

PREGNANT WOMEN'S EXPERIENCES OF MODELS OF CARE IN SOME HOSPITALS IN VICTORIA

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ABSTRACT

During the data analysis of a much larger study on 13 women's experiences of their first pregnancy, their interactions with the health system emerged as significant. Two grounded theory procedures, the *making of comparisons* and the *asking of questions* were used to analyse their experiences. Elements of three models of care were identified, medical/technocratic model, midwifery model, and a feminist perspective model. In some instances, there was blurring and overlapping of models. Tape-recorded, individual interviews were held with 13 pregnant women (aged 34-42 years) in their homes at the end of each trimester and with 10 women again 10-14 days post birth. (Three women were unavailable.) All the women delivered their babies in hospital. Eleven women had an epidural anaesthetic and 11 women had an episiotomy. Information received at antenatal education classes had a marked effect on the women's expectations and the reality of their experiences. The future of implementing midwifery models of care into the hospital system will depend on effective change management and an acknowledgment of consumer needs by administrators.

INTRODUCTION

In the analysis of a grounded theory study of 13 women's experiences of their first pregnancy, their interactions with the health system emerged as relevant and important for health professionals. The women's interactions with the health system included antenatal visits, antenatal education classes, and hospitalisation. This paper explores which models of care the women experienced and also how useful the women found the information disseminated at antenatal education classes. Direct quotations from the women are included.

The frame of reference for the present discussion depicts pregnancy as a social phenomenon. The social nature of pregnancy is obvious: human beings are part of a family, community, and society. Pregnancy is constructed through human beings' actions, that is, the cultural creation of mores and conventions. These actions take place through social interactions in social institutions (Davis-Floyd 1992). Pregnancy and birth have cultural and biological definitions. Herein lies the paradox. The medical model of care espouses, indeed prescribes, behaviours for interacting with the health care system, and there is much evidence that hospital midwives perpetuate the prescriptions while often encouraging the women in antenatal classes to question these same prescriptions (Callaghan 1993).

Feminists and some midwives champion a humanistic, woman-centred, holistic approach to pregnancy and childbirth within a *wellness* and natural framework with increased choice and control and without unnecessary intervention (Crouch and Manderson 1993; Gregg 1995; Lazarus 1994). They also ask for equality of women and men (whoever and wherever they are), and a ritual reintegration of the new mother into society. In addition, midwives advocate continuity of care and a 'partner' relationship between the women and themselves (ACMI 1999; Barclay and Jones 1996).

Both midwives and feminist groups encourage women to ask questions, ask for information, and insist on participation in making decisions about their care. A labouring woman entering the hospital cannot but be in conflict. The messages received during her antenatal visits and education program have engendered a list of behaviours, often conflicting; the community, and often her own preference, are urging her to behave otherwise. The phenomenon of pregnancy is thus prescribed, but the meanings attached to a particular pregnancy at a particular time are individual, specific, and unique.

Recruitment of participants

A convenience sample was obtained through placing flyers, with the researcher's name and contact number, advertising the study in the Health Clinic at La Trobe University, and the Royal Melbourne Institute of Technology (RMIT) both in Melbourne, Australia. Permission to attend a maternity hospital's antenatal clinic was granted. During the initial phone call, the requirements and voluntary nature of the study, and issues of privacy and confidentiality, were explained in a way that enabled the women to give their consent from a position of knowledge and understanding of the purpose of the research. An appointment was then made for the first interview.

In depth interviews, lasting about one hour were conducted with 13 women (aged 34-42 years) in their homes at the end of each trimester. Only 10 women participated in the post birth interview. Three women were unable to keep their appointments. Multiple interviews were chosen because many women experience marked differences between the three trimesters of pregnancy. The interviews were taped and transcribed *verbatim*. Hard copy was posted to each woman giving her the opportunity to read her transcript and make modifications if appropriate.

METHOD

Two qualitative research approaches are incorporated in this study, namely, grounded theory, and a feminist, phenomenological interviewing technique, sometimes called '*phenomenological interviewing*'. This method refers to 'an interviewee-guided investigation of a lived experience that asks almost no prepared questions' (Reinharz 1992, p.21). Data were coded and categorised using the grounded theory method (Strauss and Corbin 1990). The categories created became the concepts that were then examined theoretically. Subcategories that related to the key questions facilitated the grouping of the concepts. Concurrent with the process of identifying concepts were theoretical sensitivity and memoing (Strauss and Corbin 1990). A colleague knowledgeable in

the grounded theory method was invited to read an unmarked first trimester transcript. There was agreement on the numerous concepts and categories identified. This process was followed by axial coding, that is, integrating categories according to their relationship, and selective coding, that is, selecting the core category (Strauss and Corbin 1990). The core category was initially named *adaptation to pregnancy*. Using the *constant comparative method* of data analysis, the aim was to establish the extent of the congruency between what each woman was experiencing and the technical literature in the area. All the data were analysed manually.

