but we noted considerable disjuncture between the midwives' stated aims of the visits and our analysis of the transcripts themselves, which is briefly addressed below.

Data analysis

All tapes were transcribed fully, checked and annotated by the researchers. The notes taken were used to link drawings to appropriate sections of the transcript. The transcription did not use the full conventions of conversational analysis (Dingwall, 1980), since we were not aiming at a linguistic approach, but key elements such as pauses, overlaps and non-verbal expressions were annotated against the text by the researchers. The analysis was conducted by three researchers, who worked independently at each stage and then met to compare and verify their findings. No major differences were found. Detailed feedback was offered to the midwives involved, and a meeting with hospital midwives generated considerable response and reflection.

The initial stage of data analysis was used to compare this method with casenote audit and has been reported elsewhere (McCourt & Beake, 2001). In summary, this structured 'checklist' analysis showed that interviews in all settings scored highly for physical checks, routine data collection and provision of health educational type information. Visits in conventional care, however, tended to score less highly on types of information needed to underpin choice, and on social or partnership aspects of care, and about offering screening and other choices.

The second stage was a structured analysis of the transcripts to explore patterns of interaction in terms of who talked and when, patterns of talk, asking questions and introducing topics. As Silverman (1987) notes, simple measures such as a log of number of questions asked can give a useful quantified view of the nature of the interview and supports comparison on a more qualitative level.

The third stage was a qualitative analysis, which combined elements of conversational analysis and thematic analysis, using open cross-sectional coding. This focused on the more subtle aspects of interaction, which may not be highlighted by structured analysis.

Findings

Key characteristics of the settings and the women involved are summarised in Table 1. In general, women receiving caseload care were more diverse in terms of ethnicity and socio-economic class, and number of previous births, and the characteristics of women 'booked' in the hospital or community clinics also differed somewhat, with women visiting the hospital-based clinic being mainly of higher occupational class and white European ethnicity, and first-time mothers. This reflects the locality basis of the service organisation, since the area immediately surrounding the main

Table 1
Key characteristics of the settings and the women involved

Details of women seen	Hospital clinic	GP clinic	Conventional total ($n = 20$)	Caseload care ($n = 20$)
Parity				
0	7	6	13	8
1	3	2	5	10
2	0	1	1	0
3	0	1	1	1
4	0	0	0	1
Occupational class[a]				
1	8	2	10	5
2	0	2	2	6
3	0	3	3	5
n/k	2	3	5	4
Teenage mother[b]	0	1	1	3
Ethnicity[a]				
White	9	3	12	10
Black	0	0	0	2
Asian	0	0	0	1
Other	0	1	1	2
Also present				
Husband/partner	3	1	4	6
Family members	0	0	0	2
Own child(ren)	0	1	1	3

[a]Not all women had these details recorded by the midwife. OPCS categories were used but grouped due to small numbers.
[b]We did not make note of women's age except where this was under 19.

maternity unit was relatively affluent, while that served by the caseload practices and some of the GP practice-based community clinics was more diverse with pockets of socio-economic deprivation. As this was not a quantitative study, any possible differences between the women should be viewed very cautiously. This may have had a bearing on the differences between the two conventional care settings, which are discussed below. However, the differences between those women receiving caseload or conventional care do not conform to what might be expected from earlier studies of professional–patient communication, where 'working class' mothers are generally described as receiving poorer information and choice.

As the proportion of first-time mothers differed according to setting, it was difficult to consider what impact this might have on the visit. However, drawing on the qualitative analysis, described below, we could not see any particular pattern that would distinguish these. Hospital and community-based visits tended to follow a history-taking format which is uniform regardless of parity or other characteristics of the woman, even though the qualitative nature of the interaction might vary. There was little evidence of interviews drawing on women's previous pregnancy and birth experiences in conventional care, despite the recording of an 'obstetric history' but this was found in caseload care, where midwives tended to commence a dialogue by talk about women's previous experiences, whether of previous pregnancies or other relevant issues, placing this new pregnancy within a life context. Similarly, there was little evidence that the woman's agency — such as through asking questions or raising topics — differed according to parity.