To facilitate reading, where models of care are identified, they are compared with the literature from which they are derived, followed by a discussion on antenatal education classes.

RESULTS

Models of care

The women did not experience only one particular model of care, rather aspects of the three models on different occasions during their antenatal visits and hospitalisation. Some women appeared to experience clear instances of one or another model, but generally, they experienced only the medical model. For example, the rigid medical model they encountered during their hospitalisation was occasionally tempered by a particular midwife's philosophy and care either at the bedside or in antenatal education classes. Some childbirth-parenthood educators spoke about the philosophy underlying midwifery and feminist models in their classes, and encouraged the women to behave accordingly, that is, to ask questions, question procedures, and be aware of their choices and options.

During the first interview at the end of the 1st trimester, the women had visited the clinic only once or twice and appeared to be trying to cope with the physical symptoms of fatigue and nausea. They all expressed concern about their inability to control the symptoms. Instances of the pervading medical model during their visits were apparent in their responses.

The person who did the ultrasound didn't give me a chance to look at the baby - he was moving the probe around so quickly. I asked him to slow down - he was just so business-like.

When I told the doctor that I had some spotting he said I should come back next week because 'you could miscarry or anything. Come back and we'll see if you're still pregnant'. I was very upset.

I felt I couldn't ask the doctor any questions - he was very quiet and very busy.

Initially, and during early labour, some women were assertive in their requests to be included in the consultation process. However, by virtue of the fact that all the women considered having an epidural anaesthetic, they were aware that they would be placed in a 'patient' role. Earlier protestations and plans to make their own decisions were no longer relevant. Eleven women had an epidural anaesthetic and 11 women had an episiotomy. Thus, conflict was experienced during hospitalisation when it became clear to them that the environment was not always conducive to permitting alternative choices. However, the women accepted the status quo without question and were very satisfied with their experience. They rationalised that hospitals require rules, regulations, and protocols to function effectively.

The medical/technocratic model

A clear and unequivocal philosophy underpins the medical/technocratic model; the nature and progress of pregnancy are viewed in relationship to an obstetrician, midwife and hospital (Duden 1993; Tavris 1992). The doctor is in charge, the midwife subordinate to her/him, and the woman subordinate to the midwife (Barclay and Jones 1996). The medical model that views birth as potential pathology where anything can go wrong at any time, is the dominant model (Lazarus 1994) that permeates hospital birth and is focused on standards and outcomes (Brodie 1999). Duden (1993, p.75) suggests that the ultrasound plays a 'symbolically predominant role' in antenatal care because of the financial advantages to the doctor and the manufacturers, and 'it promises information, certainty, and control'. Moreover, with the increased use of technology a pregnant woman begins to believe that others are better informed about her condition (Bluff and Holloway 1994). Indeed, even before she embarks on motherhood, 'she is habituated to the idea that others know better and she is dependent on being told' (Duden 1993, p.29). There is evidence to suggest that all health professionals working in the medical model are perceived as experts, and this perception places them in a position of authority, permits them to make decisions for the labouring woman, and thus, tacitly assume control. As a result, the medical model of care has fostered dependency (Ernst 1994).

In western society, it is acknowledged that pregnancy and birth are under the control of the medical profession (Reinharz 1992). One aim of this position is to optimise the safety of mother and foetus/baby during pregnancy and labour (O'Meara 1993). With the increase in sophisticated technology and medical intervention during this period, one adverse effect is that women no longer feel in control of what had always been considered a natural process (Willis 1989). In other words, the greater the sophistication of the technology used, the less control a woman has. Another important aspect of hi-tech childbirth

is that the woman, who would like to know that the technology is available should it be needed, must perforce deliver her baby in a hospital.

Since pregnancy is socially constructed, it is assumed that the women's views reflect, more or less, the views of the health professionals, family, and friends, and those in the literature. However, adding to the confusion is the absence of concord among health professionals on such basic tenets as: whether pregnancy is a natural event or a medical condition; whether birth is as safe for low risk pregnant women inside a hospital as it is at home; the safety of medical intervention (ie, epidural anaesthetic and analgesics during labour); whether women should be encouraged to hand over their care to health professionals at some stage, if at all; the extent to which pregnant women should not only participate in decision making about their care, but also be permitted to make decisions (eg, refuse an episiotomy), and finally, the notion of rights and choices. Some comments about control illustrate that some women, early in their pregnancy, did not feel ambivalent about handing their care over to the health professionals:

I suppose that while I say I like to be in control, I still have enough confidence in health professionals that ... at certain times I understand that I'm going to have to put myself in their hands and accept what's going to happen to me.