Structured analysis

Clear patterns were found across the two types of care and between hospital and community clinic visits. The ordering of the interviews also showed interesting patterns. Put simply, the order of conventional care interviews tended to be led by the formal history taking, with information and then questions to follow, following a common pattern. The ordering of caseload interviews was more fluid and variable, often commencing with a general discussion about this or previous pregnancies, with the history taking and more formal information giving either 'sandwiched in' to the discussion or following on from it. This gave them a more narrative form.

In hospital visits, the interaction as reflected in the text was equally divided between a brief answer–response

Table 2
The number of questions asked by women

Setting	Mean	(range)	Led by woman	Led by midwife[a]
Hospital	6.8	(0–20)	3.3	3.5
Community	4.6	(1–9)	1.7	2.9
Caseload	11.8	(1–32)	5.9	6

[a]Led by the midwife signifies questions asked by the woman in direct response to a prompt by the midwife (see example in the text).

type pattern (mainly single lines) and a more mixed pattern: still mainly question and response but with several lines or short paragraphs suggesting more interaction and discussion in these cases. Similarly, they were equally divided between visits where the midwife talked the most and those where midwife and woman each talked for about half the time.

The typical pattern was of midwife asking questions and the woman providing responses, sometimes brief, sometimes with more information according to the issue and the woman occasionally offering information or raising a topic which she thinks the midwife will want to know about.

In community clinic visits, the majority followed a similar line-by-line pattern, with the midwife doing most of the talking. These included the shortest visits, although they were similar in average length to hospital clinic visits (see Table 3). The community midwives commented in interviews that they often had very limited time due to the large number of visits they carry out each day, although times might vary according to how busy a GP clinic was on a particular day. When time is very limited, the midwife, conscious of a long list of questions and topics she is expected to cover in the history taking, may tend to manage the interview in this way. However, it was noted in our qualitative analysis that the tone of these visits varied widely: while some midwives conducted visits in a short space, with a 'brisk but friendly and interested' tone which could leave women feeling positive about an essentially quite rushed visit, and able to ask some questions or save them for later visits, some conveyed an air of lack of interest and a routine job to be done, as illustrated by the following extracts:

W Well at the beginning I think my breasts might have (interrupted)
MW But it is alright now
W Yeah, it is alright now
MW Do you feel tired at all?
W Yeah, sleep a lot, sleep a lot and I get headaches as well
MW Okay good, have you had any smear tests done?
(community midwife, GP clinic visit)

Sixteen of the 20 caseload midwife visits observed took place in women's homes, the remainder at the hospital. The majority of transcripts showed a mixed pattern with midwife and woman talking to equal degrees. A minority of visits showed a pattern where midwife or woman might talk for longer periods with little interruption except brief responses to signal interest. This was also the only set in which some women talked more than the midwife (four cases) and appeared to lead the interview. Most showed a shared, mixed conversational pattern.

Asking questions

A log of number of questions asked by each woman echoed the patterns found in the text and the lengths of the visits, with smallest numbers asked in community clinic visits and largest numbers in caseload visits (see Table 2). In all settings, questions were equally prompted by the midwife or asked independently by the women. The following extract is typical of women's questions prompted by the midwife:

MW Now, are you aware that when you come to book the bed we do a series of blood tests on all mums and mainly to check that you're not carrying … (describes Spina Bifida and Downs test briefly)
W What was the blood test I had on that then for?
MW I believe it's exactly the same thing
W It is, oh right
(community clinic visit)

The range in the numbers of questions asked in visits in each group was also instructive, following a similar pattern, with the narrowest range in the community clinic and the widest in the caseload group. In all settings, however, there was considerable variation between visits in the numbers of questions asked, which could be influenced by both the woman and the midwife. Some women approached the visits clearly ready and confident to ask questions and therefore appeared to influence the pattern of the visit itself. In other cases, women may have wanted to ask questions but found it difficult to do so, even though the

Table 3
Length of the interview and number of topics raised by the woman

	Length of interview[a]		Number of topics	
	Mean	(range)	Mean	(range)
Hospital	3288	(2283–4320)	5.1	(1–10)
Community	3257	(1521–5635)	4.8	(1–7)
Caseload	8217	(2323–14893)	19.3	(2–50)

[a]Length of interview as measured by number of words in transcript

majority of midwives invited the woman to ask questions.[1]

In the caseload visits, which showed the widest variation, this appeared to reflect the opportunity for the midwife to vary the length of the visit and to respond to the woman's expectations. For example, one woman appeared not to have any questions, although the midwife paused with each topic to ask whether she had any, while another asked 32 questions: there was a detailed discussion relating to previous pregnancy loss the woman had suffered, her experiences and concerns.