I'm not making decisions about what's going to happen any more. I've rationalised that what will happen will happen and I'll just take it as it comes.

I want to be in a position to make decisions, but of course the doctor knows better than I do and will make the ultimate decision.

Midwifery models of care

Midwives have responded to the criticisms of the medical model and the erosion of their role by restaking their claim to 'being with the woman' throughout pregnancy and the postpartum period. According to a discussion paper (ACMI 1999, pp.v-vi), women have indicated:

...a growing preference for midwives to be their primary carers, are wanting improved continuity of care and caregiver, increased choices about their birth place, avoidance of unnecessary intervention, and humanistic rather than technical care.

Midwifery models attempt to address women's demands for a midwife primary carer (Goer 1995; Johnston 1998), and increased choice and control over their pregnancies (Campbell and MacFarlane 1994; Davies and Evans 1991; NHMRC 1996; Rowley 1995).

Midwives espouse a woman-centred model of care within a natural framework (ACMI 1999); midwife as primary carer throughout the pregnancy to postpartum period, continuity of care, humanistic rather than technical care, increased choice and control, and avoidance of unnecessary intervention (ACMI 1999). This philosophy is congruent with their *wellness* framework.

In terms of the childbirth process (care, information, family involvement, technology, and outcome), another midwifery model of care (Barclay and Jones 1996) provides continuity of care, an holistic, positive outlook, shared information, the presence of family members, and the woman's active participation in decision making. The desired outcome is a healthy mother and infant. The women's interactions with midwives during the antenatal period were positive and appreciated.

I'm having shared care. When I saw the doctor my visit was always hurried, but the midwives were patient and friendly and answered all my questions.

I really didn't have much opportunity to ask the doctor any questions. If I had questions, I asked the midwife at the classes.

I'm having shared care and I've been lucky to have nice doctors and midwives.

A feminist perspective of pregnancy and childbirth

The feminist perspective demands that women should be free to choose from a variety of options of procreative technologies; individual rights and choices are emphasised as is the need to contextualise a pregnancy (Gregg 1995). The 'right to choose is an essential value and key organising theme for feminist health activists and the women's health movement' (Gregg 1995, p.11). The message from consumers and feminist movements is that pregnant women must control their lives, accept responsibility for their health, become assertive, and make choices in treatment options (Lazarus 1994).

But prior to this directive, a much older edict from the health professionals, especially the doctors, had been inculcated into the community. The warning was that pregnancy can be hazardous and frequent monitoring is necessary. It would be simplistic to leave the matter there. The situation is compounded by a dual dilemma: from a woman's perspective something can go awry with her pregnancy and birth, and she feels safer in the hospital environment. From the doctor's perspective, s/he must maintain a close watch on the progress of the woman's pregnancy not only in the interests of good antenatal care, but also because of the prospect of litigation. Decisions that were once controlled by the doctor are now controlled by insurance companies (Lazarus 1994).

The feminist critique of the medical model of birth is that the interventionist procedures are not always in the

interests of the woman, and that the model is not conducive to providing the woman with a 'natural' childbirth experience (Crouch and Manderson 1993).

Another problem feminists have with the medical model is that it assumes control of the reproductive process, and, therefore, the woman and her unborn child. Also, the medical model portrays pregnancy as pathology: it is an illness model. Feminists want a woman-centred model. Although feminist perspectives on procreation differ in some respects, collectively they want a model that encourages freedom of choice, with emphasis on rights and choices based on a woman's understanding of her own best interest, the equality of women and men (whoever they may be), and that she should be involved in developing, using, evaluating and disseminating information about the available technologies (Gregg 1995).

There is a view that feminist theories have acted to emancipate nurses and women from medical ideologies (Fleming 1992), but it appears that nurses have been slow to accept feminism as a strategy for liberating themselves (Speedy 1987). Speedy argues that from a feminist perspective nurses are an oppressed group because they do not have autonomy, a criterion of a profession. Nurses exhibit characteristics of oppressed groups (eg, dislike of other nurses, lack of interest in participating in professional organisations, a desire to avoid others in a similar situation, and low self-esteem) (Speedy 1987). And lastly, nurses may have been unwilling to embrace feminism 'due partly to the confusion of what is meant by the concept' (Speedy 1987, p.25).

Antenatal education classes

The importance of antenatal education cannot be overemphasised or overvalued. Antenatal education programs are probably the single greatest source of information for pregnant couples. A central aim of the program is purportedly to provide women with the knowledge to prepare themselves emotionally, physically, and intellectually for their pregnancy, delivery, and subsequent care of themselves and the infant. The information and guidance provided in these programs have the potential to facilitate active participation in decision-making.

To participate in this process, both client and practitioner enter into a dialogue in which the client explicates her needs and expectations. This is clearly a reciprocal process. Dialogue with the client regarding her participation in decision making is often neglected by health professionals who are accustomed to assuming responsibility for the client and making decisions for her (Bluff and Holloway 1994). There is little evidence that any informal discussions are initiated by professionals about choice of place of birth and models of care (Simic et al 1995).

Childbirth/parenthood preparation, or fundamental education, has avowedly two principal components (Birrer 1977, p.276); the first is to prepare couples for the reactions each may feel during the pregnancy, that is, promoting pregnancy adaptation, and the second is to prepare the mother 'for the optimal patterning of the transition period, that is, promoting maternal adaptation'. Collectively, these aims are designed to assist pregnant women and their partners to develop realistic expectations of pregnancy, labour, birth, and early parenting. This view is supported by Nolan (1997) who believes that the pregnant woman and her experiences should be the focus of the educational program.

According to the Ministerial Review of Birthing Services (HDV 1990, p.61), the objectives of childbirth education classes in Victoria are 'typically quite ill-defined' and no apparent systematic evaluation of the classes exist. Also, in respect of qualifications, Brown (1999) found that of the 14 childbirth/parenting educators she interviewed, only one had undertaken a short eight hour course.

Regarding antenatal education programs, the women in the present study made positive comments about the information they received, the friendliness of the childbirth/parenting educator, and the social benefits of being part of a group. They found sharing experiences useful, and felt comfortable and supported by being with other pregnant couples. They all felt that the classes were their major source of information.

The classes are OK, but I think they could have been more realistic. They could have spoken about an induction and this is why we do it. But the explanation about the birth process was good.

I thought the classes were good. I don't think any of us in the group wanted to have a natural birth - I mean without drugs. I think everyone was really keen to find out the pros and cons of pain relief. The midwife brought in a lot of her medical books and we had good discussions.

At the post delivery interview, the women were asked to reflect on the information they had received in the classes and to comment on the extent to which they felt that the classes had prepared them for the onset of labour, delivery, breastfeeding, infant care, and the early days at home. Their comments indicate that, in retrospect, they believe that nothing could have prepared them for these events, especially the intense emotional and physical experience of labour and delivery. They appeared unanimous in the view that too much time was spent on talking about labour (about 10 hours were spent on labour and pain relief, and one half to two hours were spent on breastfeeding, infant care, and going home). They thought that more time should be spent on informing them about breastfeeding (and bottle feeding), looking after oneself following delivery (eg, episiotomy care, pain on passing

urine and having a bowel action, tiredness), infant care and behaviour (eg, how to soothe a crying baby, colic, appropriate responses to infant behaviour, the baby's bowel actions, cord care) and going home. In general, the classes were conducted in six two-hour sessions.

When the contractions started I remember thinking of all the things they taught us about being active, and walking around and using different positions - but I just couldn't do anything.

There was too much information on labour. No one can explain the pain to you. I don't think it's true that we don't want information about baby care and going home.

The classes were OK. We have different labour and different pain thresholds, so you can't tell people what to expect, and so you can't be prepared in one sense, and there's nothing you could learn that would have made any difference.

The classes didn't prepare me for the reality of labour at all but I don't think they could. It didn't happen at all like they said. The best part of the classes was the social aspect.

In particular, most women found the onset of labour distressing because it did not correspond with what they had been told - a unanimous complaint was that '*it didn't happen at all like they said*'. The conflicting information about breastfeeding made some women feel anxious particularly for those women who had difficulty getting the baby to latch on, and if breastfeeding was not established prior to discharge. With the exception of one woman who managed to breastfeed without assistance from a midwife, all the women felt that they were not given sufficient advice and support during feeding times.