Length of interviews

Overall, this pattern is reflected in the length of the interviews (see Table 3). Caseload visits were the longest on average but also the most varied in length. Hospital and community clinics were similar on average but community visits were more varied in length than hospital. With only four caseload visits taking place in hospital it is difficult to consider how far setting, rather than organisation of care, may have influenced these patterns. However, in either setting, caseload midwives were not required to follow a fixed clinic schedule and several described time spent in the initial visit as 'time invested for the future' to build knowledge and confidence through developing a relationship with the woman. Hospital-based caseload visits were not among the longest visits, but their pattern in terms of number of questions or topics, and conversational style did not appear to differ from those taking place in the home.

Raising issues

Women often appeared to seek information or discussion more indirectly by raising a topic rather than asking a question (see Table 3). Many of the topics raised were pieces of personal or medical information, which the woman thought might be important or relevant to the history taking. In other cases, they were more indirect means of raising worries, wishes or concerns, suggesting that many women may feel that not all their concerns fall into the realm of proper or valid questions for health professionals. The manner in which topics were raised, as well as the number, varied greatly according to the conversational style of the interview. In those with a very fluent and relaxed conversational style, topics emerged more in the manner of a general 'getting to know you' or wide-ranging discussion about experiences, rather than as indirect forms of questioning. This pattern was found particularly in the caseload interviews and was found alongside the different ordering noted above, where the specific history taking followed on from a more general, open introductory discussion.

Qualitative analysis

The analysis identified a series of core tasks or business of the booking visit: risk and genetic/anomaly screening; health education; information and advice; psycho-social support and introduction to the service/establishing a relationship. The priority given to each varied according to the system and setting of care. In hospital clinics, the focus was primarily on screening, followed by giving information and advice and establishing a corporate relationship. In community clinics, the primary focus was on giving information and advice of a health education type and establishing a team relationship. In caseload visits, the focus was more mixed, across these categories and there was a focus on establishing the midwife-woman relationship.

Screening, information and choice

In conventional practice, although the midwives described introduction to the service as a key aim of the visit, and screening was not emphasised, risk screening occupied a dominant place in terms of time and ordering of the visit. We found that much of the work of screening is invisible in that it is not explicitly acknowledged as such. Some midwives, for example, described the 'booking (ultrasound) scan' as 'a picture of the baby' without explaining its role in 'dating'

[1]Researcher notes record that in instances where the midwife was called away from the room during the visit, women who had been very quiet often quickly turned to the researcher and started to ask questions of them.

gestational age for screening purposes, or the possibility that it would identify anomalies.[2]

MW and you'll have your scan, see baby, they might well tell you the sex if you wanted
(newly appointed caseload midwife, hospital interview)

MW You will be seen by a doctor in which he or she just goes through the history again and check you're in general good health and everything, then you go over to the scan department and have booking in scan, see the baby
W yeah, I can get a picture?
MW it's £3, there's a little place where you pay. And then come back and have another test done which I'll go through and then we'll speak again
(hospital clinic visit)

Established screening technology was treated as routine, despite the rhetoric of informed or consumer choice. Midwives rarely offered information about routine blood tests, or sought explicit (rather than implied) consent for these or for scans.

MW and the hospital will send a letter to tell you when to come to the hospital to be seen by the doctor and to have a scan and some blood taken
(community midwife, GP clinic visit)

MW Now, you are booked under Mr (consultant) and it's likely that he is in the clinic today, so once you've seen me and you've seen the doctor who will examine you, listen to your heart, examine your breasts, he'll give you a smear, examination to take a smear, then you will be asked to wait to see Mr (name) once you have seen Mr (name) then you will be, you are offered a routine scan so you decide whether you would like to have a scan today or not, if you would like a scan go round to the scan department, have your scan and then the booking parentcraft, relaxation classes, having the bloods taken at the end and then booking your appointment for the next visit.
W Hmm, OK
(hospital clinic visit)

In the few instances where women asked for more detailed information, or queried whether they should have them, response tended to block rather than encourage more detailed discussion, and to seek agreement.