DISCUSSION

The women all gave birth in a hospital. Twelve women asked for an epidural anaesthetic, but only 11 women had one. One woman was refused an epidural because of her advanced stage of labour. The medical model was clearly identified but only elements of the midwifery and feminist models became apparent and these mainly through discussions in antenatal education classes. However, the context for each model was different. All the women appeared to be assertive. They had declared during our interviews that they would ask questions, question their treatment, and make decisions about their care. However, most of the women did not engage in any discussions with health professionals regarding their care. Only one woman firmly told the doctor that she did not want an episiotomy. The doctor complied with her request and her perineum did not tear. The other women, having chosen an epidural anaesthetic, were perforce restricted to bed, and assumed a 'patient' role. They had their partners with them, were satisfied with the care they received, and were happy to let

the doctor, midwife, or even their partner, make decisions for them. In fact, two women had instructed their partners to tell the doctor that s/he was not to perform an episiotomy. Since they had asked for an epidural anaesthetic, their instruction was irrelevant. They felt that the health professionals knew best, notwithstanding that the women had previously said that they wanted to be included, and even consulted, in the management of their care.

There is abundant evidence (Brown and Lumley 1994; HDV 1990; McKay and Yager-Smith 1993) that women are not always given the opportunity to assume responsibility for their health and their bodies. Decision-making is crucially bound up with what information is available, what significant others do with any information they have, and how others communicate their own prejudices.

The quality of the information available in turn depends upon how well informed the health professionals are. Simic et al (1995) found that there was little evidence that any informed decisions were initiated by health professionals regarding place of birth or models of care. The women in their study made few demands on the professionals for information: they remained passive. It has been suggested that both health care professionals and consumers become passive in their interaction within an 'established system' (Simic et al 1995, p.40).

CONCLUSION

Trying to determine the particular model of care the women in this study experienced was not difficult. In fact, there were no instances during their hospitalisation that the women experienced anything but the medical model. In defence of this model, having an epidural anaesthetic of necessity results in a woman being restricted to a bed and reliance on health professionals to assist her with the birth. There were glimpses of aspects of midwifery models in some antenatal education lecturers' philosophy. The feminist model was apparent in one instance only: one woman wanted to give birth in a birth centre but was prevented from doing so because of her baby's breech presentation.

If health professionals are serious about getting the community to accept responsibility for their self-care, and the demands on the decreasing health dollar indeed make this imperative, then they must be equally serious about educating their clients so that they are equipped to accept this responsibility.

Messages from the health professionals conducting antenatal education classes are less clear. In many instances, midwives were encouraging the women to be assertive and make their choices known. However, there were occasions when the midwives told the women that the information and procedures discussed in class may

differ from hospital to hospital, and that what was said in the classes was not necessarily the same in the hospitals.

This kind of information and advice may be confusing for some women who want to participate in decisions about their care, particularly in the absence of continuity of care, when the midwife is not present to support them.

The impasse arising from issues surrounding antenatal education classes needs to be addressed as a matter of urgency. Pregnant couples are now asked to pay a fee for the classes and the educators should perforce be made accountable for the information they are disseminating. Hospital administrators should employ suitably educated, qualified, and accredited personnel for this important task. Teachers should articulate an understanding of educational philosophy to direct program content, and have a sound knowledge of teaching and learning strategies. An educational conceptual framework should be used for program development, implementation, and evaluation.

It seems that the future of implementing midwifery models of care into the hospital system will depend to a large extent on effective change management and a very real desire on the part of hospital administrators to acknowledge consumer needs, and make the necessary changes to improve the delivery of services.

IMPLICATIONS FOR HEALTH CARE

If health professionals agree that women do have options and the right to make choices, the hospital environment should be examined for the feasibility of introducing midwifery/feminist models of care. The question of continuity of care needs to be addressed by hospital administrators in the interests of providing the best service: this means continuity of care from the first antenatal visit to the home visit post birth. Together with this activity, an investigation should be conducted into what choices and options are realistically available to pregnant women, and the criteria the women use when making choices.

In order to alleviate some of the anxiety and feelings of loss of control experienced during the 1st trimester, health professionals could focus on preparing the women at their initial and early subsequent visits for the physical and emotional symptoms and thus circumvent the distress they experience at this time. Introducing midwifery models of care into the system will *ipso facto* ensure continuity of care.

Antenatal education classes are a very important source of information and almost all pregnant couples enjoy the social aspect, receiving information and having the opportunity to discuss their concerns. In light of the women's experiences and comments, it is timely for a review and evaluation of the classes and their content. Directives about the course of a pregnancy, labour and

birth are inappropriate: these processes are seldom predictive. Health professionals conducting antenatal education classes should have current knowledge, an understanding of teaching and learning principles, and good teaching skills. Finally, consideration should be given to producing *broad national guidelines and standards* for the classes.

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