In contrast, information was usually given about Downs screening, although this tended to focus on the screening process, rather than information about the condition or discussion of its meaning to the woman, and the language used tended to imply that consent was the norm. This echoed the work of Williams, who found that information tended to stress the negative aspects of the condition being screened for (Williams, Alderson, & Farsides, 2002). It also followed straight on from the discussion of routine tests, which are run through in a rather conveyor-belt fashion, an issue also noted in Pilnick's study, which she suggests tend to normalise the ostensibly less 'routine' tests (2004). The few women who declined the tests were gently tested on their knowledge of the screening, whereas those who agreed were not questioned further. As Pilnick (2004) notes, 'The interactional context in which the information about screening is given appears to be one where the benefits are, to some extent, taken for granted'. This is illustrated by a discussion of cervical screening in one visit:

MW Right, when did you last have a smear test done?
W Years ago
MW Well, I am sure you had it with one of them (older children)
W The last one was after (name)
MW Yes, OK, so that's (year). Were you changing your GP, is that why you haven't had one done?
W No, I just never got around to it
MW Never got around to it
W Doctor (name) gave me a lecture a few months ago
MW OK, so I better not give you another one. You know that you should have it done every three years – yes?
(community midwife, GP clinic visit)

The exception to this pattern was found mainly in caseload visits, where the discussions were wider and more open, appearing to centre on the woman's understanding of and response to the screening on offer. In the following, for example, the midwife discusses with a young mother how she can think about whether to have Downs screening:

MW I mean you don't have to, am, what I mean, the other thing is with most, we start having dating scans for everybody so we can arrange for you to have a scan and then you can have a think about this. There's a leaflet on this stuff and think about whether you want it or not, all right — are you undecided?

[2]At the time of data collection, 'nuchal fold' screening for Downs syndrome was not yet in routine use in this unit, and serum screening was offered to all women.

W I'm undecided
MW No that's fine, what we'll, we'll we'll get you a date for a date scan and you can take that leaflet home and you can, who would you talk to about it?
W Don't know
MW Has anybody else had it (test) in the family?
W Not that I'm aware
MW (continues with explanation of the process, how risk screening works)
(caseload midwife visit)

The language or 'rhetoric' of choice

Two main rhetorical patterns were identified in the use of language relating to choices. We have termed these 'routine as choice' and 'choice as routine'. Routine as choice implies that what is routine is the normal, common and therefore right choice to make. This commonly included terms in describing the visit such as 'you will have' or 'and then you have', or the language of a product for consumption such as 'we do', 'we offer' or 'everyone has'. Choice as routine implies more openness, but still presents certain choices as the routine ones, which most people are likely to make. It also commonly uses consumerist terms, for example, 'what we offer here', 'you can have' or 'it's your choice'. The use of language around choice in the majority of visits appeared to promote what Kirkham and colleagues, in their study of informed choice leaflets in maternity care, termed 'informed compliance' (Stapleton, Kirkham, & Thomas, 2002) since it was difficult for women (and could have appeared disruptive) to interject in the flow or to challenge it.

Conversational patterns

The caseload interviews showed more overlapping, conforming more to the patterns of ordinary conversation rather than the more formal ordering characteristic of much institutional talk (Silverman, 1987, 1997). In certain contexts, and particularly in women's talk, this can be a co-operative form, where participants in a conversation help to make a story together (Gluck & Patai, 1991). This was particularly found in interviews where the midwife had provided care to that woman before, so that the business of the interview was partly about re-establishing a pre-existing relationship and narrative. We also found that at times midwives would join in with a woman's speech, speaking the words with her, as a means of signalling understanding, or echoing her words to signal empathy or sympathy. This latter form was used more when women talked about problems, worries or in the few instances where they had a complaint to make. It was used by some midwives in all settings, but was more common with caseload midwife visits. In community clinic visits, by contrast, interruption appeared to reflect a task-centred approach and failure to listen and respond to the other speaker, since the tone is quite different. The hospital-based midwife, although usually female and in a female-gendered role, acts in the interview as representative of the corporate body of the health service.

Styles of communication

The 'tone' of the visits was generally friendly and efficient and appeared to rely on mutual acceptance that the 'business' of the interview was to 'take a history' and provide outline information on a range of topics identified as important by service providers.

We identified three main styles of communication in the visits. These were adopted in differing degrees in the different systems of care we studied, and were also reflected in the educational styles midwives used in such a way as to indicate that the two styles can characterise an overall approach to the nature and purpose of the visit:

Interactional style	*Health educational model*
Professional: expert guidance	didactic, information transfer
Partnership: participative or collaborative	learner- or adult-centred
Disciplinary: expert surveillance	didactic and correctional

The most common, professional style was characterised by a ceremonial order in which, for the most part, the professional talks, beginning with questions or a brisk introduction to the service, and the client listens but offers relevant information and asks appropriate questions. It typically employs a friendly formality, and impersonal terms such as the corporate 'we' are used. Its functioning appeared to rest partly on assumptions of shared behaviours, expectations and goals and limited, focused communication.

The partnership style was characterised by listening and turn taking in a conversational manner, rather than a ceremonial order, interjection but not interruption (as discussed above) echoing and mirroring of language, posture and movement. It was more likely to employ a narrative style and order.

The disciplinary style was similar to that of the professional style, but with less attention given to client responses, more closed forms, and more use of conversational devices to steer the discussion. The focus on giving correct health information appeared to reflect an assumption of the patient as having faulty or inadequate health knowledge or beliefs and behaviours as illustrated by the following discussion in a community clinic visit:

MW Would you breastfeed the baby or bottle-feed the baby (short pause) you're not keen on the breastfeeding?
W I'm not no, I tried it (interrupted)
MW personal reasons for not wanting to breastfeed
W No, I just, I just felt it too uncomfortable
MW OK, but you know it's best for the baby
W I know it is yeah
MW (goes through health reasons for breastfeeding in detail) …but we can't force you to do anything, its your choice, you've already had two and you said you want to bottle-feed and that's what we have to abide by, ok? But think about it anyway, yes?
W Well I did put it down but because she was so small I never had a chance, she was in the incubator and by the time I got round to it, and then with (name) I tried but like I say I found it too uncomfortable
MW Right, do you have any problem with accommodation?

These styles not only reflect relationships of power and knowledge but they are also likely to differ in their effectiveness in achieving aims of change in health-related behaviour, with the most health-education oriented likely to be the least effective in practice, since the patient's knowledge and experiences are not taken into account.

The disciplinary style was the least common, as might be expected for a voluntary and health-oriented form of care. Although it appeared to be more likely where there was a wide perceived social or cultural difference between professional and patient, small numbers and the class differences between women in hospital or community-based clinics make this difficult to judge This form was only found with midwives in the GP surgery-based antenatal clinics and this may have been co-incidental with socio-economic differences between women attending hospital or GP-based clinics in conventional care. The professional model was characteristic of almost all the remaining conventional care visits. However, the partnership model was found in the majority of the caseload visits, and with a diverse range of women, from teenagers to older professional women and it was notable that the disciplinary style was not found in any of these visits, despite the diversity of the women seen.

The interviews with the midwives clarified that such approaches were not self-consciously adopted. All tended to describe the aims of the visit as being to give information and support (as well as to gather information) and to establish a relationship with the woman — with the team or service in the case of conventional care, and with the individual midwife and her group practice in caseload care.

Midwives described both screening and health education as roles of the booking in their research interviews and these activities are clearly recognised as important aspects of maternity care. However, the extent to which care is oriented around these rather than other potentially important activities is often underestimated. Other aspects of care valued by women, such as social support, or someone knowledgeable to talk things through with, someone to build their trust and confidence in giving birth, were described as important by the midwives but given a secondary role in conventional practice. In the clinic visits, it appeared that they were squeezed out by the format and style as well as the setting of the interview. The screening emphasis has increased in recent years, with technological developments, so that it takes considerable time and attention if tackled with any regard to informed choice (Hewison, 2004; Pilnick, 2004; Sandall & Hundt, 2004).

Midwives' own accounts of what made a 'good visit' also included reference to tacit notions of the 'good patient' and it was apparent in the process of analysis that we had initially underestimated the role of the 'patient' (as opposed to that of the context or professional) in constituting the relationship: relaxed and confident women, who asked appropriate questions tended to put the midwife at ease too, and reduce the appearance of social distance. While it was clear that the ways in which midwives worked and the setting of the visit shaped the nature of the relationship, the perceived characteristics of the woman and her own actions were also important.

Discussion

In summary, the caseload midwife interviews can be viewed as primarily following a partnership model, while those in conventional care primarily follow a professional/client model. The caseload model was developed with specific aims of promoting women-centred care but it is important to consider how a change in the model of care can facilitate such a change in form, within a single professional group, in the same institutional setting.

The data from the interviews can be analysed not only as a particular form of conversation but also as a cultural performance, in which the nature of pregnancy and birth and of the maternity services is represented, and expectations defined. The character of such performance in each of the two systems differs, with the definition of the main actor (professional or pregnant women, or a collaborative performance) differing in each. In the hospital-based system, the nature of such a performance is more ritualised—the form is quite highly prescribed and predictable—and the professional is acknowledged as the main actor (the expert), the client as the audience, although of

course the role of the audience is necessary in order to make up the performance. This latter point is reflected in the ways differences between individual women could modify the prescribed form and order to some, albeit limited, degree—occasional breaks from the order which is quickly restored. It is important to note, also, that the professional actor is not an individual so much as a representative of the service and one might argue that the professionalism of the role has been diminished in favour of a more routine role, which is characteristic of the hospital as an industrial mode of production. Even in our post-industrial healthcare context, features of the production line system persist in hospitals, and the rise of monitoring technology, an audit culture and clinical governance ensure that professionals conform to a relatively protocol driven model of action.

It would appear from this analysis that midwives working in the caseload system were less constrained by either an industrial or a post-industrial protocol driven model of health care. The work reflected greater autonomy in terms of opportunity to make choices and decisions, to self-manage and develop flexible boundaries (Stevens & McCourt, 2002). This could be seen as a more professional model of midwifery (Sandall, 1996) although it displayed fewer overt signs of a professional approach in interacting with women. This may signal a more gendered version of professionalism, but which is not one of semi-profession, as described for nursing (Davies, 1995; McCourt, Page, Hewison, &Vail 1998). The analysis suggests that innovative models of midwifery, such as caseload practice, can offer more choice and control to women, partly through continuity of carer in itself but also since this appears to facilitate a primary orientation towards the 'client' and her community, rather than towards the institution (Kirkham, 1996; Stevens & McCourt, 2002). The caseload model appears closer to the stated midwifery ideal of being 'with the woman' — an ideal which all the midwives expressed in our interviews with them, and in the feedback sessions subsequent to the analysis. The midwives in our study who worked in conventional care experienced considerable dissonance between their ideals and their practice, feeling effectively 'piggy in the middle' between the woman and the hospital. However, the caseload model remains a minority in the UK at the beginning of the 21st century.

This study had strengths and weaknesses. Differences between individual women and professionals in a small study may influence unduly the conclusions which are drawn. However, depth of qualitative analysis and acknowledgement of the complexity of real-life interaction can help to guard against drawing unwarranted conclusions. Our findings were also consistent with those found through other methods of data collection, including a large-scale survey of women, ethnographic study of midwives and audit of casenotes (op.cit.) and our discussion is necessarily informed by this wider work, particularly in understanding the conditions of midwives' work and women's continuing reports of receiving limited information, choice or control in maternity care. They were also consistent with the findings of earlier studies of doctor–patient and midwife–woman interaction. Indeed, the resonance with earlier work was a surprise to us, since consumerist health policies, and the stated midwifery aims of working 'with-woman' might have been expected to effect change. Instead, the relative lack of change with conventional care, as compared to an innovative scheme introduced on a small, pilot scale, required consideration.

Conclusions and implications of the study

As Pilnick (2004) notes, while there has been much discussion and debate about informed choice in health services, very little attention has been given to 'how these policies are practically applied and how they are talked into being'. By focusing on this micro-level, this analysis has been able to illuminate practices which are influenced by, and which inform, the wider social and cultural context of health service delivery. In this system, we see that the rhetoric of informed choice, consumerism and woman-centred care are present, but they are not functional within the current conventional system of maternity care. In many ways, the data were strikingly reminiscent of earlier work on professional–client interaction, even that focused on doctors and their patients. The analysis suggests that greater attention to the issues of power and hierarchy, with consequent structural changes, are needed in order to achieve genuine health service reform and that mainstream maternity care cannot currently be said to be either consumer or midwife driven.

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